Development of Instructional Competencies for Assessing and Managing Suicide Risk for Baccalaureate Nursing Education

Abigail Kotowski

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DEVELOPMENT OF INSTRUCTIONAL COMPETENCIES
FOR ASSESSING AND MANAGING SUICIDE RISK
FOR BACCALAUREATE NURSING EDUCATION

by

Abigail M. Kotowski

April 1, 2015

A dissertation submitted to the Graduate Faculty in Nursing in partial fulfillment of the requirements for the degree of Doctor of Philosophy, City University of New York

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Abstract

DEVELOPMENT OF INSTRUCTIONAL COMPETENCIES
FOR ASSESSING AND MANAGING SUICIDE RISK
FOR BACCALAUREATE NURSING EDUCATION

By Abigail M. Kotowski

Sponsor: Professor Carol F. Roye

Suicide is a major health problem and a leading cause of death throughout the world. Reforming health professional education has been identified as a primary goal for suicide prevention, and although nursing leadership is involved in this reform, nurses frequently lack the competence to care for patients in suicidal crisis. An identified gap in baccalaureate nursing education is instructional competencies for assessing and managing suicide risk. Instructional competencies are targeted components of knowledge, attitudes, and skills that nursing students need to know in order to assess and manage patients expressing suicidal ideation. This study aimed to develop a set of instructional competencies for assessing and managing suicide risk for baccalaureate nursing education using a modified Delphi Method, which is a systematic polling of the opinions of an expert panel knowledgeable on a given topic through iterative surveys, in an attempt to reach group consensus. A focus group, which is a group session moderated by a group leader with the purpose of collecting information on a designated topic, was first conducted in order to develop the Round I Survey which included forty-four competencies. After scoring these competencies, thirty-four were scored for inclusion, two were dropped and eight were revised according to panel members’ comments. During Round II, the eight revised competencies were scored for inclusion, resulting in forty-two competencies in the final set of instructional competencies. Incorporating these instructional competencies into baccalaureate nursing
education might increase the competence of nursing students in caring for patients at risk for suicide.
Acknowledgements

Obtaining a Doctor of Philosophy degree in nursing has always been my goal. I would not have been able to achieve this without the support and love of many people along the way. I want to first thank my husband, John. Without him, this would never have been possible. I thank my sons, Bryan, Kevin, and Owen, for their patience and love. They are the joy of my life! I thank my mother who has always been a guiding light for me. I thank my sister, Helen, who always listened. I thank Dr. Carol Roye, for her kindness, guidance, and wisdom. I will forever be indebted to her. I thank my committee members, Dr. Keville Frederickson, Dr. Steven Baumann, Dr. Jackie Merrill, and Dr. Regina Miranda, for their insight and encouragement. I thank my cohort peers, Joan and Mary, and all faculty at the Graduate Center, who I had the pleasure of getting to know, and who inspired me every step of the way.

Dedication

*To those who have lost their lives by suicide,*
*To those who struggle with thoughts of suicide,*
*To those who have made an attempt on their lives,*
*To those caring for someone who struggles,*
*To those left behind after a death by suicide,*
*To those in recovery, and*
*To all those who work tirelessly to prevent suicide and suicide attempts in our nation.*

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Chapter I. INTRODUCTION

Statement of the Problem

Each year, approximately one million people worldwide die by suicide (American Foundation for Suicide Prevention, [AFSP], 2010). This toll is higher than the total number of deaths each year from war and homicide combined, making suicide the leading cause of violent deaths worldwide (World Health Organization, [WHO], 2013). Suicide is the tenth leading cause of death in the United States (Centers for Disease Control and Prevention, [CDC], 2010a). There were more than 38,000 suicide deaths reported in 2010 in the United States (U.S.) (CDC, 2010b). Moreover, in the U.S., suicide ranks as the third leading cause of death among persons aged 15-24 years (CDC, 2010b), second among persons aged 25-34 years, fourth among persons aged 35-54 years, and eighth among those 55-64 (CDC, 2010b).

The U. S. Surgeon General released a Call to Action to Prevent Suicide (United States Public Health Service, [USPHS], 1999), which introduced a blueprint for reducing suicide in the United States. In 2001, the National Strategy for Suicide Prevention (NSSP) (2001) was developed, which is a coordinated coalition of advocates, clinicians, researchers and survivors to prevent suicide and recommends specific training in the assessment and management of suicidal patients. The New Freedom Commission on Mental Health (NFCMH) (2003), formed to evaluate the mental health care system in the United States, endorsed the proposals of the NSSP (Granello & Granello, 2007). The most recent goals and objectives of the 2012 National Strategy for Suicide Prevention (2012) include the following: promoting suicide prevention as a core component of health care services, implementing effective professional and clinical practices in suicide prevention, and assessing and treating those identified as at risk for suicidal behaviors. In addition, the Institute of Medicine (IOM) (2002) underscored suicide prevention as
a significant health problem, and also advocated for the identification and assessment of potentially suicidal persons. Education for health professionals was identified as a primary goal to aid in suicide prevention, and was included in all the recommendations produced by these initiatives.

Although nursing leadership, particularly the American Nurses Association (ANA) (2012), the National League for Nursing (NLN) (2003), and the American Association of Colleges of Nursing (AACN) (2008) are involved in reforming nursing education, reference to suicide prevention education is absent in any documents critical for curricula development in baccalaureate nursing programs (AACN, 2008; Cronenwett et al., 2007). As one of many key people who come into contact with those at risk for suicide, nurses frequently lack the competence necessary to assess and manage suicide risk (Kalafat, 2006; (Brunero et al, 2008; Chan, Chien, & Tso, 2009a; McAllister et al, 2009; Aflague & Ferszt, 2010). This may be due, in part, to serious gaps in nursing education programs (Puntil et al, 2013) including instructional competencies that nursing students need to know in order to assess and manage a patient expressing suicidal ideation. This study aimed to develop instructional competencies for assessing and managing suicide risk for use in baccalaureate nursing education.

**Need for the Study**

Ongoing advances in science and technology and changing patient demographics are a reality of healthcare practice resulting in an ever changing and increasingly complex healthcare environment. Health professions education must keep up with these changes to build a safer healthcare system. This objective has become a key focus of health professions education following reports from the American Hospital Association (2002), the Robert Wood Johnson Foundation (Kimball & O’Neill, 2002), the Joint Commission on Accreditation for Healthcare
Organizations (JCAHO) (2002) and the Institute of Medicine (IOM) (2001, 2003a, 2003b, 2011). The IOM report “Crossing the Quality Chasm” (2001) described serious deficiencies in the quality of care and patient safety in hospitals, and recommended restructuring education for all health professionals. The publication of “Health Professions Education: A Bridge to Quality” (IOM, 2003a) advocated health care education reform for the 21st century, and proposed a set of core competencies for all health care professionals: provide patient-centered care, work as members of an interdisciplinary team, employ evidence-based practice, apply quality improvement approaches, and utilize informatics. The more recent IOM report, *The Future of Nursing: Leading Change, Advancing Health* (2011) addressed the critical role of nursing, and inspired the IOM to partner with The Robert Wood Johnson Foundation (RWJF) in creating the RWJF Initiative on the future of nursing. In this partnership, the IOM and RWJF are in agreement that accessible, high-quality care cannot be achieved without exceptional nursing care and leadership, and that achieving a successful health care system rests on the future of nursing.

In response to calls for transforming the healthcare system and the way in which health care professionals are educated, the AACN has taken a leadership role in crafting a preferred vision for nursing education. *The Essentials for Baccalaureate Education for Professional Nursing Practice* (AACN, 2008) serves to transform baccalaureate nursing education and focuses on such concepts as patient-centered care, interprofessional teams, evidence based practice, quality improvement, patient safety, informatics, clinical reasoning /critical thinking, genetics and genomics, cultural sensitivity, professionalism, practice across the lifespan, and end of life care.
The Quality and Safety Education for Nurses (QSEN) Project (Cronenwett et al, 2007), funded by the Robert Wood Johnson Foundation and comprised of three phases between 2005 and 2012, is also focused on meeting the challenge of preparing future nurses to have the knowledge, skills and attitudes necessary to continuously improve the quality and safety of the healthcare systems within which they work. These include: patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics. Although the Essentials document (AACN, 2008) and the Quality and Safety Education for Nurses Project report (QSEN) (Cronenwett et al, 2007) use the IOM (2003a) competency guidelines, which stress the importance of patient safety and the prevention of harm to patients through both system effectiveness and individual performance (AACN, 2008; Cronenwett et al, 2007), competencies for assessing and managing specific prevalent health problems are not described. Suicide is an example of such a problem. No actual reference to suicide is present in any of the documents critical for curricula development in baccalaureate nursing programs (AACN, 2008; Cronenwett et al, 2007).

In addition, the Joint Commission on Accreditation for Healthcare Organizations mandates the identification of suicidal patients as a National Patient Safety Goal (JCAHO, 2012) because in healthcare facilities in the United States, patient suicides have ranked in the top five most frequently reported sentinel events since the Sentinel Event Policy was instituted by the U.S. Surgeon General in 1995 (USPHS, 1999). A sentinel event is defined as “an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof” (JCAHO, 2007, p. 5). In 2012, suicide was the 4th most frequently reviewed sentinel event in general hospitals in the U.S. (JCAHO, 2012). Root causes identified by the Joint Commission include: insufficient staff orientation and training, absent or inadequate suicide assessment at
intake, absent or incomplete reassessment during hospitalization and/or at discharge, and incomplete communication among caregivers (JCAHO, 2013a). The majority of nurses (Chitty & Black, 2011) in the U.S continue to work in the hospital setting where approximately 6% of all suicide deaths occur each year (Simon & Hales, 2006). Suicide accounts for many of the largest monetary settlements and judgments against clinicians, and lawsuits related to suicide are one of the most common reasons for litigation against health care professionals (Roberts, Monferrari, & Yeager, 2008).

Suicide is tragic for many reasons. There is the human tragedy, the incalculable impact of loss of life and the emotional trauma experienced by surviving family, friends, health care professionals, and communities that are affected by each person’s completed suicide or suicide attempt. It is estimated that there are typically at least five family members who are affected when a family member dies by suicide, and as many as sixty people in the larger social network who also may be affected (Jordan & McIntosh, 2011). Alarmingly, there is compelling evidence that individuals bereaved by suicide may have an increased risk for suicide completion themselves (Jordan & McIntosh, 2011).

Compounding these costs, recent U.S. data puts yearly medical and work loss costs for nonfatal, self-inflicted injuries at $7 billion, and for completed suicide at nearly $35 billion (CDC, 2010a). Internationally, the annual economic cost of attempted and completed suicide is also estimated to be in the billions of dollars (Corso et al, 2007). Even more tragic is that many people who have attempted suicide reported afterward, that they just wanted their suffering to end; they wanted to be free of their “psychache;” the psychological pain of negative emotions that can cause overwhelming pain (Shneidman, 2005). Extreme ambivalence is also reported; some say they just wanted someone to talk to (Cardell, 2008). Thus, it is likely that many people
who have succeeded in taking their lives could have been saved, if someone had noticed and
intervened.

Nurses are quite likely to be that “someone.” As the largest group of health care
providers in the United States, (ANA, 2012), and the most trusted health care professionals
(Jones, 2010), nurses have frequent contact with individuals seeking health care, whether in the
hospital, in the outpatient setting, or in the community. Nurses are readily positioned to
intervene with individuals who are at risk for suicide because people who contemplate suicide
often complain of physical problems (Aflague & Ferszt, 2010), and make contact with health
care professionals within relatively short periods of time before their deaths (New York City
Health and Hospitals Corporation, [HHC], (2005). An identified gap in baccalaureate nursing
education is instructional competencies for nursing students for assessing and managing suicide
risk.

Purpose of the Study

In response to the need for competent graduate nurses, the goal of this study was to
develop instructional competencies for assessing and managing suicide risk in all patient
populations for use in baccalaureate nursing programs. This set of instructional competencies
was developed through expert consensus using a modified Delphi Method (Dalkey et al, 1972)
beginning with a focus group. Recruitment for the focus group participants was through the
Principal Investigator’s (PI) professional network. A two-round Delphi Study followed after
recruitment of the Delphi Study panel members through the American Psychiatric Nurses
Association (APNA) (www.apna.org) and the American Nurses Association (ANA)
(www.ana.org).
Significance of the Study

Nurses are the largest group of health care providers in the United States, numbering more than 3 million (ANA, 2012), and people who are feeling suicidal often make contact with health care professionals prior to completing the act of suicide (New York City Health & Hospitals Corporation (NYCHHC), 2005; Perhats & Valdez, 2008). The majority of nurses (Chitty & Black, 2011) in the U.S continue to work in the hospital setting where approximately 6% of all suicide deaths occur each year (Simon & Hales, 2006). It is important to note though, that only 0.1 - 0.4% of inpatient suicides are psychiatric admissions (Simon & Hales, 2006), making suicide prevention education a priority for all nurses in any health care setting and with any patient population.

A patient population at high risk for suicide is the elderly population (Lapierre et al, 2011). The elderly are the fastest growing segment of our population (Chitty & Black, 2011), and greater users of health care than any other population segment (Valentino, 2002). Although suicide rates continue to increase in many populations, suicide rates are now highest among the elderly (Lapierre et al, 2011). This indicates that older adults may possibly die by their own hand unless health professionals are competent in assessing and managing suicide risk. Increasingly, nurses must be able to care for the elderly and for all populations.

The goals and objectives of the National Suicide Prevention Strategy (2012) include the following: promoting suicide prevention as a core component of health care services, promoting and implementing effective professional and clinical practices, assessing and treating those identified at risk for suicidal behaviors, and promoting and implementing effective professional and clinical practices in suicide prevention (United States Department of Health and Human Services, [USDHHS], 2012). Although nurses are committed to providing quality assessment
and care management, the current literature describes a lack of competence in nurses in assessing and managing suicide risk. Nurses and student nurses must be competent in assessing and managing suicide risk because suicide can be prevented (Perhats & Valdez, 2008).

**Research Question**

This study addressed the question: What are the instructional competencies for assessing and managing suicide risk for baccalaureate nursing education? The specific aim was to develop instructional competencies for assessing and managing suicide risk for baccalaureate nursing education with a modified Delphi study. The traditional Delphi Method is a systematic polling of the opinions of a panel of experts knowledgeable on a given topic through iterative questionnaires, referred to as “rounds” (Dalkey, et al., 1972), administered either through postal rounds or electronically via email (Keeney, Hasson, & McKenna, 2011). The traditional Delphi Method can be modified based on the research question, and may include a different mode of interaction such as a focus group.

In this modified Delphi Method, a focus group was undertaken for the development of the Round I Survey. A focus group is defined as a “semi structured group session, moderated by a group leader, held in an informal setting, with the purpose of collecting information on a designated topic’ (Carey, 1994, p. 226). An initial list of competencies for assessing and managing suicide risk suggested by a focus group of nursing experts was compiled with suggested competencies from the Best Practice Registry of the National Strategy for Suicide Prevention. After revision, the suggested competencies became the Round I Survey for the first round of this modified Delphi Study. A second round resulted in a set of instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.
Theoretical Framework

The MACH Model (Miner, Childers, Alpern, Cioffi, Hunt, 2005) offers a conceptual framework which serves as a logic map that represents the associations among the objectives and challenges within the development of individual competence and workforce competence, thus addressing the need for instructional competence. The model, named using the first initials of the five authors’ last names, was developed at Emory University, Rollins School of Public Health, in response to the Centers for Disease Control and Prevention (CDC, 2003) imperative to develop a competent and sustainable workforce (Miner et al, 2005). As shown in Figure 1, the MACH Model (Miner et al, 2005) contains eight main components: workforce competencies; defining elements; instructional competencies; curriculum process; individual performance; organizational performance; credentialing and accreditation; and intervening variables.

Figure 1. The MACH Model
The MACH Model demonstrates the reciprocal relationship shared between individual performance and organizational performance. The underlying assumption is that once enhanced individual performance is achieved, organizational performance will improve. A systematic approach is offered which describes the identification of workforce competencies as the first step toward improved workforce capacity. *Workforce competencies* are often condensed summaries that focus primarily on the final set of outcomes expected for the workforce (Miner et al, 2005).

Within the workforce, certain elements must be defined: the “who, what, where, and how” (Minor et al, 2005, p. 120). Information must be gathered on who the workers are, and what their experiences and skill levels are. Where they perform their job must be examined, as well as, how they perform their job. Requirements of the workforce must be determined, and when there are gaps in worker capabilities, instructional competencies can be developed to bridge these gaps.

*Instructional competencies* are the basic steps that build on and reinforce one another, leading to higher levels of learning (Miner et al, 2005). These competencies are modeled after the sequential learning illustrated in Bloom’s taxonomy (Bloom et al, 1956) which describes a hierarchy of education that is categorized from the simplest actions to the most complex (Gronlund, 1995). Through the use of instructional competencies, larger skills are broken down resulting in small, targeted components of knowledge, attitudes, and skills.

The development of instructional competencies is an important process for any discipline, as competencies define the expected capacities of individuals, and are complementary to the performance standards for organizations (Gebbie et al., 2002a). Having these competencies in
place provides a structure by which individual needs can be assessed and subsequently met. Once the instructional competencies are developed, the components described in the MACH Model (Miner et al, 2005) can guide individuals and organizations in taking steps to improve their performance. Mechanisms that assess individual and organizational performance according to relevant and consistent standards are the processes of credentialing and accreditation (Miner et al, 2005). Credentialing provides evaluation criteria for individual abilities, and offers recognition of individual performance. Accreditation is similar to credentialing but is related to organizational performance, whereby an organization is evaluated and held accountable for its performance.

**Rationale**

The approach described by the MACH Model (Miner et al, 2005) describes a reciprocal process among organizational and individual performance, and workforce and instructional competencies. The expected organizational performance is defined, followed by the explicit or implicit definitions of workforce competencies, which are the expected outcomes for the workforce. Within the health care environment, workforce competencies for nurses targeting suicide prevention do not exist, yet the challenge of preventing suicide relies initially on a systems-wide approach within the organization (Covington & Hogan, 2011). Organizational performance and workforce competencies should be defined in the area of suicide prevention thereby ensuring a commitment to patient safety, which is the most fundamental responsibility of health care (Covington & Hogan, 2011). An example of a workforce competency for this study could be the statement: “The baccalaureate graduate nurse will develop a response plan for assessing and managing suicide risk in the health care environment.”
Although not formally stipulated within the health care environment, competence in assessing and managing suicide risk is implied. Nurses, as part of the workforce, must be competent in suicide prevention because nurses have continuous access to individuals at risk for suicide, and implicit within their professional and ethical obligations (ANA, 2010), is the duty to provide patient-centered care and ensure patient safety (IOM, 2003a; Cronenwett et al, 2007; & AACN, 2008). Due to a gap though in the assessment and management of suicide risk in baccalaureate nursing education (Puntil et al, 2013), nursing leadership must address this and ensure that nurses are prepared to face the challenge of assessing and managing those at risk for suicide. Instructional competencies can bridge this gap through preparation during baccalaureate nursing education. For example, an instructional competency for this study might read: “The baccalaureate graduate nurse will demonstrate knowledge of the risk factors for suicide.”

Once instructional competencies have been identified, nursing faculty can use these competencies as a guide for developing and administering training and education programs through the curriculum process, which is a central piece of the MACH Model (Miner et al, 2005). Through the cyclical interaction among the five components of the curriculum process: assessment, planning, development, delivery, and evaluation, a structure is in place by which individual needs can be targeted resulting in individual competence. Future implementation and evaluation of these competencies is expected to improve individual performance in assessing and managing suicide risk. Ultimately, appropriate competencies will improve organizational performance in the area of suicide prevention.

Credentialing in the assessment and management of suicide risk may be a future goal of the developed instructional competencies. Further investigation will determine the need for certification in suicide risk assessment and management, and ongoing renewal with nurse
licensure. Accreditation, which evaluates organizations and holds them accountable for workplace performance, may be impacted by the workforce competence in suicide prevention. Through these processes, individual and workforce competence in assessing and managing suicide risk will result in improved capacity of the workforce to meet the challenging demands of persons at risk for suicide.

The MACH Model identifies the importance of competency in ensuring both individual and organizational performance. Recognition of the reciprocal relationship between individual performance and organizational performance is imperative. Individual competence in assessing and managing suicide risk must be ensured during baccalaureate nursing education, because improved individual competence results in improved workforce competence. This leads to overall improved workforce capacity and organizational performance in the area of suicide prevention.

Assumptions

Assumptions of this study were: (1) nursing students may lack the necessary competence to assess and manage suicide risk because of limited theoretical education and clinical preparation in suicide prevention during baccalaureate nursing education; (2) nursing students may feel that patients who are physically ill are more in need of their attention, and are, therefore, more focused on the physiological needs of patients, rather than their psychological needs; and (3) nursing students may think suicide prevention education is only necessary for patients with mental illness.

Limitations

Limitations of this study were: (1) the ongoing time and attention commitment from participants may have resulted in attrition of panel members (Zinn, Zalokowski, & Hunter, 2001;
(2) the wording of the Delphi survey may have led to misinterpretation (Linstone, 1975); (3) Delphi panel members may have felt group pressure to change their responses in order to conform (Stewart, 1987; Geist, 2009) resulting in consensus representing collective bias rather than true opinion (Chan, 1982); (4) the opinions of the expert panel were limited to the knowledge, skills, and experiences that members possess, and their interpretations of the issues being investigated; (5) the researcher brought her own limited knowledge, skills, and experiences to this study, and her own unique ways of interpreting the issues being investigated; and (6) since this study is based on the opinions of a select group of experts, generalization of results should be made with caution.

**Delimitations**

Delimitations in this study were: (1) the quasi-anonymity afforded participants because the researcher knew them by their email address and their responses which may have inhibited full disclosure; (2) the criteria for “expertise” of participants which was determined by the researcher, as well as, the selection of participants (Hill & Fowles, 1975; Preble, 1983); and (3) the researcher’s invitation to include only members of the ANA and the APNA for participation on the Delphi panel who met three specific inclusion criteria (see Table 3.6).

**Organization of the Study**

This research study will be presented in five chapters. The first three chapters encompass the proposal. Chapter 1 includes the statement of the problem, need for the study, purpose of the study, significance of the study, research question, theoretical framework and rationale, assumptions, limitations, and delimitations. This chapter provides an introduction to the problem of suicide, suicide prevention efforts, and nurses’ lack of competence in assessing and managing suicide risk. This study was needed because, although health professions education is being
reformed because of deficiencies in the quality of care and patient safety, instructional competencies for assessing and managing suicide risk are absent in baccalaureate nursing education. The purpose of this study was to develop instructional competencies for assessing and managing suicide risk for baccalaureate nursing education. The significance of the study is that nurses are the largest group of health care providers in the United States, numbering more than 3 million (ANA, 2008), and many people who are feeling suicidal often make contact with health care professionals prior to completing the act of suicide. The MACH Model (Miner et al, 2005) provided the framework for the study which represents a systematic process for identifying and meeting training and educational needs of individuals that ultimately meet organizational needs. Assumptions, limitations and delimitations of the study were also described.

Following Chapter 1, Chapter 2 presents a review of the literature, which includes suicide prevention education research involving nurses, baccalaureate nursing education, competency development, instructional competency development related to pre-assessment, assessment and management competencies for suicide risk, and a chapter summary. Chapter 3 describes the methodology used for this research study. An introduction and an overview of the research method are followed by the proposed research, a modified Delphi Method, and a chapter summary. Chapter 4 includes a presentation and analysis of the data, and a chapter summary. Chapter 5 provides a summary of the study, a discussion of the findings, implications for practice, recommendations for further study, and the conclusions of the study.
Chapter II. REVIEW OF THE LITERATURE

Introduction

This chapter includes a review of the literature for the study variables; baccalaureate nursing education, competency development, and instructional competency development related to pre-assessment, assessment and management competencies for suicide risk. Research investigating the impact of suicide prevention education on nurses will first be reviewed, followed by a brief introduction to the history of baccalaureate nursing education. Competency development and instructional competency development are then presented with an introduction to the topic of suicide, and necessary components for assessing and managing suicide risk. Finally in the summary, the relationship among the variables is discussed.

Suicide Prevention Education Research

A review of the literature related to assessing and managing suicide risk for student nurses and graduate nurses was performed using CINAHL, Medline, Pubmed, PsycINFO, and SocINDEX. The search was limited to English language articles published between 2003 -2013. Search terms were used in numerous combinations, for example, “student nurses,” “graduate nurses,” “assessment and management of suicide risk,” and “suicide prevention education,” resulting in few results.

Interdisciplinary Research on Suicide Prevention

The Skills Training On Risk Management (STORM) training initiative, which consists of four modules completed over two days, was evaluated in a mixed methods study (Gask et al, 2006) in three mental health services in the North-West of England, United Kingdom (U.K.), because training for health workers has been widely advocated as a key route to suicide prevention. Quantitative data were obtained from staff members (n = 458), who included
nursing students \((n = 21)\), nurses \((n = 218)\), nursing assistants \((n = 95)\), medical and psychiatric physicians \((n = 26)\), occupational therapists \((n = 25)\), support workers \((n = 23)\), social workers \((n = 13)\), administrative staff \((n = 2)\), a psychologist \((n = 1)\), and an art therapist \((n = 1)\). Attitudes, confidence, and skill acquisition, such as assessment, crisis management, problem-solving, and crisis intervention, were evaluated before training, immediately after training, and four-months after training.

Significantly positive changes in attitudes and confidence were shown on immediate posttest and at four-six month follow-up. Participants expressed a more positive attitude and increased confidence toward caring for persons with suicidal ideation due to STORM training which provided them with the knowledge that suicidal ideation is often due to depressive symptoms and hopelessness, and not attention-seeking behavior; and that people with suicidal ideation will often respond to intervention. No differences were found between pre- and immediate post-training, or at four-month follow-up regarding skill acquisition.

Qualitative interviews \((n = 16)\), conducted to explore the impact of the STORM training initiative on clinical practice, included six nurses. These interviews revealed important insights into changes they implemented in their clinical practice, particularly for less experienced nursing staff, but also revealed concerns about the lack of an educational culture to foster and support STORM interventions in practice within the organizations. STORM training for the assessment and management of suicide risk is both feasible and acceptable in that setting, however, uncertainty remains regarding its longer-term impact because follow-up was only done at four months post training. Engagement of senior staff in the importance of STORM training and regular supervision that links STORM training to actual clinical experience would likely be necessary for the training initiative to be more effective.
A longitudinal pre-postsurvey (Matthieu et al, 2009) identified training outcomes and educational preferences of New York State Veterans Health Administration (VHA) employees \((n = 71)\) (physicians, nurses \((n = 5)\), psychologists, social workers, administrative staff and paraprofessional community outreach workers) related to suicide prevention education. In response to case reports of suicides of deployed soldiers upon return from the wars in Iraq and Afghanistan, the increased risk of suicide among veterans in the community, and the elevated rates of suicide among older cohorts of healthcare-seeking veterans with psychiatric disorders, training and a needs assessment of VHA clinical professionals and nonclinical staff were initiated.

VHA employees participated in a brief 2-hour standardized gatekeeper program; the Question, Persuade, and Refer Gatekeeper Program (Quinett, 1995). Gatekeepers are defined as community members and staff who, with training, can identify individuals in distress and refer them to care before a suicidal crisis (Mann et al, 2005). A 1-hour multimedia training was presented to study participants followed by an opportunity to practice gatekeeper skills in a small peer group format. Results indicated significant increases in knowledge and self-efficacy for all participants from pre- to immediate posttest. At 1-year follow-up however, knowledge scores reverted back to scores similar to pre-training levels, whereas improvement in scores for self-efficacy in identifying and referring those at risk for suicide remained significantly better than before the intervention at 1-year follow-up. Participants at immediate posttest also rated the educational program highly indicating it was valuable (96%) and recommendable (96%); and at 1-year follow-up, ratings of the educational program remained high, though were slightly lower; valuable (86%) and recommendable (81%). Finally, the educational needs assessment revealed
that nearly all participants were interested in more training on the topic of suicide and suicide prevention.

A three-hour nurse-led suicide prevention training (Jones, 2010) in North Wales was provided to multidisciplinary staff (*n* = 215), including nurses, psychiatrists, health care support workers, occupational therapists, social workers, and project workers. The number of participants in each occupational category was not identified. The training acknowledged risk factors and risk assessment tools, but was primarily focused on the importance of empathy in assessing for suicidality. The central theme of establishing and maintaining empathy in interaction with all patients was included, and much of Barker’s (2004, 2006) ‘ten commitments’ were discussed; for example, ‘valuing the voice,’ developing genuine curiosity,’ and ‘becoming the apprentice.’ Media involvement and case discussion were also part of the training.

Media involvement specifically discussed newspaper coverage of people who had recently died by suicide, with an emphasis on how people living anywhere might consider that their life is no longer worth living and how individual citizens and members of a community can play a role in stimulating hope in others. The British Broadcasting Corporation medical drama, *Casualty*, is featured which provides a sensitive portrayal of self-harm and attempted suicide focusing on a junior doctor who attempts to end her life by hanging. The drama is included to demonstrate to staff that suicide affects people in all walks of life and with different personality attributes as well as to show that false confidence may mask significant insecurities. An area of the training which also encourages debate and learning is the case discussion, where clinical cases present a variety of challenges in assessing and managing suicide risk.

Questionnaires on topics such as national strategies for suicide prevention and establishing empathy with persons in suicidal crisis were completed immediately after training.
Results of the brief reviews were not described, but positive feedback was received with comments ranging from requests for a longer training program to feeling better prepared to talk with a person at risk for suicide. Comments relating to what could have been done better included: more time to discuss cases, more than just a half-day, and more emphasis on young people at risk for suicide.

A three-hour suicide risk assessment and management workshop (Pisani et al, 2012) to improve provider knowledge, confidence, and risk assessment and management skills involved a multidisciplinary sample of professionals and trainees (n = 338), including registered nurses (n = 77), working in ambulatory or impatient services in Upstate New York. Pre- and immediate post-workshop questionnaires were completed on clinician competency domains targeted by the Commitment to Living Curriculum (CTL) which included: attitudes and approach, understanding suicide and collecting assessment information, formulating risk and developing a treatment and services plan. Three innovative strategies for teaching suicide risk assessment and response were used in the CTL curriculum: (1) the CTL content was delivered through a visual concept map, which is a diagram which shows relationships between concepts; (2) examples from medical record documentation were used to teach core competencies in assessment and safety planning; and (3) context-specific options were provided for responding to suicide risk. Participants’ knowledge, confidence, and risk assessment and management skills improved significantly, and participants’ expectation about their ability to transfer workshop content to their clinical practice was high (mean = 4.10 on 1–5 scale). These findings suggest that CTL may be a promising, innovative, and efficient curriculum for educating practicing clinicians to assess and respond to suicide risk.
A 6.5 hour educational program (Huh et al, 2012), using a mixed-method design, was developed and implemented to increase awareness and improve suicide risk assessment and management training for a range of healthcare providers (n = 130) working with older adults in Veterans Affairs Medical Centers in California. Providers across the spectrum of care have limited training in suicide risk assessment and management and particularly lack training in suicide prevention for older adults, who are at high risk for completing suicide, and more likely to seek mental health services from providers outside of traditional mental health care settings (Juurink et al, 2004; Simning et al, 2010). Participants included nurses (n = 24), medical physicians (n = 3), psychiatrists (n = 9), psychologists (n = 31), social workers (n = 58) an occupational therapist (n = 1), a recreational therapist (n = 1), a chaplain (n = 1), and an administrator (n = 1) from a variety of care settings, including outpatient and inpatient medical, outpatient and inpatient mental health, specialty clinics, home-based, and community settings.

Participants were presented with vignettes describing older adults at risk for suicide, and asked to write a case note reflecting their suicide risk assessment and management for those patients. Pre-, immediate postworkshop, and 3-month follow-up case notes were completed by the participants, asking them to report on subjective changes in knowledge, attitudes, and confidence in assessment and managing suicide risk in older adults. Improvement in the overall quality of case notes, greater ability to recognize important conceptual suicide risk categories, and reported heightened awareness of the prevalence of late-life suicide was demonstrated by the participants. Qualitative comments from the participants focused on practice level changes in which participants reported incorporating knowledge gained from the workshop into their professional practice, such as the use of suicide risk assessment scales. The results suggest that
educational training may have a beneficial effect on the ability of multidisciplinary care providers to identify suicide risk in older adults.

**Table 2.1: Interdisciplinary Research on Suicide Prevention**

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>STUDY DESIGN</th>
<th>SAMPLE POPULATION</th>
<th>LEARNING OBJECTIVE</th>
<th>STUDY OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Gask et al / 2006)</td>
<td>Mixed-methods; 2 days;</td>
<td>Multidisciplines (n=458); RNs (n=218)</td>
<td>Evaluation of Skills Training on Risk Management (STORM) training initiative</td>
<td>Improvement pre-post-four m f/u in attitudes &amp; confidence; No change in skill acquisition</td>
</tr>
<tr>
<td></td>
<td>Quantitative / Pre-test/</td>
<td>Nursing students (n=21)</td>
<td></td>
<td>Changes in clinical practice but lack of support to maintain change voiced</td>
</tr>
<tr>
<td></td>
<td>Immediate post/ 4-6 m f/u;</td>
<td>Interviews (n=16); RNs (n=6)</td>
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<tr>
<td></td>
<td>Qualitative</td>
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<tr>
<td>(Matthieu et al / 2009)</td>
<td>Quantitative; 2 hours</td>
<td>Multidisciplines (n=71); RNs (n=5)</td>
<td>Evaluation of Question, Persuade, &amp; Refer (QPR) Gatekeeper Program</td>
<td>Improvement pre-post in knowledge &amp; self-efficacy At 1 yr f/u, knowledge levels reverted to pretraining levels; self-efficacy sustained</td>
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<td></td>
<td>Pre-test/</td>
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<td>Immediate post/ 1yr f/u;</td>
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<tr>
<td></td>
<td>Qualitative</td>
<td></td>
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<tr>
<td>(Jones / 2010)</td>
<td>Mixed-methods; 3 hours</td>
<td>Multidisciplines (n=215); RNs (n=?)</td>
<td>Evaluation of a suicide awareness course based on Barker’s Ten Commitments</td>
<td>Results of the brief reviews were not described</td>
</tr>
<tr>
<td></td>
<td>Quantitative/</td>
<td></td>
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<td>Requests for longer training and comments of feeling better prepared to talk with a person at risk</td>
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<td></td>
<td>Pre-test/</td>
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<td>Immediate post/</td>
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<td></td>
<td>Qualitative</td>
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<tr>
<td>(Pisani et al / 2012)</td>
<td>Quantitative; 3 hours</td>
<td>Multidisciplines (n=338); RNs (n=77)</td>
<td>Evaluation of the Commitment to Living Curriculum</td>
<td>Improvement in knowledge, confidence, suicide risk assessment &amp; management skills</td>
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<td></td>
<td>Pre-test/</td>
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<td>Immediate post/</td>
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<tr>
<td></td>
<td>Qualitative</td>
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<tr>
<td>(Huh et al / 2012)</td>
<td>Mixed-methods; 6.5 hours;</td>
<td>Multidisciplines (n=130); RNs (n=24)</td>
<td>Evaluation of a suicide risk assessment &amp; management (older adult) training</td>
<td>Improvement in knowledge, attitudes; &amp; confidence</td>
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<tr>
<td></td>
<td>Quantitative / Pre-test/</td>
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<td>Knowledge put into practice</td>
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<td>Immediate post/ 3 m f/u;</td>
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<td>Qualitative</td>
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Synthesis of Interdisciplinary Research on Suicide Prevention

Suicide prevention education research that has included nurses has involved interdisciplinary studies (Gask et al, 2006; Matthieu et al, 2009; Jones, 2010; Pisani et al, 2012; Huh et al, 2012) that have investigated many variables: attitudes and beliefs about suicidality, knowledge of suicide (i.e. depressive causation) and suicide prevention (i.e. the use of empathy), and confidence and self-efficacy in skill acquisition in intervening in a suicidal crisis. Only aggregate results were provided from each study.

On immediate posttest in every study, significant improvements were noted on most study variables. Some studies (Jones, 2010; & Pisani et al, 2010) did not investigate the maintenance of improvement beyond the immediate posttest period. Of those studies that did long-term follow-up, improved attitudes and confidence were maintained at 4-6 month follow-up (Gask et al, 2006), increased self-efficacy remained at 1-year follow-up (Matthieu et al, 2009), and subjective improvement in knowledge, attitudes, and confidence levels were reported at 3-month follow-up (Huh et al, 2012). Skill in intervening in a suicidal crisis never significantly improved during suicide prevention training (Gask et al, 2006), and knowledge of suicide and suicide prevention declined at 1-year follow-up (Matthieu et al, 2009).

A limitation was noted within the interdisciplinary studies (Gask et al, 2006; Matthieu et al, 2009; Jones, 2010; Pisani et al, 2012; Huh et al, 2012). Ideally, if a study involves an experimental treatment, the design should call for a control group. Outcome measures for individuals in the control group who do not receive the experimental treatment are compared to individuals in the experimental group who do receive the experimental treatment (Burns & Grove, 2009). The use of a control group allows the researcher to more accurately evaluate the effectiveness of the intervention (Polit & Beck, 2012). Control groups were not used in any of
the interdisciplinary studies. In addition, if significant results are obtained from the experimental group compared to the control group, the researcher can assume that the immediate posttest results are due to the experiment, and not to outside events that may have occurred between the pre-test and the posttest that could have influenced the posttest results for both groups (Burns & Grove, 2009).

Another limitation within some of the interdisciplinary studies (Jones, 2010; Pisani et al, 2012) was the lack of long-term follow-up. Other studies herein described (Gask et al, 2006; Matthieu et al, 2009; Huh et al, 2012) investigated maintenance of improvement at four-six months, one-year, and three months respectively. Long-term follow-up can determine what improvement achieved through the education and training persists over time. Focus can therefore be placed on those areas that do not show maintained improvement. Given the importance of effective suicide risk assessment and management, investigation of the maintenance of improvement in suicide prevention from these studies would be critical to determine the most optimal timeframe for booster sessions and follow-up investigation to ensure that clinicians use their knowledge and skills in their practice with patients expressing suicidal ideation. Clinician reminder systems (Pisani et al, 2012) are one strategy that can promote the transfer and continued use of suicide risk assessment and management skills in the clinician’s daily practice, so that improvement is maintained after education and training.

**Nursing Research on Suicide Prevention**

A two-hour interactive educational pilot study (McAllister et al, 2009) aimed to improve understanding and teach solution-focused skills to emergency nurses (n = 28) so that they may be more helpful and better prepared to care for patients who self-harm. The program was focused on several outcome measures: attitude, confidence, and clinical reasoning. Using Power Point
presentations, short video excerpts, narratives from clinical experience and patient reports, participants were engaged in learning about self-injury theories, as well as evidence-based treatments.

Participants also learned about ‘Solution Focused Nursing,’ which explicitly shifts the clinician’s orientation from a deficit approach towards a concern for the future, and how it could be applied to self-injury (McAllister 2003, 2007). The think-aloud procedure is a well-used method for measuring clinical reasoning among nurses that involves providing participants with real or simulated patient situations and asking participants to ‘think aloud’ their plans and decisions and then analyze them (Simmons et al, 2003).

Participants were asked to read four scenarios in total – two before the intervention and two approximately 2 weeks after the intervention. These scenarios were derived from actual self-harming patients seen in the emergency department. The ‘think aloud’ procedure, which was audiotaped by the participant, was then used as a way of exploring and improving the solution-focused nature of nurses’ clinical reasoning in a range of self-harm scenarios. Qualitative analysis indicated that interactive education not only improves emergency nurses’ attitude and confidence in helping patients who self-harm, but enlarges their clinical reasoning skills to include psychosocial needs within the typical biomedical context of the emergency department.

A one-hour performance improvement project (Giordano & Stichler, 2009) in California that involved the development of an educational module to enhance emergency department (ED) nurses’ \( n = 118 \) knowledge and skills in suicide prevention was conducted to enhance awareness among nurses about suicide risk factors, resources for intervention and treatment, and potential adverse patient and organizational outcomes when risk is not identified. The project
was identified as a high priority for the hospital because there had been several recent instances when patients at risk were not properly identified, and ED staff had voiced fear and concern about their lack of competency in assessing patients at risk for suicide.

A missed identification of a single patient at risk for suicide who subsequently kills himself or herself has the potential of exposing a hospital to significant legal and monetary risk estimated to be in the millions of dollars, depending on the deceased patient’s work life expectancy, medical costs associated with the events leading to death, and the facts associated with the missed occurrence (Giordano & Stichler, 2009). Meanwhile, the cost to educate all ED triage nurses using this educational module was estimated to be less than $5,000.

A pre-test survey, designed to determine nurses’ existing knowledge and assessment skills, was administered prior to the educational module, and a post-test using the same survey was administered immediately after completion of the module. Findings revealed a significant improvement pre- and immediate posttest in ED nurses’ knowledge and skills in suicide prevention, with overall improvement in the ED nurses’ ability to identify and intervene to prevent an act of suicide. The project enhanced nursing efficiency by improving assessment and decision-making skills for the appropriate patient disposition to the appropriate level of care or discharge to home. The performance improvement project was also significant to the organization because it mitigated legal risk by improving safety of patients and staff in the emergency department and reducing the risk of missed diagnosis and improper dispensation of patients who were at risk for suicide.

A two-hour screening skills training course (Taur et al, 2011) in Taiwan was provided to general nurses (n = 54) caring for hospitalized patients diagnosed with either chronic obstructive pulmonary disease or lung cancer. The patients were rated by trained nurses according to the
Screening of Risk for Suicide (SRS) Scale, originally developed by Haber (1997) for assessing patients with mood disorders. The patients then self-rated using the repulsion of life subscale of the Multi-attitude Suicide Tendency Scale (MAST) (Orbach et al, 1981) which evaluates suicide tendency.

The trained nurses compared their results with a trained psychiatric head nurse within twenty-four hours for inter-rater consistency, followed by patients’ self-rating. A high inter-rater reliability between nurses and their trainers was noted, and the screening of risk for suicide rated by nurses correlated significantly with repulsion to life rated by patients. The nurse’s screening collected more in-depth data than patients’ self-rating and the screening of risk for suicide was useful in alerting the general nurses to high-risk patients.

A randomized controlled study (Tsai et al, 2011) evaluated whether a short training program can improve nurses’ ability to recognize and effectively respond to patients exhibiting suicidal behavior. The Awareness of Suicide Warning Signs Questionnaire (Tsai et al, 2011), a modification of the Sensitivity of Suicide Warning Signs Questionnaire (Wang, 1997) was completed before the control group participants ($n = 97$) and the experimental group participants ($n = 98$) attended a 90-minute continuing education class that focused on four areas: professional issues, quality control, ethical questions, and legal concerns. The experimental group then attended a 90-minute Gatekeeper Suicide-Awareness Program (GSAP).

Posttest questionnaires were completed by the control group immediately after the continuing education class, and immediately after the GSAP for the experimental group. Findings revealed that the nurses who participated in the Gatekeeper Suicide-Awareness Program were much more aware of suicide warning signs and more willing to refer patients for professional counseling.
A seven-hour training program of lectures and case studies (Kishi et al., 2014) was provided to emergency department (ED) nursing personnel (n=52) because emergency department nurses have been found to have negative attitudes toward patients who express suicidal ideation. Research has shown that ED nurses are less likely to understand patients who express suicidal ideation, and are less inclined to be sympathetic or to verbally interact with patients who express suicidal ideation (Kishi, Kurosawa, Morimura, Hatta, & Thurber, 2011; & Samuelsson et al., 1997). The educational program focused on basic suicide risk assessment, immediate crisis intervention, appropriate referral, and attitudinal change toward suicide prevention.

The Understanding Suicidal Patient (USP) Scale (Samuelsson et al., 1997) and additional questions addressing training and psychiatric treatment for those who have attempted suicide were administered to study participants. Significant improvement in nurses’ understanding of and willingness to care for patients expressing suicidal ideation was noted as a result of the training program. At immediate posttest and at 1-month follow-up, many participants felt they had acquired adequate skill to care for patients at risk for suicide, but they expressed the need for further training to be more effective in preventing suicide.
<table>
<thead>
<tr>
<th>SOURCE</th>
<th>STUDY DESIGN</th>
<th>SAMPLE POPULATION</th>
<th>LEARNING OBJECTIVE</th>
<th>STUDY OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>(McAllister et al / 2009)</td>
<td>Mixed-methods; 2 hours</td>
<td>ED RNs (n=28)</td>
<td>Evaluation of solution-focused skills and think-aloud procedure</td>
<td>Improvement pre-post in attitudes &amp; confidence</td>
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<td></td>
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<td>Improvement pre-post in clinical reasoning skills</td>
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<tr>
<td>(Giordano &amp; Stichler / 2009)</td>
<td>Quantitative / 1 hour</td>
<td>ED RNs (n=118)</td>
<td>Evaluation of a suicide prevention program in the emergency department</td>
<td>Improvement in knowledge &amp; skill in suicide prevention</td>
</tr>
<tr>
<td>Taur et al / 2011)</td>
<td>Quantitative / 2 hours</td>
<td>RNs (n=54)</td>
<td>Evaluation of a suicide screening skills training course</td>
<td>Improvement in suicide screening skills</td>
</tr>
<tr>
<td>(Tsai et al / 2011)</td>
<td>Quantitative / 3 hours</td>
<td>RNs (n=195); Control group (n=97) / Experimental group (n=98)</td>
<td>Evaluation of a continuing education class and a Gatekeeper Suicide Awareness Program</td>
<td>Improvement in awareness of suicide warning signs and more willing to refer patients at risk noted in the experimental group</td>
</tr>
<tr>
<td>(Kishi et al / 2014)</td>
<td>Quantitative / 7 hours</td>
<td>ED RNs (n=52)</td>
<td>Evaluation of an suicide prevention education program</td>
<td>Improvement in attitudes / Uncertain the impact on patient interventions</td>
</tr>
</tbody>
</table>

**Synthesis of Nursing Research on Suicide Prevention**

Suicide prevention education research that has focused exclusively on nurses (McAllister et al, 2009; Giordano & Stichler, 2009; Taur et al, 2011; Tsai et al, 2011; & Kishi et al, 2014)
has investigated many similar variables: attitudes toward suicidality, confidence and clinical reasoning in intervening with persons at risk for suicide, knowledge about suicide and suicide prevention, applying knowledge to practice, screening for suicide risk, and competence in caring for persons with suicidal intent. One study (Tsai et al, 2011) used both control and experimental groups; the other studies (McAllister et al, 2009; Giordano & Stichler, 2009; Taur et al, 2011; & Kishi et al, 2014) used only experimental groups. This is a limitation of these studies.

Posttest findings immediately after the intervention in many of these studies revealed significant improvements in all study variables. Beyond immediate posttest, two studies conducted follow-up at two-week and at one-month (McAllister et al, 2009; Kishi et al, 2014), which is not sufficient time to determine maintenance of improvement. Other studies (Giordano & Stichler, 2009; Taur et al, 2011; Tsai et al, 2011) did not investigate the maintenance of improvement beyond the immediate posttest period.

Overall, research on suicide prevention education for nurses revealed significant improvement in the aforementioned study variables, but maintenance of such improvements is mostly unknown because strategies to maintain improvement were not implemented, nor was maintenance investigated, either at all or for long-term. Maintenance of improvement in study variables is often not investigated in research, and when noted, significant declines are often reported. A diminishing effect over time is typically found in intervention studies (Gask et al, 2006; Roye, Perlmutter-Silverman, & Krauss, 2007; Wyman et al, 2008; & Chan, Chien, & Tso, 2009a; Matthieu et al, 2009; Tompkins, Will, & Abraibesh, 2010; Suldo et al, 2010). These findings, therefore, indicate that suicide prevention education interventions can play an important role in improving the attitudes, knowledge, and skills of health care professionals including
nurses, but strategies to maintain these improvements need to be implemented, and long-term follow-up studies should be done.

**Baccalaureate Nursing Education**

Nursing care had been administered by patient’s relatives, religious or military personnel, or by self-trained persons until Florence Nightingale created the first education system for nurses in 1860 with the opening of a school of nursing in London (Chitty & Black, 2011). In the United States, the first training schools for nurses were established in 1872 at Bellevue hospital (New York), the New England Hospital for Women and Children (Connecticut), and Massachusetts General Hospital (Boston) (Chitty & Black, 2011). Out of concern for the education being offered at these and other newly-formed schools of nursing, a nationwide investigation of nursing education was conducted in 1912, entitled, *The Educational Status of Nursing* (Christy, 1969). The material being taught, as well as, the teaching methods being used were examined. In 1923, the *Study of Nursing and Nursing Education* in the United States, often referred to as the Goldmark Report, focused on issues important to nursing, such as the clinical learning experience of students (Kalisch & Kalisch, 1995). *Nursing Schools Today and Tomorrow*, published in 1934, was another study that described nursing school curricula (National League of Nursing Education [NLN], 1934). All these studies made similar recommendations which included that standards should be established for nursing practice and that all students should meet certain minimum criteria for graduation. It was also recommended that the minimum preparation for entry into professional nursing practice should be the baccalaureate degree in nursing (American Nurses Association, 1979).

Baccalaureate programs of nursing were seen as important to nursing in that the Bachelor of Science in Nursing would qualify nursing as a recognized profession in order to provide
leadership in teaching, administration, and public health for the health care workforce. National studies of nursing and nursing education stated and restated the need for nursing education and practice to be based on knowledge from science and the humanities. In particular, *Nursing for the Future* (the Brown Report) published in 1948, and sponsored by the Carnegie Foundation, recommended that schools of nursing be established within a system of higher education (Brown, 1948). In 1965, the American Nurses Association (ANA) published a position paper entitled, *Education Preparation for Nurse Practitioners and Assistants to Nurses*, which had a significant impact on the growth of baccalaureate education in nursing (ANA, 1965). In 1970, the National Commission for the Study of Nursing and Nursing Education published *An Abstract for Action*, also known as the Lysaught Report, which identified that an enhanced education system and curricula were a priority for nursing education (Lysaught, 1970). The National League for Nursing (NLN) in *Position Statement on Nursing Roles: Scope and Preparation* (1982), and the American Association for Colleges of Nursing (AACN) in *The Baccalaureate Degree in Nursing as Minimal Preparation for Professional Practice* (1996) both affirmed the nursing baccalaureate degree as the minimum educational level for professional nursing practice. In 1979, the ANA proposed additional positions regarding nursing educational preparation: one was that competencies should be devised for nursing practice (ANA, 1979).

During the last decade of the 20th century, nursing organizations focused on the future of nursing with the publication of the NLN’s *A Vision for Nursing Education* (1993, 1995) and the AACN’s *Nursing Education’s Agenda for the 21st Century* (1999). The Pew Health Profession Commission released its report entitled *Health Profession Education for the Future: Schools in Service to the Nation* (O’Neil, 1993). Common themes included the concepts that curricula
should develop students’ critical thinking skills, and health promotion and health maintenance skills.

At the start of the 21st century, the ANA (2002) issued a document entitled *Nursing’s Agenda for the Future: The Future Vision for Nursing*, which was later updated with the release of the *Health System Reform Agenda* (2008), which outlined strategies for providing safe, quality care to all patients. The Institute of Medicine (IOM) also called for an overhaul in health profession education with the release of the 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, and the updated 2003 report, *Health Professions Education: A Bridge to Quality*. As a follow-up to the initial report, a multidisciplinary summit of health profession leaders met and recommended that all health professions develop and share a set of core competencies that would result in better educational quality and relevance. In 2005, the NLN issued a position statement entitled *Transforming Nursing Education* (NLN, 2005) which promoted evidence-based education, i.e. educational practices based on research with an emphasis on faculty input, design, and implementation.

The AACN’s *The Essentials of Baccalaureate Education for Professional Nursing Practice* (2008) served to transform baccalaureate nursing education by providing the curricular elements and framework for building the baccalaureate nursing curriculum for the 21st century. These *Essentials* (AACN, 2008) address landmark documents such as the IOM’s recommendations for the core knowledge required of all healthcare professionals. This document emphasizes such concepts as patient centered care, interprofessional teams, evidence based practice, quality improvement, patient safety, informatics, clinical reasoning /critical thinking, genetics and genomics, cultural sensitivity, professionalism, and practice across the lifespan in an ever changing and complex healthcare environment.

Today, pre-licensure nursing baccalaureate programs combine nursing courses with general education courses in a four-year curriculum in a college or university. Courses in the nursing major focus on nursing science, communication, decision-making, leadership, and care to persons of all ages in a wide variety of settings. Nursing programs must be approved by their respective state boards of nursing in order for graduates to take the licensure examination, and many programs also seek accreditation, which is a voluntary review process by a professional organization. Nursing programs can choose either the National League for Nursing or the American Association of Colleges of Nursing, through the Commission on Collegiate Nursing Education, for national accreditation (Chitty & Black, 2011). Baccalaureate graduates are prepared to take the National Council Licensure Examination for Registered Nurses (NCLEX-RN), (Chitty & Black, 2011) and after licensure, assume beginning practice in health care settings, including hospitals, community agencies, schools, clinics, and homes.
The Quality and Safety Education for Nurses (QSEN) Project (Cronenwett et al, 2007) was also designed to meet the challenge of preparing nurses for the future who will have the knowledge, skills, and attitudes necessary to continuously improve the quality and safety of the health care systems within which they work. Using the Institute of Medicine (IOM) competencies as a framework, QSEN and a National Advisory Board defined quality and safety competencies for nursing and proposed targets for the knowledge, skills, and attitudes to be developed in pre-licensure programs for each competency. These competencies include: patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics.

Competencies necessary to effectively assess and manage suicide risk are vaguely evident within the QSEN competencies. Assessing the patient’s emotional comfort, eliciting expectations for the relief of suffering, and initiating effective treatment to relieve suffering are skills described in the patient-centered care competency. Teamwork and collaboration are also described, and are important aspects of effective assessment and management of suicide risk, especially as regards an awareness of one’s strengths and limitations in intervening in a suicidal crisis, and an ability to effectively communicate with the healthcare team especially to minimize the risks when essential information and the responsibility of care of the patient is transferred from one health care provider to another (Patterson, Roth, & Woods, 2004). This transfer of information, often referred to as a “handoff” (Patterson, Roth, & Woods, 2004) is an integral component of communication in health care, and must include an opportunity to ask questions, clarify, and confirm information transfer (TeamSTEPPS, 2006). The complexity and nuance of the type of information, communication methods, and various caregivers for each of these factors
impact the effectiveness and efficiency of the handoff as well as patient safety. The IOM (2001) has reported that “it is in inadequate handoffs that safety often fails first” (p. 45).

Demonstrating knowledge of evidence-based practice with an ability to discriminate between valid and sub-par research is certainly necessary in regard to suicide prevention. The incidence of suicide is a top sentinel event, and participating in a root cause analysis of a sentinel event will likely improve the quality and safety of the healthcare environment. Minimizing risk of harm to patients through the use of effective strategies as described in national patient safety resources is relevant to suicide prevention efforts. Using information and technology to communicate a coordinated plan of care for all patients, and documenting a confidential assessment and appropriate management of suicide risk are necessary when dealing with a person at risk for suicide. The development of instructional competencies for assessing and managing suicide risk is clearly needed within baccalaureate nursing education.

Competency Development

Competency is defined by Webster’s Dictionary as “the quality of being adequately or well qualified physically and intellectually” (Merriam-Webster Online). In the workplace, competency is defined as “the required capabilities that the job holder must possess or acquire in order to perform his job effectively” (Dillon, 2012). Related to modern healthcare practices, competency can be further delineated as “those behavioral and technical characteristics that discriminate outstanding leadership performance from typical performance across the health professions” (Calhoun et al., 2008, p. 377). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) defines competence as “a determination of an individual’s skills, knowledge, and capability to meet defined expectations” (JCAHO, 2006, p. 394).
Competency is multifaceted and difficult to measure (Tilley, 2008). The concept encompasses many attributes which can be broadly divided into categories of knowledge, skills, and attitudes (Traynor, Inoue, & Crooks, 2011). A combination of these attributes is necessary for an individual or profession to be regarded as competent. Relevant to nursing, defining attributes of competency that appear consistently in the literature are: (a) knowledge or information, (b) actions or skill, (c) professional standards or qualifications, (d) internal regulation or accountability, and (e) dynamic state or consistent improvement (Axley, 2008).

The National Council for State Boards of Nursing (NCSBN) defines competency as “the application of knowledge and the interpersonal, decision-making, and psychomotor skills expected for the practice role, within the concept of public health” (National Council of State Boards of Nursing, 2005, p. 1). Today’s practicing nurses are faced with ever-changing roles and duties due to the emergence of new medications, equipment, procedures, and treatments available in the healthcare industry. Graduate nurses evaluate and treat patients’ health problems autonomously and in collaboration with other healthcare professionals (Buppert, 2012). This level of practice certainly requires that nurses are appropriately trained and capable of providing care in a safe manner. In order to assure quality care, providers must be deemed competent to provide the best possible standard of care (Axley, 2008). This concept of competency is key to assuring patient safety. However, competencies for assessing and managing suicide risk are nonexistent in baccalaureate nursing programs.

**Instructional Competency Development**

Development of instructional competencies for assessing and managing suicide risk should derive from established suicide prevention programs. The Best Practice Registry (BPR) of the Suicide Prevention Resource Center (SPRC) [http://www.sprc.org/bpr](http://www.sprc.org/bpr) identifies, reviews,
and disseminates information about best practices that address specific objectives of the National Strategy for Suicide Prevention. These programs suggest pre-assessment, assessment, and management competencies for assessing and managing suicide risk. Information on suicidology, which is the study of suicide and suicide prevention (www.merriam-webster.com/medical/suicidology) is provided.

**Pre-Assessment Competencies**

**Definition of Suicide**

Suicide is defined as the act of intentionally killing oneself often due to extreme psychological pain that captures the mind and leads to overwhelming despair (Granello & Granello, 2007). It is a complex phenomenon that results from interactions of biological, psychological, social and cultural factors (New York City Health & Hospitals Corporation (NYCHHC), 2005; Mann, Apter, & Bertolote, 2005; Stuart & Laraia, 2005). Intrapsychic factors, such as psychological pain, rigidity in thinking, and poor problem-solving skills, as well as, interpersonal factors, such as difficulty in establishing and/or maintaining interpersonal relationships, and environmental stressors, are involved in suicidal decisions (Granello & Granello, 2007).

**Field of Suicidology**

Suicide has been discussed globally in scientific writing for centuries (Donne, 1647; & Merian, 1763). Durkheim (1951) provided a sociological perspective on suicide and a comprehensive overview of suicide was described by Dublin and Bunzel (1933). In the United States, the field of suicidology is generally traced back to the 1940s and the 1950s (Maris, Berman, & Silverman, 2000; & Shneidman, 2004). At that time, Edwin Shneidman, considered the father of suicidology (Maris, Berman, & Silverman, 2000), and Norman Farberow began
publishing scientific research on suicide (Shneidman & Farberow, 1957a,b), and the field of suicidology began. Since that time, the field of suicidology has expanded significantly and a number of theories about the causes of suicide have been posited. Because suicidal behavior occurs in the context of an individual’s physiological, psychological, and social situation, biologic, psychological, and social theories have been developed to explain the occurrence of suicide (Qin, Agerbo, & Mortenson, 2003; Eng et al, 2002; & Cohen, Mason, & Bedimo, 2003). Overall, the literature suggests that a small number of people have had a significant influence on this field in its short history.

**Suicide Prevention Movement**

In addition to the creation of the field of suicidology, the suicide prevention movement also began with the establishment of the Los Angeles (L.A.) Suicide Prevention Center and the first suicide prevention crisis line in 1958 (Didi Hirsh Mental Health Services, 2011). In the late summer of 1962, with the sensational and sudden suicide of actress Marilyn Monroe, a dramatic surge in phone calls was noted at the L.A. Suicide Prevention Center, which highlighted the need for a significant corps of trained volunteers to handle the influx of calls. From the initial grassroots movement and the catalyzing event of Monroe’s suicide, the field of suicidology and the suicide prevention movement began. Over the last several decades, the momentum has accelerated and the movement has accomplished significant milestones. This movement has included the founding of suicide prevention centers across the nation, the start of a national suicide prevention hotline, the development of support groups for survivors of loved ones’ suicides, the establishment of a national strategy for suicide prevention, and government support and funding for suicide prevention programs. Although suicidology and suicide prevention are
relatively new fields of study in the United States, they have made significant progress in their brief 60-year history.

Suicide is a global health problem that claims approximately one million lives a year throughout the world. Nations around the world have implemented suicide prevention programs. In 1999, The World Health Organization (WHO) launched a worldwide initiative for suicide prevention (SUPRE) (1999). The objectives are: to reduce mortality and morbidity due to suicidal behaviors, to break the taboo surrounding suicide and to bring together national authorities and the public to overcome challenges. In Europe, OSPI-Europe was begun which stands for Optimizing Suicide Prevention and their Implementation in Europe. The aim of OSPI-Europe is for diverse policy makers to provide an evidenced-based, efficient concept for suicide prevention (Hegerl, 2009).

In the United States, the Surgeon General released a Call to Action to Prevent Suicide (USPHS, 1999), which introduced a blueprint for reducing suicide in the United States. In 2001, the National Strategy for Suicide Prevention (NSSP) was developed, which is a coordinated approach of advocates, clinicians, researchers and survivors to prevent suicide. In addition, in 2002, the Institute of Medicine (IOM) underscored suicide prevention as a significant health problem in its publication, Reducing Suicide: A National Imperative (IOM, 2002). In 2002, President Bush ordered a special commission to evaluate the mental health care system in the United States and to recommend goals for improvement (Granello & Granello, 2007). The New Freedom Commission on Mental Health endorsed the proposals of the NSSP. In September 2010, the 13th edition of the European Symposium on Suicide and Suicide Behaviour (ESSSB, 2010) was held and the theme of the ESSSB was “Integration of Knowledge for an Interdisciplinary Approach to Suicidology and Suicide Prevention.” Many recommendations
were made from all of these programs and education for health professionals, especially nurses, was identified as a primary goal to aide in suicide prevention (SUPRE, 1999; Mann, Apter, & Bertolote, 2005; Hegerl, 2009).

**Suicide Prevention Resources**

Awareness of suicide prevention resources is important. These resources include: 1-800-SUICIDE; the National Suicide Prevention Lifeline: Phone: 1-800-273-TALK (8255); the American Foundation for Suicide Prevention: Phone: 516-869-4215 and Website: http://www.afsp.org.; Suicide Prevention Resource Center: Website: [www.sprc.org](http://www.sprc.org); the Suicide Prevention Action Network, USA: Website: [http://spanusa.org](http://spanusa.org); the Surgeon General’s Call to Action to Prevent Suicide: Website: [www.surgeongeneral.gov/library/calltoaction/default.htm](http://www.surgeongeneral.gov/library/calltoaction/default.htm); and the National Institute for Mental Health: Website: [www.nimh.nih.gov](http://www.nimh.nih.gov).

**Incidence and Prevalence of Suicide**

In the United States, the incidence of suicide increased 12% between 1999 and 2009 making suicide the tenth leading cause of death (Centers for Disease Control and Prevention, [CDC], 2010a). In the United States, every fourteen minutes, a human life is lost to suicide (CDC, 2010a), equating to nearly 100 suicides per day. There were more than 38,000 suicide deaths reported in 2010 in the United States (CDC, 2010a) and approximately one million people worldwide died by suicide in 2010 (AFSP, 2010). This toll is higher than the total number of deaths each year from war and homicide combined, making suicide the leading cause of violent deaths worldwide (Busch, Fawcett, & Jacobs, 2003). A markedly consistent underreporting of suicide rates has been noted in numerous studies making the “true” suicide rates higher than the actual reported rates (Granello & Granello, 2007).
Estimates of attempt rates vary widely, with some data indicating that attempts are 10–40 times more prevalent than completed suicides (WHO, 2013). In the United States, it is estimated that nearly one million people make a suicide attempt every year (CDC, 2010a). Approximately 10% of previous suicide attempters will eventually die by suicide (Granello & Granello, 2007). This estimate is further clouded by research which indicates that more than 50% of persons who engage in suicidal behavior never seek health services (Granello & Granello, 2007). Consequently, prevalence figures based on health records substantially underestimate the societal burden of suicidal behavior.

**Populations at Risk**

Populations at risk for suicide differ by age, gender, and ethnicity. Although less common during childhood, suicide attempts are more common in adolescence than in any other time in life (Miranda & Shaffer, 2013), and in the United States, suicide is the third leading cause of death among those aged 15-24 years, accounting for at least 100,000 deaths of adolescents every year (CDC, 2010b). It is the second leading cause of death among persons aged 25-34 years, and fourth among those aged 35-54 years, and eighth among persons 55-64 years (CDC, 2012). Suicide rates increase with age and are highest among those over age 75 years (CDC, 2012).

There is a gender disparity related to suicide. The rate of completed suicide is four times higher among males than females, making suicide the seventh leading cause of death overall for males, with the highest rate among those aged 75 and older (CDC, 2010b). Suicide attempt rates are three times higher for females than for males (CDC, 2010b). Suicide is the fifteenth leading cause of death for females, with the highest rate among those 45-54 (CDC, 2010b).
Examining suicide rates by ethnicity, the rates are more than twice as high for Caucasians as for African Americans, yet the rate of suicide for African Americans male adolescents more than doubled in the period from 1980 to 1996, making the suicide risk for African American male adolescents nearly level with the suicide risk for Caucasian male adolescents (Granello & Granello, 2007). Certain other populations in the United States, such as American Indians/Alaska Natives, also have their highest suicide rates among adolescents and young adults, whereas, the rates for other groups such as Asian-Americans and Hispanics are highest among older adults (Granello & Granello, 2007).

Other populations at high risk for suicide include: those with diagnosed psychiatric disorders, and/or chronic and terminal physical illnesses, lesbian/gay/bisexual/transgendered (LGBT) populations, prisoners and incarcerated individuals, soldiers and veterans, and health care professionals. These categories are consistently given attention in the research because of their high risk of suicide. Psychiatric illness is associated with more than 90% of suicides (Granello & Granello, 2007). Individuals with psychotic disorders, mood disorders, anxiety disorders, personality disorders, and substance abuse disorders have significantly higher rates of suicide than the general population (Conner et al, 2001; Range et al, 1997; Rihmer & Kiss, 2002). It is difficult to determine the exact rates of suicide or suicide risk in people with physical illnesses because it has not been widely studied except in some medical populations. Across many studies, there is consistent support for elevated risk in illnesses such as: certain cancers, multiple sclerosis, Huntington’s disease, HIV/AIDS (Granello & Granello, 2007), epilepsy, Parkinson’s disease (Lewis et al, 2014), and chronic traumatic encephalopathy (McKee et al, 2009).
Studies have helped explain the suicide risk for lesbian/gay/bisexual/transgendered (LGBT) populations; these support the widely held belief that suicide risk is higher especially in adolescence and early adulthood for LGBT persons (Bagley & Tremblay, 1997; Safren & Heimberg, 1999). In prisoners and incarcerated individuals, there are higher rates of completed suicide and suicide attempts than in the general population. Estimates vary but approximately 20-30 inmates per 100,000 commit suicide each year, compared to approximately 12 per 100,000 in the general population (Granello & Granello, 2007). Inmates at particular risk are those who are experiencing moral shock, chronic despair, manipulation, and/or self-punishment (Granello & Granello, 2007).

Individual risk factors and occupation-based circumstances can elevate the risk of suicide (Mohandic & Hatcher, 1999; Marzuk et al, 2002). Higher rates of suicide have been found in World War II veterans who were war amputees, experienced a spinal cord injury, or were prisoners of war (Bakalim, 1969; Cohen & Cooper, 1955; Keehn, 1980). Vietnam era veterans have been found to have a 65% higher rate of suicide than nonveterans (Hearst, Newman & Hulley, 1986). The rate of suicide has dramatically increased within the military: among young soldiers, the rate is estimated to be two to four times higher than any other age group in the general population (Hefling, 2010). According to the Department of Defense (DOD) (2011), every 36 hours, a service member dies by suicide, yet according to the New York Times, every 80 minutes a veteran dies by suicide (Kristof, 2012). More than 6,500 veterans die by suicide every year which is more than the total number of soldiers killed in Afghanistan and Iraq combined since those wars began (Kristof, 2012).

There is some evidence that people in the health care professions, specifically dentists, social workers, physicians, and nurses, are at higher risk of suicide than those in the general
population. Dentists have the highest rate of suicide of any profession, being more than five times as likely to kill themselves (Stack, 2001). Social workers have higher rates of lifetime prevalence of thoughts that life is not worth living, of death wishes, and of suicidal thoughts than the general population (Ramberg & Wasserman, 2000). Medical doctors have a suicide rate over twice the national average, with female physicians at higher risk than male physicians (Stack, 2001; Lindeman et al, 1998). Physicians who completed suicide tended to be dissatisfied with their families and personal lives, very critical in their personal relationships, dissatisfied with their professional abilities, and workaholics (American Medical Association Council on Scientific Affairs, 1987). There is also evidence of a higher suicide risk for nurses. A large epidemiological study of nurses found that nurses who were experiencing the combination of high stress at home and high stress at work had a fivefold increase in suicide risk (Feskanich et al, 2002).

Suicide Survivors are also a population at risk. Anyone affected by a completed suicide is considered a suicide survivor (Granello & Granello, 2007). There are over four million suicide survivors in the United States. One in every 59 Americans is a survivor of suicide. For every completed suicide, at least six people are intimately affected (McIntosh, 1999), leaving them with serious emotional consequences, questioning “why?” and feeling guilty and remorseful that they could have and should have done more. The burden of bereavement caused by suicide can have a tremendous impact on the psychological and physical health of affected families and friends (AFSP, 2010). The stigma of suicide can add to the devastating loss felt by suicide survivors and can complicate the grieving process (Granello & Granello, 2007). Children with a parent who has attempted suicide have nearly a fivefold increased risk of attempting suicide themselves (Brent et al, 2015). The aftermath of those who attempt suicide
can also affect significant others, leaving families and friends anxious and concerned about the risk of further suicidal behavior, and about their responsibilities in trying to prevent further attempts.

Patient suicide is also a serious incident for health care professionals, especially nurses (Takahashi et al, 2011). The feelings experienced by clinicians following the suicide of a patient are quantitatively smaller than in the case of suicide by a family member but are similar to the feelings of family members qualitatively (Sudak, 2007). Nurses who have lost a patient due to suicide are troubled by the thought that they may be responsible for the death. A sense of guilt and self-condemnation can result in depression and other symptoms similar to post-traumatic stress disorder, impacting not only the nurses’ professional life, but their personal lives as well (Fukuyama, 2004; Takei, 2001).

**Economic and Emotional Cost of Suicide**

Tremendous economic costs are associated with lives lost to suicide due to: the loss of economic potential of those who suicide, the loss of productivity of those bereaved by suicide, the burden of family care for those who have made suicide attempts, and the medical and mental health costs associated with suicide attempts. Substantially more persons are hospitalized as a result of nonfatal suicidal behavior than are fatally injured, and an even greater number are either treated in ambulatory settings or not treated at all (Niska, Bhulya & Xu, 2010). Approximately 500,000 people a year in the United States are treated in the emergency room as a result of a suicide attempt (Niska, Bhulya & Xu, 2010), and in 2008, 163,489 people were hospitalized due to suicidal behavior (CDC, 2010b).

Recent data estimates that yearly medical costs for suicide in the United States are nearly 100 million dollars (CDC, 2010b) and internationally, the annual economic cost of suicidal
behavior is estimated to be in the billions of dollars (Corso et al, 2007). Worldwide, the most recent figure for total lifetime costs associated with completed suicide and suicide attempts was approximately $33 billion, including $1 billion for medical treatment and $32 billion for lost productivity (Corso et al, 2007). Compounding these costs is the incalculable impact of loss of life and the emotional trauma experienced by surviving family, friends, and communities that are affected by each person’s completed suicide or suicide attempt (Crosby & Sacks, 2002).

**Myths vs. Facts about Suicide**

Suicide had not been an openly-discussed subject until very recently, and oftentimes, in the absence of education, misinformation can be perceived as fact, and myths result. This has happened regarding the topic of suicide. This misinformation leads people to believe that persons who express suicidal ideation are not really sick, but are attention-seeking, and can’t be helped (McCann et al, 2006; Brunero et al, 2008; Jones, 2010). Hostile and negative attitudes result. If nurses feel this way, these attitudes can impact the nurse-patient relationship, and nurses’ ability to effectively assess and manage suicide risk (Sun, Long, & Boore, 2007; McAllister et al, 2009; Saunders et al, 2011). Following are some of the common myths about suicide (Granello & Granello, 2007).

**Myth 1: Asking someone if he/she is suicidal will encourage the person to attempt suicide**

**Fact: Asking a person about suicide allows the person to disclose his/her feelings.**

Fears and anxieties that are shared are more likely to be diminished and this expression acts as a deterrent to suicidal behavior. Research shows that talking about suicide actually decreases risk and creates an immediate connection which provides suicidal persons with an outlet for their thoughts and feelings. The simple inquiry concerning a person’s suicidal intent is the first step to a dialogue and the processing of emotions that may save a life.
Myth 2: Suicide happens without warning.

Fact: People who commit suicide often give some warning of their intent to harm themselves.

Approximately 80% of those who commit suicide spoke to someone before taking their lives (Granello & Granello, 2007). There are often verbal statements, and/or behaviors that indicate suicidal intent.

Myth 3: If a suicidal person is determined to kill him/herself, nothing can stop the person.

Fact: Suicide can be prevented.

Most people who feel suicidal do not want to die, but they do want their pain to end. In the moment, they cannot see alternatives to suicide that will bring their suffering to an end. Most suicidal crises are short-lived and can be managed. Immediate help, such as staying with the person, encouraging them to talk, or helping them see positive alternatives for the future, are often very helpful during the crisis of suicide.

Myth 4: People who threaten suicide are just seeking attention.

Fact: All suicide attempts must be taken seriously.

It is essential that nurses never dismiss a suicide threat or attempt as simply an attention-gaining device. If a person has to go to the extreme of threatening suicide, it is not that he/she wants attention, he/she needs attention. When it comes to working with suicidal patients, it is always better to err on the side of being overprotective than to dismiss their attempts to communicate and regret the later completion of a suicide.

Myth 5: Once an individual is past a suicidal crisis or survives an attempt, the person is free from danger.
Fact: Many people, who were suicidal at one time in their life, will not feel that way again. Others who survive an initial suicide crisis may show significant improvement, but be at risk later on in their lives. Approximately 10% of previous suicide attempters will eventually go on to take their lives.

Risk Factors for Suicide

Risk factors for suicide are characteristics that make it more likely that a person will think about suicide or engage in suicidal behaviors. Although risk factors generally contribute to long-term risk, stressful events, such as relationship problems, financial difficulties, or public humiliation could provide the impetus for a suicidal act (SPRC & Rodgers, 2011). Risk factors for suicide can be divided into four categories: demographic factors, psychosocial factors, disease factors, and associating factors. Demographic risk factors include: male gender, increasing age, White race, unmarried, unemployed, and a lack of a spiritual connection (American Psychiatric Association, (APA), 2003; Granello & Granello, 2007; Cooke et al, 2013). Psychosocial risk factors include: history of childhood abuse, lack of social support and isolation, recent stressful life event, impending incarceration, sexual orientation concerns, history of a suicide attempt, suicidal ideation/intent, self-injurious behavior, access to means, and a family history of suicide. Disease risk factors include: co-occurring psychiatric illnesses, such as, depression, schizophrenia, substance abuse, personality disorder, and anxiety disorder, and co-occurring medical illness, such as, cancer, dementia, disfigurement, loss of mobility, and chronic pain (Sadock & Sadock, 2008). Associated factors include: low frustration tolerance, hopelessness, impulsivity, and aggressiveness. Risk factors are typically thought of as ongoing patient characteristics that increase risk, whereas, warning signs are behaviors that patients engage in that warn of imminent risk (Granello & Granello, 2007).
**Warning Signs of Suicide**

Warning signs of suicide include threats to harm self, a suicide plan, talking or writing about suicide, hopelessness, rage, anger, seeking revenge, impulsive or reckless actions, feeling trapped, social withdrawal, anxiety or agitation, increasing substance use, dramatic mood changes, and no purpose/reason for living (Busch, Fawcett, & Jacobs, 2003; Rudd et al, 2006; Granello & Granello, 2007). Giving away prized possessions, putting personal affairs in order, deterioration in activities of daily living, school and/or work performance, and reading books on methods for committing suicide and/or obtaining materials (e.g. gun, poison, rope, pills) that could be used for suicide are also warning signs.

**Protective Factors Against Suicide**

Protective factors against suicide are quite varied and include an individual's attitudinal and behavioral characteristics, as well as attributes of the environment and culture (SPRC & Rodgers, 2011). Protective factors are conditions that promote strength and resilience and ensure that vulnerable individuals are supported and connected with others during difficult times, thereby making suicidal behaviors less likely. Protective factors include: a sense of responsibility to family, pregnancy, religious beliefs (that stigmatize suicide), strong connections to family and community support, satisfaction with life, positive social support, access to effective clinical health care, effective coping skills, effective problem-solving skills and conflict resolution, intact reality testing, and restricted access to lethal means of suicide (APA, 2003).

**Legal and Ethical Issues related to Suicide**

Legal and ethical issues related to suicide must be acknowledged. Several legal rights of persons contemplating suicide must be considered. Obtaining informed consent protects patients’ autonomy. People cannot be deprived of the right to self-determination unless no other
course is available to ensure their safety. Competence must be determined in order for informed consent to be truly informed. Placement in the least restrictive environment is a legal right of all patients. The least restrictive environment is the setting that puts the fewest constraints on patients’ liberties while still ensuring patients’ rights. Rights to privacy and anonymity must be preserved unless clinicians cannot protect patients without disclosing their suicidal intent to others. Patients have the right to beneficence, which is the right to be free from harm. Physically restraining or hospitalizing patients against their will has the potential for both physical and emotional harm. These options should only be used under the threat of imminent suicide. The extent of patients’ legal rights must be known so that clinicians are able to provide ethical care to persons expressing suicidal ideation.

**Cultural Issues related to Suicide**

Cultural issues related to suicide are especially important today as the U.S. population becomes more diverse. Interacting with patients from many different cultural and linguistic backgrounds, and providing appropriate services to patients at risk for suicide is critical. Understanding the culture and language of the patient and communicating that understanding are key elements in the clinician-patient relationship, and have the potential to improve the health outcome of the patient (Frederickson et al, 2005). Cultural and linguistic issues related to suicide risk assessment and management must be considered because there is evidence that suicide risk is high among some cultural subgroups, suicide risk is increasing at an alarming rate among other cultures, and suicidal ideation and attempts are prevalent within other cultures (Granello & Granello, 2007). Aside from differences in rates of completed or attempted suicides among various cultural groups, there are differences in attitudes about suicide, levels of acceptability, and appropriate intervention strategies (Range et al, 1997).
Some cultures have strong cultural injunctions against suicide which can be a protective factor, but can also prevent the person contemplating suicide to reach out and seek help. Other cultures have negative beliefs about the mental health care system, and are unlikely to utilize available services leaving people from these cultures to turn to suicide. Finally, some cultures have inherent risk factors (i.e. high rates of poverty and alcoholism among Native American tribes) that put their members at high risk for suicide (Granello & Granello, 2007). Although there is certainly between-group variation in suicide risk, it is important to remember there is also within-group variation within each cultural group. Individual factors must always be the overriding principles used in suicide risk assessment and management.

Although cultural consideration must be part of suicide risk assessment and management, there is scant research available on suicide in a multicultural context (U.S. Department of Health and Human Services, OPHS Office of Minority Health, 2001; Granello & Granello, 2007). Clinicians must strive to overcome cultural and linguistic barriers, and provide an environment in which patients from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options. Patients must feel able to express their spiritual beliefs and cultural practices, and nurses must be familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrate these approaches into treatment plans. When individuals need additional assistance, it may be appropriate to involve a patient advocate or case manager with special expertise in cross-cultural issues. Providing culturally and linguistically appropriate services to patients has the potential to improve access to care, quality of care, and, ultimately, health outcomes, especially when patients are in suicidal crisis.
Clinicians should be able to assess and manage suicide risk in all populations. Intervening with children, adolescents, and adults, at risk for suicide is challenging because risk factors are often different within these populations. In most cases, though, a psychiatric diagnosis is present (Conner et al, 2001). In children, a diagnosis of depression, attention deficit disorder or oppositional defiant behavior disorder, can increase the presence of suicidal ideation (Granello & Granello, 2007). In adolescents, a diagnosis of depression, bipolar disorder, or an anxiety disorder are risk factors (Weller & Jenuwine, 2001). Because suicide is the third leading cause of death among adolescents over fifteen (CDC, 2010b), nurses should be especially watchful of this population.

In adults, each developmental stage brings new challenges and difficulty in successfully moving through the stage, can result in depression which is a significant risk factor for young, middle-age, or older adults (Cohler et al, 1996). Persons who are at risk for suicide may present in many different settings. The school setting is an obvious place to identify children, adolescents, and young adults who are at risk for suicide. Different community settings, as well as, inpatient settings, are also places where clinicians must be able to assess and manage suicide risk.

**Issues related to Documentation**

Documentation is the single most important action clinicians can take to protect themselves against litigation (Simpson & Stacy, 2004). Courts recognize that not all suicides are preventable, and they tend to support health care professionals who make consistent and systematic efforts to keep their patients safe. The only way for the legal system to determine these efforts (or lack of them) is through documentation. According to the law, a completed suicide risk assessment that is not documented did not happen. In other words, it is not sufficient
for a clinician to say that a patient was not suicidal, the nurse must document that he/she did an assessment and documented the results of that assessment (Simpson & Stacy, 2004). Documentation must be done every time the assessment is done. This fulfills a legal obligation (Granello & Granello, 2007).

**Assessment and Management Competencies in Suicide Risk**

Pre-assessment competencies are followed by assessment and management competencies necessary in order to provide appropriate care for someone at risk for suicide. Awareness of one’s beliefs and values about suicide is crucial because these can impact one’s verbal and nonverbal communications with a person in suicidal crisis. Oftentimes, when someone’s life is at stake, clinicians, including nurses, are uncomfortable with that amount of responsibility (McAllister et al, 2009; Anderson & Standen, 2007; Brunero et al, 2008; & Sun et al, 2011). Most clinicians have intense personal reactions (Pompili, 2011) to dealing with a potentially suicidal person, and risk being so uncomfortable as to become de-skilled. The single most important intervention with a suicidal person is the development of a therapeutic relationship, and the direct questioning of suicidal feelings (APA, 2003). Evidence-based clinical practice guidelines emphasize the importance of this yet health care professionals report a surprisingly low amount of probing about suicidal ideation. Possible reasons for this lack of probing include lack of personal comfort, and lack of professional confidence (Sockalingam, Flett, & Bergmans, 2010). Therefore, clinicians must be able to communicate assertively to intervene with persons at risk for suicide.

The initial contact with the suicidal person is very important. Clinicians must be aware of their verbal communication: the sound of their voice, the words they use, how they speak, and the language they use. They must be aware of their nonverbal communication: the environment
(i.e. privacy must be assured), body language (i.e. facial expression, eye contact), prosodic voice features (i.e. volume, pitch and rate of speech), and paralinguistic voice features (i.e. emphasis, pauses and tone) (O’Toole, 2012). An active presence and a calm manner are important. Empathic listening techniques to both facts and feelings must be used, along with a caring and concern shown by using reflective techniques so patients know they are being listened to. Psychological contact does not always happen solely through verbal communication. Sometimes, nonverbal physical contact is effective. A gentle touch on the forearm or placing an arm around the shoulder may have an important calming effect and signify human concern. Showing respect (Baumann, 2005) and non-judgmental acceptance are important. The focus must be on the person’s feelings, and sufficient time allocated for the person in crisis. Knowledge and application of verbal and nonverbal therapeutic communication techniques is crucial.

Clinicians must observe and interpret the verbal and nonverbal communication of a patient at risk for suicide. Most people communicate verbally and nonverbally their suicidal intent. Examples include: overt statements, such as, “I can’t take it anymore,” “Life isn’t worth living anymore,” “I wish I was dead,” and “Everyone would be better off if I died.” Covert statements include: “It’s okay now. Soon everything will be fine,” “Thing will never work out,” “I won’t be a problem much longer,” and “Nothing feels good to me anymore and probably never will.” Most often it is a relief for people contemplating suicide to finally talk to someone about their despair and loneliness. Asking about suicidal thoughts leads to a decrease in the isolation they are feeling and can increase problem-solving abilities. People are often extremely receptive to talking. Clinicians should also be alert for nonverbal behavioral clues, including giving away possessions, or organizing their financial affairs. A sudden brightening of mood with more energy may indicate that the patient has made the decision to suicide. Assessment of
this change in mood and behavior is critical especially if the patient was recently prescribed an antidepressant medication.

Effective interviewing skills are important. The most common method to assess suicide risk is simply to ask, but nurses must use therapeutic verbal and nonverbal communication when intervening with persons at risk for suicide. Therapeutic communication skills will also help to elicit the presence of suicidal ideation. Risk factors and warning signs that increase the likelihood of suicidal behavior should be identified, as well as possible protective factors that may decrease suicidal behavior. In the presence of multiple risk factors and warning signs in unfamiliar patients, the ability of protective factors to decrease risk should not be overestimated. In a crisis, protective factors may be easily overwhelmed, particularly in an impulsive, intoxicated, or otherwise disinhibited patient. A suicide risk assessment can elicit risk factors, warning signs, and protective factors.

A suicide risk assessment is a structured process to organize clinical impressions and decision making and to suggest clinical interventions. Clinicians should be able to complete a reliable and valid suicide assessment instrument. A comprehensive suicide risk assessment typically involves several types of assessments from different sources of information.

A physical examination should be included, and could reveal signs and symptoms of substance abuse (impaired attention, irritability, euphoria, slurred speech, unsteady gait, flushed face, psychomotor agitation, needle tracks), previous suicide attempts (e.g. scars on wrists), and/or debilitating medical conditions, including chronic pain. A mental status examination should also be included which could reveal a disturbance in concentration, orientation, and memory, which may suggest a possible organic brain syndrome or a severe major depressive disorder. The examination may show impairment in the patient’s impulse control which
increases the potential for suicide. A disturbance in thought processing, evidenced by delusions, and/or a disturbance in sensorium, evidenced by hallucinations, place the patient at greater risk for suicide.

A step-wise approach in a suicide risk assessment starts with a general question and becomes more specific with each successive question (Shea, 1998; 2002; McDowell, Lineberry, & Bostwick, 2011). A lethality assessment is important. Clinicians should start by asking whether the patient feels hopeless or has thoughts of death. They should then ask whether the patient has explicit thoughts of suicide, a specific plan and means for carrying it out, and the intention to carry it out. In addition to assessing the patient's current suicidal thoughts and behaviors, clinicians should gather further information about the patient's family history of suicide and previous suicide attempts. Recognizing a cluster of symptoms within a given time frame is necessary to accurately assess suicidal intent.

The assessment will determine the level of suicide risk as low, medium, or high, and the level of care needed. Clinicians must be able to effectively triage individuals at risk for suicide while determining the care setting required to maintain safety of the patient and the health care team. Patients at low risk for suicide are those with vague suicidal ideation, no history of active suicidal behavior, and no specific plans or intent to commit suicide. These patients should have recommended outpatient follow-up. Those at moderate risk include those with suicidal ideation and a plan but with no intent to carry out their plan. The decision whether to urgently refer a patient to a psychiatrist or emergency department depends on that patient's presentation. Patients who are referred may be hospitalized if further evaluation reveals that their level of illness or other clinical findings warrant it. High-risk patients include those with serious thoughts of suicide, those with a plan and/or intent to commit suicide, and those with prominent agitation,
impulsivity, psychosis, or a recent suicide attempt. In such cases, nurses should ensure constant observation and monitoring. One-to-one observation, including observation of the patient and environment, should be arranged, and therapeutic verbal and nonverbal communication should always be used during one-to-one observation. An extensive psychiatric evaluation should be called for. While efforts are made to refer patients for an extensive evaluation, patient safety must be assured.

Environmental factors must be managed. For patients in the emergency department, general hospital, or outpatient offices, the potential of medical equipment (i.e., intravenous tubing) or the patients' own belongings being used in a suicide attempt should be carefully evaluated. Clinical situations should be reassessed as needed and the level of monitoring increased on the basis of changing presentations. Patients should be monitored closely both before and during their transitions between care settings during emergency evaluations because of the potential for suicide.

Communicating and coordinating with the interdisciplinary team is crucial during a suicide risk assessment, as is following the organization’s policies and procedure for suicide risk assessment and management. Collaborating with patient, family, and significant other, regarding the plan of care is also important. Information and records from collateral sources, while maintaining confidentiality, may be helpful in designing a plan of care. As the final step in the process of suicide risk assessment and management, clinicians should document the data supporting the assigned level of risk, the level of care required, and treatment plans to reduce suicide risk.
Chapter Summary

This chapter began with a description of the research investigating the impact of suicide prevention education on nurses, which revealed that suicide prevention education results in improvement in nurses’ attitudes, knowledge, and skills in assessing and managing suicide risk. Oftentimes, maintenance of such improvement was not investigated. A brief introduction on the history of baccalaureate nursing education followed which reported on the transformation of baccalaureate nursing education but noted a gap because specific instructional competencies for assessing and managing suicide risk have not yet been identified for baccalaureate nursing education. The term, competency was then conceptually defined, leading to an introduction to the topic of suicide, and the necessary components for assessing and managing suicide risk. This information provided a foundation for the development of instructional competencies for assessing and managing suicide risk for baccalaureate nursing education which will be surveyed using a modified Delphi Method, which is described in the following chapter.
CHAPTER III. METHODOLOGY

Introduction

In this chapter, an overview of the traditional Delphi Method is provided and the study methodology is described including modification of the traditional Delphi Method in order to develop instructional competencies for assessing and managing suicide risk for baccalaureate nursing education. It is important to develop these competencies because suicide is a major public health problem in the United States and throughout the world (AFSP, 2010; CDC, 2010a; WHO, 2013); and to date, no such competencies have been identified. Therefore, although they are a key contact within the health system for those at risk for suicide, there is evidence that nurses may lack the competence necessary to assess and manage suicide risk (Kalafat, 2006; Brunero et al, 2008; Chan, Chien, & Tso, 2009a; McAllister, 2009; Aflague & Ferszt, 2010). This may be due, in part, to a gap in baccalaureate nursing education.

Consensus by experts is a recognized method for competency development for professional education (Gebbie et al, 2002; Thangaratinam, & Redman, 2005; Lewis, D’Andrea & Rosenblum, 2012; Madsen & Bell, 2012). Because the Delphi Method (Dalkey et al, 1972) is a recognized method for reaching consensus, it is a process well-suited to accomplish the aims of this study.

Overview of the Research Method

The Delphi Method was developed at the beginning of the cold war to forecast the impact of technology on warfare (Custer et al, 1999). Project RAND was started in the 1950’s by the Douglas Aircraft Company to examine the potential effects of an atomic attack for the U.S. Air Force (Dalkey et al., 1972). Shortcomings were noted in traditional forecasting approaches which included theoretical frameworks, quantitative models, trend extrapolation (Keeney,
Hasson, & McKenna, 2011), and focus groups (Dalkey, 1969). Researchers at the Rand Corporation decided that the opinions of a panel of experts should be sought (Dalkey, 1969) because early studies found group opinion to be superior to that of an individual (Landeta, 2006). The conventional group decision-making process though included threats to methodological rigor (Kaplan et al, 1949) such as: swaying of group decisions by dominant, more vocal personalities, which can result in more extreme positions (Jaeger & Busch, 1984); semantic noise that reflects irrelevant individual or group interests over problem solving discourse (Dalkey, 1969); reluctance to change prior expressed opinions for fear of “loss of face”; reluctance to express opinions that differ from the perceived group consensus; and a potential fear among junior members of reprisal or criticism from senior, more powerful group members for expressing conflicting opinions. The RAND researchers therefore proposed a new approach to the group decision-making process (Heimer & Rescher, 1959), and named the process, Delphi, in deference to the legend of the Greek Delphi oracle (Fontenrose, 1959), who had a network of informants and was considered to be one of the most truthful – with data derived from many sources.

The traditional Delphi Method is a systematic polling of the opinions of a panel of experts knowledgeable on a given topic through iterative questionnaires, referred to as “rounds” (Dalkey et al., 1972), administered either through postal rounds or electronically via email (Keeney, Hasson, & McKenna, 2011). Basic characteristics of the traditional Delphi Method (Dalkey & Heimer, 1963) are: iterative polling of the experts, absence of direct contact among the experts, and controlled opinion feedback. Round I of the traditional Delphi starts with an open-ended set of questions, allowing the expert panel freedom in their responses (Keeney, Hasson, & McKenna, 2011). Panelists are asked to provide as many relevant issues as possible
which are then analyzed according to the qualitative research paradigm (e.g. qualitative coding) (Skulmoski, Hartman, & Krahn, 2007) and become the survey for Round II. Following each round of questions, summary feedback of the previous round’s responses, collated by the researcher, is sent to each panelist for consideration. The panelists are asked to identify: individual changes in response, agreement with the group summary response of each issue, or to provide a rationale for disagreement. This process is an attempt to reach group consensus among individuals, and lasts until response stabilization occurs (Dalkey et al, 1972). This qualitative approach, however, can yield unwieldy amounts of data which can prolong the research process as the researcher analyzes data for themes, and also increases the panelists’ participation time which is associated with increased dropout rates (Keeney, Hasson, & McKenna, 2001). (See Table 3.1 and Table 3.2 for the stages in the traditional Delphi Method and appropriate research objectives for the Delphi Method).

Table 3.1: *Stages in the Traditional Delphi Method* (Linstone & Turoff, 1975):

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Exploring the subject under discussion, wherein each individual in the group contributes additional information pertinent to the issue by answering the open-ended questionnaires;</td>
</tr>
<tr>
<td>2</td>
<td>Reaching an understanding of how the group views the issue;</td>
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<tr>
<td>3</td>
<td>Exploring any significant disagreement to bring out the underlying reasons for the difference and possibly evaluating those differences; and</td>
</tr>
<tr>
<td>4</td>
<td>Providing a final evaluation.</td>
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Table 3.2: *Appropriate Research Objectives for the Delphi Method* (Linstone & Turoff, 1975):

<table>
<thead>
<tr>
<th>Objective</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>To explore or expose underlying assumptions or information leading to differing judgments;</td>
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<tr>
<td>2</td>
<td>To seek out information that may generate a consensus on the part of the respondent group;</td>
</tr>
<tr>
<td>3</td>
<td>To correlate informed judgments on a topic spanning a wide range of disciplines; and</td>
</tr>
<tr>
<td>4</td>
<td>To educate the respondent group as to the diverse and interrelated aspects of the topic.</td>
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</table>

The traditional Delphi Method has evolved into a widely used, flexible and adaptive research technique (Skulmoski, Hartman & Krahn, 2007), and the modified Delphi Method has been used in business (Kaynak, Bloom, & Leibold, 1994; Addison, 2003; Ilbery et al. 2004),
defense (Roberts, 1969; Gilbride, 2002), policy-making (Hilbert, Miles, & Othmer, 2009), education (Dailey & Holmberg 1990; Volk, 1993), public health services research (Gebbie et al, 2002), and in particular, nursing research (Alexander & Kroposki, 1999; Sharkey & Sharples, 2001; Gebbie & Qureshi, 2002; McIlfatrick & Keeney 2003; Lofmark & Thorell-Ekstrand, 2004; Scott et al, 2006; Crawford, Brown, & Majomi, 2008; & Hewitt, 2012). The importance of adapting the method to suit the particular needs of the project has been recognized in nursing research (Keeney, Hasson, & McKenna, 2006) particularly to develop competencies for nursing curricula (Thangaratinam, & Redman, 2005). A focus group is a design factor used in modified Delphi Studies. In nursing, research projects using focus group have covered different spheres, such as clinical nursing and nurse education Gray-Vickery, 1993; Carey, 1994; Powell et al, 1996; Millar et al, 1996).

<table>
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<tr>
<th>Table 3.3: Design Factors for modified Delphi studies:</th>
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<tbody>
<tr>
<td>(a) methodological choices can be qualitative, quantitative or a mixed methods approach;</td>
</tr>
<tr>
<td>(b) the initial question can be broad or narrowly focused;</td>
</tr>
<tr>
<td>(c) technical knowledge and/or experience can determine the expert criteria,</td>
</tr>
<tr>
<td>(d) a heterogeneous or homogeneous sample can be recruited;</td>
</tr>
<tr>
<td>(e) the number of Delphi rounds can vary; and</td>
</tr>
<tr>
<td>f) the mode of interaction can include face-to-face interviews, online surveys, or focus groups</td>
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**Focus Groups**

A focus group is defined as a “semi structured group session, moderated by a group leader, held in an informal setting, with the purpose of collecting information on a designated topic’ (Carey, 1994, p. 226). Focus groups have been used as a strategy for understanding attitudes and opinions, and depend primarily on focused interaction among participants to generate data. Focus groups originated in 1926 and were first used in marketing research (Powell et al, 1996), and later incorporated into the social sciences (Morgan, 1996; Gray-Vickery, 1993).
A focus group is guided by a moderator, who should possess good communication and group facilitation skills. The moderator’s role in a focus group is to ‘create a non-threatening supportive climate that encourages all participants to share views; facilitating interaction among members; interjecting probing comments, transitional questions and summaries without interfering too brusquely with the dialogue; covering important topics and questions while relying on judgments to abandon aspects of the outline, noting non-verbal responses’ (Basch, 1987, p. 415). The most appropriate type of content- and process-related moderator style for a focus group is low control and high process, in which control over content is minimal but the moderator ensures that all relevant issues are covered in depth (Millward, 1995). However, group dynamics dictate how well this can be followed, as there is a tendency to move to a more didactic style if members of the group are discussing issues through the moderator rather than with each other.

There are no general rules as to the optimal number of focus groups for a given study, but one focus group may be enough to obtain the necessary information on the designated topic (Stewart and Shamdasani, 1990). The number of participants in focus groups may vary from four to twenty (Howard et al. 1989; Kitzinger, 1996; Twinn 1998; Merton et al, 1990). Difficulties in facilitating a large number of people in a focus group suggests that four to six participants will ensure equal contribution to the discussion (McLafferty, 2004).

Ground rules should be developed for all focus groups, and should be given to all members in writing before the actual group meets, and repeated verbally prior to beginning the group. A time limit is often put on the discussion. An atmosphere conducive to facilitating trust is essential if all members of the group are to participate (White & Thomson 1995). The process of the focus group should also be explained to all members in writing before the actual group
meets, and once again prior to beginning the group (Krueger 1994). Focus group questions should progress from general to specific questions (Kingry et al, 1990). However, the questions should act only as a guide, and the focus group moderator may ask other questions or use comments as necessary to stimulate and focus discussion.

The focus group may be audio- and/or video-recorded. Audio-recording will obtain verbal behavior, while video-recording is useful for gathering both non-verbal and verbal data (Bottorff, 1994; Polgar and Thomas, 1995). Recorded data allows events to be reviewed as often as is desirable or necessary (Bottorff 1994). Consent must be obtained for audio- and video-taping before beginning the focus group. Assurances regarding confidentiality may increase focus group members’ comfort in being audio- and video-taped (Polgar & Thomas 1995). True anonymity is impossible when using focus groups, but confidentiality is achievable. Participants also need to be told that they can stop the group at any time if they wish. Focus group members must also be assured that there will be privacy in gathering, storing and handling data.

Analyzing data from focus groups is essentially the same as analyzing qualitative data from other sources. The analysis process is sometimes referred to as content analysis. Statements generated by the focus group members can be grouped into similar areas and then examined. Statements that are exactly the same can be collapsed into one statement. If statements are similar, a decision should be made about whether they can be collapsed into one statement without changing the meaning or whether they are sufficiently different to warrant returning them as different statements. Issues of rigor in focus group research are addressed by having more than one researcher analyze the data to establish reliability (McDaniel & Bach, 1996; Higginbottom, 1998), and the data analysis should be provided to the focus group members for ‘member checking’ of its validity (Higginbottom, 1998).
There are notable limitations with the focus group technique: the relative lack of consistency in make-up and content of groups; the number of groups which should make up a project; the number of participants within each group; the importance of heterogeneity versus homogeneity; and the importance of the moderator as an influencing factor (Fern, 1982; Calder, 1977; Morgan, 1996). But a number of researchers have recommended the use of focus groups for the development of new surveys for modified Delphi studies (Gray-Vickery 1993, Morgan 1996; McKinley et al, 1997).

**Delphi Method**

The Delphi Method uses a panel of experts who have been variously defined as an ‘informed individual’ to a ‘specialist in the field’ to ‘someone who has knowledge about a specific subject’ (Keeney, Hasson, & McKenna, 2001). An expanded definition of expert is someone who not only possesses relevant knowledge and experience but whose opinion is also respected by colleagues (DeVilliers, DeVilliers & Kent, 2005). The researcher’s task is to define what constitutes expertise for the panel members and to justify the criteria for the expertise of the participants (Keeney, Hassan & McKenna, 2006; Vernon, 2009).

<table>
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<tr>
<th>Table 3.4: <strong>Requirements for a Delphi panel member</strong> (Skulmoski, Hartman, &amp; Krahn, 2007):</th>
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<tbody>
<tr>
<td>(1) knowledge and experience with the issues under investigation;</td>
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<tr>
<td>(2) capacity and willingness to participate;</td>
</tr>
<tr>
<td>(3) sufficient time to participate in the Delphi; and</td>
</tr>
<tr>
<td>(4) effective communication skills.</td>
</tr>
</tbody>
</table>

The selection of the expert panel is one of the most important steps in the Delphi Method (Okoli & Pawlowski, 2004) because the results of the study depend on the opinions expressed by the Delphi panel. There are no universally agreed criteria for the selection of experts, but experts may be identified in a number of ways (Gordon, 1994; Polit & Hungler, 1999): literature searches that reveal persons who have published works relevant to the topic of investigation;
through institutions, such as universities, organizations and government agencies; through referrals made by members of professional listservs; and by personal referrals from professionals within the field of investigation.

No guidance exists on the minimum or maximum number of experts on a panel, but the number must be adequate to ensure a reasonable representation of expert opinion (Cornick, 2006). Delphi studies have used as few as four to as many as 100 panelists (Vernon, 2009). More than 30 members on a panel does not appear to improve results (Fink et al., 1984). Recommendations suggest that panel size should depend upon whether the sample is heterogeneous or homogeneous; where the sample is homogeneous, a smaller sample of between ten to thirty people may yield sufficient results, and where the sample is heterogeneous, a sample of five to ten per category from different professional groups may be necessary (DeVilliers, DeVilliers, & Kent, 2005). Of note, heterogeneous groups can greatly increase the complexity and difficulty of collecting data from multiple sources, reaching consensus, conducting analysis, and verifying results (Skulmoski, Hartman, & Krahn, 2007). Although participant numbers are small compared to statistically-oriented modes of inquiry, it is important to understand that “…Delphis do not, and are not intended to, produce statistically significant results: in other words, the results provided by any panel do not predict the response of a larger population or even a different Delphi panel. They represent the synthesis of opinion of the particular group, no more, no less” (Gordon, 1994, p. 4).

Another characteristic of the traditional and modified Delphi method is the use of controlled feedback and statistical group response. Controlled feedback is the exchange of information between experts carried out by the researcher, so that all irrelevant information is eliminated. Feedback to panel members consists of (a) the individual panelists’ scores for each
item in each round, (b) individual panel comments from each round, and (c) group scores for each competency (Gebbie et al, 2002). Group statistical response means that all the opinions determine the final answer (Landeta, 2006).

In the first round in a modified Delphi Method, the expert panel is given the Round 1 Survey and asked to give their opinion about the topic under discussion. Panel members are also encouraged to suggest new items for inclusion. The results of Round I are then analyzed according to the quantitative research paradigm (i.e. statistical summarizing into medians plus upper and lower quartiles) (Skulmoski, Hartman, & Krahn, 2007), and is provided to the expert panel. A second questionnaire is developed using the results and feedback from the first survey round (De Villiers et al, 2005; Vernon, 2008), and the same analytic procedure is followed for ensuing rounds. The number of rounds may be predetermined by the researcher, or may continue until general agreement (www.merriam-webster.com/dictionary/consensus) or consensus is achieved.

The current literature provides few clear guidelines on what consensus level to set for a Delphi Method. A key question in any Delphi study is what percentage agreement should be accepted as synonymous with consensus. Some researchers have suggested that consensus should be equated with 51% agreement amongst respondents (Loughlin and Moore, 1979); others have recommended a cautious 70% (Bork, 1993; Walker & Selfe, 1996; Polit & Beck, 2012), whereas still other researchers have employed an 80% consensus level (Green et al, 1999). Recent Delphi studies suggest it is common practice to set consensus between 70%-75% (Cornick, 2006; De Villiers, DeVilliers, & Kent, 2005; Gebbie et al, 2002). Researchers should decide on the consensus level before commencing the study because establishing the standard is crucial as the level chosen determines what items are discarded or retained as the rounds unfold.
Recent Delphi studies suggest it is common practice to set consensus between 70%-75% (Cornick, 2006; De Villiers, DeVilliers, & Kent, 2005; Gebbie et al, 2002).

A response rate needed for consensus for a Delphi study is usually within 50%-80% (Edwards, 2002) for each round. The largest adjustment in participants agreement levels typically happens between Rounds I and II (De Villiers et al, 2005), and although there are no strict guidelines on the correct number of rounds, typically Delphi studies use between two and three rounds (Proctor & Hunt, 1994; Beech, 1997; Green et al., 1999).

In general, questionnaire research has notoriously low response rates, typically less than 50% (Polit & Beck, 2012). A problem related to the iterative process within Delphi studies is the potential for experts to withdraw after the first round (Evans, 1997) which may lead to a response bias if the attrition rate is substantial. Therefore, panel members need to be aware that a realistic approximation of the time necessary for each round of the Delphi Method is eight weeks (Duffield, 1993). Response exhaustion has been noted to occur after two rounds, especially with busy ‘experts’ and hard-pressed clinicians (McKenna, 1994). When using multiple rounds in a Delphi study, participant dropout rates may increase with each round, and a 70% response rate becomes increasingly difficult to achieve (Keeney, Hasson, & McKenna, 2001). There have been many notable nursing research studies using the Delphi Method that have experienced acceptable attrition rates (Davis & Read, 2001; Gebbie et al, 2002; Edwards, 2002; Barton et al 2009; Chang et al 2010; Hewitt, 2012).

**Research Method: Modified Delphi Method**

A modified Delphi Method was used for this study beginning with a focus group followed by a two-round Delphi Study. A timeline of the study is provided below:

**Table 3.5: Modified Delphi Study Process Timeline:**
<table>
<thead>
<tr>
<th>DATE:</th>
<th>FOCUS GROUP:</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/10/14</td>
<td>Focus Group Email to Professional Contacts sent.</td>
</tr>
<tr>
<td>10/20/14</td>
<td>Response requested / received.</td>
</tr>
<tr>
<td>10/20/14</td>
<td>Focus Group Professional Contacts’ Thank You Letter sent.</td>
</tr>
<tr>
<td>10/20/14</td>
<td>Focus Group Recruitment Letter / Focus Group Consent Form / Focus Group Demographic Questionnaire /</td>
</tr>
<tr>
<td></td>
<td>Focus Group Individual Member’s Suggested Competencies List sent.</td>
</tr>
<tr>
<td>10/30/14</td>
<td>Return requested / received.</td>
</tr>
<tr>
<td>10/30/14</td>
<td>Focus Group Non-Participant Thank You Letter sent.</td>
</tr>
<tr>
<td>11/1/14</td>
<td>Focus Group Instructions: Part I / Focus Group Members’ and NSSP Suggested Competencies Compiled List sent.</td>
</tr>
<tr>
<td>11/10/14</td>
<td>Return requested / received.</td>
</tr>
<tr>
<td>11/10/14</td>
<td>Feedback sent to all Focus Group members.</td>
</tr>
<tr>
<td>11/10/14</td>
<td>Focus Group Teleconference Initial Scheduling sent.</td>
</tr>
<tr>
<td>11/20/14</td>
<td>Response requested / received.</td>
</tr>
<tr>
<td>11/20/14</td>
<td>Focus Group Teleconference Final Scheduling sent.</td>
</tr>
<tr>
<td>11/20/14</td>
<td>Response requested / received.</td>
</tr>
<tr>
<td>11/25/14</td>
<td>Reminder regarding the Teleconference Focus Group and the Focus Group Instructions: Part 2 and the Focus Group Individual Members’ and NSSP Suggested Competencies Revised List sent.</td>
</tr>
<tr>
<td>11/30/14</td>
<td>Response requested / received.</td>
</tr>
<tr>
<td>12/1/14</td>
<td>Audio-recorded, teleconference Focus Group held.</td>
</tr>
<tr>
<td>12/2/14</td>
<td>Feedback sent to all Focus Group members.</td>
</tr>
<tr>
<td>12/2/14</td>
<td>Focus Group Participant Thank You Letter and the Delphi Study Round I Survey sent.</td>
</tr>
<tr>
<td></td>
<td><strong>DELPHI ROUNDS:</strong></td>
</tr>
<tr>
<td>12/17/14</td>
<td>Response requested / received.</td>
</tr>
<tr>
<td>12/17/14</td>
<td>Delphi Study Non-Participant Thank You Letters sent.</td>
</tr>
<tr>
<td>12/20/14</td>
<td>Feedback sent to all Delphi Study panel members.</td>
</tr>
<tr>
<td>1/1/15</td>
<td>Delphi Study Survey Instructions (Round II) / Delphi Study Round II Survey sent.</td>
</tr>
<tr>
<td>1/10/15</td>
<td>Delphi Study First Reminder to Complete the Round II Survey sent.</td>
</tr>
<tr>
<td>1/15/15</td>
<td>Delphi Study Second Reminder to Complete the Round II Survey sent.</td>
</tr>
<tr>
<td>1/20/15</td>
<td>Response requested / received.</td>
</tr>
<tr>
<td>1/21/15</td>
<td>Feedback sent to all Delphi Study panel members.</td>
</tr>
<tr>
<td>1/21/15</td>
<td>Focus Group Participant Thank You Letter and Final Results / Delphi Study Non-Participant Thank You Letter and Final Results / Delphi Study Participant Thank You Letter (one round) and Final Results / Delphi Study Participant Thank You Letter (two rounds) and Final Results sent.</td>
</tr>
</tbody>
</table>
Focus Group Sample Selection and Recruitment: Survey Development

Institutional Review Board approval was obtained from Hunter College/City University of New York (CUNY) Human Research Protection Program (HPPR) before any research activities began. Prior to Round I of the actual Delphi Study, a two-part, four-member focus group was undertaken in order to develop suggested competencies for assessing and managing suicide risk for baccalaureate nursing education. The goal of the focus group was the development of the Round 1 Survey for the modified Delphi Study.

Recruitment for the focus group participants was through the Principal Investigator’s (PI) professional network. The PI sent a Focus Group Email to Professional Contacts (Appendix 1) to four Master's-prepared nurses known to the PI who work as a non-psychiatric nurse, a psychiatric nurse, an emergency department nurse, and a psychiatric emergency department nurse. These contacts were asked for email addresses of four nursing professionals who fit the inclusion criteria listed above, and who have an interest in suicide prevention. These contacts asked the referred nurses if they could provide the PI with their email address, to get information about a study designed to develop instructional competencies for undergraduate baccalaureate nursing students. The referred nurses were told to expect an email from the PI providing them with the Focus Group Recruitment Letter (Appendix 3). The email addresses of the referred nurses who agreed to participate in the study were sent to the PI. The referred nurses were unknown to the researcher. Sixteen nurses were contacted by email about participation in the study. A Thank You Letter (Focus Group Professional Contacts Thank You Letter: Appendix 2) was sent to the PI’s professional contacts for providing the referrals.
Table 3.6: Focus Group Inclusion Criteria:

| (1) | A Master’s-prepared nurse – a registered nurse who has been providing direct patient care to a non-psychiatric population for at least five years, and has had at least one experience with a patient who has expressed suicidal ideation; |
| (2) | A Master’s-prepared psychiatric nurse – a registered nurse who has been providing direct patient care to a psychiatric population for at least five years, and has had at least one experience with a patient who has expressed suicidal ideation; |
| (3) | A Master’s-prepared emergency department nurse - a registered nurse who has been providing direct patient care to a non-psychiatric population for at least five years in a non-psychiatric emergency department, and has had at least one experience with a patient who has expressed suicidal ideation; and |
| (4) | A Master’s-prepared psychiatric emergency department nurse - a registered nurse who has been providing direct patient care to a psychiatric population for at least five years in a psychiatric emergency department, and has had at least one experience with a patient who has expressed suicidal ideation. |

Those referrals who were interested in the study clicked the link to a specified SurveyMonkey web site (http://www.surveymonkey.com) listed on the Focus Group Recruitment Letter, and were immediately given access to the Focus Group Consent Form (Appendix 4). After reading the Focus Group Consent Form, those not interested in participating could click “No, I do not agree to participate,” and the SurveyMonkey system would not allow them to continue. Those interested in participating could click “Yes, I agree to participate,” and were immediately provided with the Focus Group Demographic Questionnaire (Appendix 5), and the Focus Group Individual Member’s Suggested Competencies List (Appendix 6). They were instructed to complete the Focus Group Demographic Questionnaire and provide five suggested competencies for assessing and managing suicide risk for baccalaureate nursing education. Interested participants were requested to complete these and return them within two weeks of receipt.

Five of the sixteen referred nurses agreed to participate on the Focus Group Consent Form, completed the Focus Group Demographic Questionnaire, and suggested competencies for assessing and managing suicide risk for baccalaureate nursing education. The first non-
psychiatric nurse, the first psychiatric nurse, the first emergency department nurse, and the first psychiatric emergency department nurse who returned the aforementioned forms to the specified SurveyMonkey web site comprised the focus group. All focus group members’ identities were known to the PI but remained anonymous to the other focus group members. The PI provided her contact information to all focus group members. One referred nurse who expressed an interest in the focus group but was not one of the first four nurses to respond, was contacted via email explaining that the focus group was formed with other referred nurses. A Focus Group Non-Participant Thank You Letter (Appendix 7) was sent to one nurse who responded after group selection was completed.

The competencies suggested by the focus group members (Focus Group Member’s Suggested Competencies List – Appendix 8) were combined with competencies suggested from suicide prevention programs that are recognized by the National Strategy for Suicide Prevention (NSSP) (Focus Group NSSP Suggested Competencies List – Appendix 9). This produced a list encompassing forty-seven suggested competencies (Focus Group Members’ and NSSP Suggested Competencies Compiled List: Appendix 11). This list and the Focus Group Instructions: Part I (Appendix 10) were then sent to the focus group members within one week of their enrollment and initial response.

The Focus Group Instructions: Part I provided information before the actual audio-recorded, teleconference focus group. Focus group members were instructed to:
Table 3.7: The Focus Group Instructions: Part I

<table>
<thead>
<tr>
<th>(1)</th>
<th>REVIEW the Focus Group Individual Member’s and NSSP Suggested Competencies Compiled List:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2)</td>
<td>SCORE each listed suicide risk assessment and management competency: (A) “include as is,” (B) “include with edits,” (and provide suggested edits), or (C) “drop” from the list;</td>
</tr>
<tr>
<td>(3)</td>
<td>RECOMMEND clarifications, make comments on any suggested competency, suggest competencies which initially do not appear on the survey, or ask questions; and</td>
</tr>
<tr>
<td>(4)</td>
<td>RETURN this list to the specified SurveyMonkey web site within two weeks of receipt. All focus group members complied on time.</td>
</tr>
</tbody>
</table>

The PI then analyzed the scores returned by all the focus group members based on the scores suggested by the focus group members regarding each competency. Each individual focus group member’s scores were determined, listing those competencies that were scored (A) “include as is,” (B) “include with edits” (and the suggested edits were listed), or (C) “drop” from the list, according to that individual member. Group scores of each suggested competency were also determined by the PI which were then tabulated listing the final score for each competency.

Forty-two of the forty-seven suggested competencies on the compiled list were scored for inclusion in the revised list. Five suggested competencies did not meet the inclusion criteria of at least 75% consensus for inclusion, and were therefore, dropped. The revised list (Appendix 16) encompassed forty-two suggested competencies. The list was sent with the Focus Group Instructions: Part II (Appendix 15) to the focus group members. Also included were member’s scores and comments, and the group scores were sent to allow each member to see all other members’ responses prior to the actual focus group. The revised list was the topic of discussion during the second part of the focus group which was a one-hour, audio-recorded teleconference.

An agreed upon date/time for the teleconference focus group was determined by the PI and all focus group members (Appendices 12/13: Focus Group Teleconference Initial and Final Scheduling Emails). A reminder regarding the teleconference focus group was also sent to all focus group members via email (Appendix 14). A middle name was also identified by each
focus group member to be used during the focus group, and the teleconference phone number was provided to all focus group members via email. The PI was the focus group moderator due to her experience in leading psychotherapy groups. Focus Group members were aware of this prior to the teleconference focus group.

An IRB certified transcription service was contracted to audio-tape the teleconference focus group. High quality services with cost-effective results are guaranteed by U. S. based certified transcriptionist experts. All documents were transcribed and uploaded to a secure server. A second team of transcriptionists reviewed the work to ensure that the audio is fully checked and edited. Within two weeks of the teleconference, the transcription and audio-tape were sent to the PI.

At the beginning of the focus group, the PI first identified, and thanked members for their participation. The overall goal of the focus group was reiterated: the development of the Round I Survey for the modified Delphi study in order to develop a set of instructional competencies for assessing and managing suicide risk for baccalaureate nursing education. The group was reminded that the teleconference was being audio-taped, and that all data collected will remain confidential. Focus group members were assured that there will be privacy in gathering, storing and handling data. A guarantee was given that the data will be kept in a password-protected computer file, and stored in the PI’s office available only to her and her dissertation sponsor. Similarly they were told that only the PI and her dissertation sponsor will have access to the audio-tape which will be kept in a locked file in the PI’s office; and at the conclusion of the study, all data including the audio-tape will be destroyed. Focus group members were again told that the final results of the research project will be made available to them at the completion of the study.
The focus group ground rules and the focus group process were reviewed before the focus group started. Members were reminded to state their identifier (middle name) each time they spoke. The PI told the group that if focus group members inadvertently use their names during the group, they would be de-identified during tape transcription. All were reminded to allow others to speak. Focus group members were told that they can drop out of the discussion at any time if they wish without repercussions. The PI asked focus group members not to share information with each other, or to others outside of the group once the focus group ends. There were no questions.

The process of the focus group was restated: the first suggested competency will be stated by the PI, members will be identified by name, and asked for their score for that competency by the PI. If the suggested competency is scored (A), “include as is,” by at least 75-percent agreement of the members of the focus group, that is three out of four of the focus group members, that competency will be included in the Round I Survey. If a suggested competency is scored (B), “include with edits,” by any focus group member, those edits will be discussed, and if 75-percent agreement is reached regarding the suggested edits, that competency, as edited, will be included in the Round I Survey. If the suggested competency is scored (C), “drop,” by at least 75-percent agreement of the members, that competency will be dropped and will not become part of the Round I Survey. This process will continue until all suggested competencies are scored. There were no questions.

The PI then asked all members to refer to the revised list of suggested competencies during the focus group discussion, and began the focus group with suggested competency # 1 and ended with suggested competency # 42. Focus group members were given an opportunity to discuss each suggested competency and score each suggested competency. Thirty-five
competencies were scored (A) “include as is.” Seven suggested competencies were scored (B) “include with edits.” These edits were discussed, revised during the focus group, and scored for inclusion in the revised list by all focus group members. No suggested competencies were dropped.

The PI asked the focus group members if there were any clarifications recommended, any comments on any suggested competency, any competencies suggested that do not appear on the survey, or any questions. A clarification was requested by a focus group member regarding the meaning of ‘protective factors’ for suicide. Clarification was given: “Protective factors are conditions that promote strength and resilience and ensure that vulnerable individuals are supported and connected with others during difficult times, thereby making suicidal behaviors less likely. For example, a protective factor is spiritual support. This support may make the vulnerable individual less likely to engage in suicidal behaviors.” Two additional competencies were suggested and scored for inclusion by the focus group members. The audio-recorded, teleconference focus group lasted approximately one hour.

Within one week after the focus group, all focus group members received their individual scores and the group scores, and the results which had now become the Round I Survey (Appendix 18a/b). All focus group members approved the Round I Survey via email. A Focus Group Thank You for Participation Letter (Appendix 17) was also sent to all focus group members. All focus group members were again informed that the final results of the research project will be made available to them at the completion of the study.

Participation in both Part I and Part II of the focus group lasted for the length of time it took to read the Focus Group Recruitment Letter, read the Focus Group Consent Form and consent to participate, complete the Focus Group Demographic Questionnaire, provide five
suggested competencies, and return these to the specified SurveyMonkey web site. This was approximately one hour. The time commitment also included the length of time it took to review the Focus Group Members’ and NSSP Suggested Competencies Compiled List, and score these competencies according to the Focus Group Instructions before the actual focus group. This was also approximately one hour. Participation in the teleconference focus group lasted approximately one hour. Overall participation in the focus group took approximately three hours over two months.

**Delphi Study Panel Selection and Recruitment**

After the focus group, the Round I Survey was distributed to a criterion-based sample ($n = 60$) of nursing experts. An adequate representation of the sample population was determined to be sixty because questionnaire research has typically less than 50% response rates (Polit & Beck, 2012), and having more than 30 members on a Delphi panel does not appear to improve results (Fink et al, 1984).

The sample was recruited with the assistance of the American Psychiatric Nurses Association (APNA) ([www.apna.org](http://www.apna.org)) and the American Nurses Association (ANA) ([www.ana.org](http://www.ana.org)). The American Psychiatric Nurses Association (APNA) is the largest psychiatric-mental health nursing membership organization, with more than 8,300 members in 40 chapters nationally and internationally. APNA is the only psychiatric mental health (PMH) nursing organization whose membership is inclusive of all PMH registered nurses (RN) including associate degree (ADN), baccalaureate (BSN), and advanced practice (APN), comprised of clinical nurse specialists (CNS), psychiatric nurse practitioners (NP), nurse scientists and academicians (PhD). The membership is composed of approximately 40% psychiatric registered nurses and 60% advanced practice registered nurses, who work in a wide
variety of settings including inpatient, outpatient, research, education, administration, clinical, private practice, military, and forensic settings.

Members of the APNA are automatically subscribed to the All-Purpose Discussion Forum which provides daily emails where members can ask questions, receive feedback, discuss a pertinent topic, or disseminate information. The APNA also has community eGroups of members with similar interests in an aspect of psychiatric mental health nursing not addressed elsewhere within the APNA. The PI is a member of the following communities through the APNA: the Administrative Council Advisory Panel, the Advanced Practice Council Advisory Panel, the Education Council Advisory Panel, the Research Council Advisory Panel, the RN-PMH Council Advisory Panel, and the Suicide Awareness Council. A Delphi Study Recruitment Letter (Appendix 19), which describes the purpose of the study, the inclusion criteria for study participants, and the expected time commitment, was posted on the All-Purpose Discussion Forum and these community eGroups at the APNA member web site.

The American Nurses Association (ANA) (www.nursingworld.org) is the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses through its constituent and state nurses associations and its organizational affiliates. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

Members of the ANA are eligible to join ANA NurseSpace (www.ananursespace.org) which offers protected online space for nurses to connect with other nurses on issues they choose via online social network community eGroups. The PI is a member of the following
communities through the ANA: Advanced Practice Nurse Community, Nurse Advocates Community, Nurse Educator Community, Nursing Community, Nursing Professional Organizations Community, and Research Community. A Delphi Study Recruitment Letter (Appendix 19) was posted on these community eGroups at the ANA member web site.

<table>
<thead>
<tr>
<th>Table 3.8: Delphi Study Inclusion Criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) “nursing faculty”</td>
</tr>
<tr>
<td>(2) “psychiatric nursing faculty”</td>
</tr>
<tr>
<td>(3) “nurse clinician”</td>
</tr>
<tr>
<td>(4) “psychiatric nurse clinician”</td>
</tr>
<tr>
<td>(5) “nursing administrator”</td>
</tr>
<tr>
<td>(6) “psychiatric nursing administrator”</td>
</tr>
</tbody>
</table>

Potential participants from the APNA and the ANA who were interested in participating in the study clicked the link to a specified SurveyMonkey web site (http://www.surveymonkey.com) on the Delphi Study Recruitment Letter, and were immediately given access to the Delphi Study Consent Form (Appendix 20). After reading the Delphi Study Consent Form, those not interested indicated “No, I do not agree to participate,” and were directed away from the survey. Those interested in participating could click “Yes, I agree to participate,” and were immediately directed to the Delphi Study Demographic Questionnaire.
(Appendix 21), the Delphi Study Round I Survey (Appendix 18), and the Delphi Study Survey Instructions (Round I) (Appendix 22). Interested participants were instructed to complete these and return them within two weeks. The Delphi Study Recruitment Letter was re-posted one week after the initial posting on both APNA and ANA web sites.

Each Delphi Study Demographic Questionnaire was examined by the PI in order to determine if the respondent met the inclusion criteria. If the respondent met the inclusion criteria, and was one of the first ten respondents in the six targeted nursing titles, that respondent became a Delphi Study panel member. The Delphi Study panel members met most of the requirements for a Delphi panel member, previously identified (Skulmoski, Hartman, & Krahn, 2007), in that they were knowledgeable and experienced with at least one person who had expressed suicidal ideation, and were capable, willing, and had sufficient time which they had agreed to when they consented to participate. Due to the nature of the Delphi, it was not possible to determine if they possessed effective communication skills.

The remaining eighteen respondents received a Delphi Study Non-Participant Thank You Letter (Appendix 23), which thanked them for their interest in the study and explained that the panel was formed with the first sixty respondents. An adequate representation of the sample population was determined to be sixty because questionnaire research has typically less than 50% response rates (Polit & Beck, 2012), and having more than 30 members on a Delphi panel does not appear to improve results (Fink et al, 1984). These respondents were offered the final results of the study.

The PI took a number of steps to ensure that quasi-anonymity was maintained and that a breach of confidentiality did not occur (Polit & Beck, 2012). Anonymity is a promise that allows participants to be open and truthful about their opinions. Participants can present and react to the
research unbiased by the identities of other participants (Goodman, 1987). Anonymity is the protection of participants’ confidentiality such that even the PI cannot link individuals with information provided (Polit & Beck, 2012). True anonymity cannot be guaranteed when using the Delphi Method because of the iterative process inherent in the Delphi technique. Although an individual panel member’s responses were unknown to other participants, they were known to the PI and the dissertation sponsor. This is termed ‘quasi-anonymity’ (McKenna, 1994).

When true anonymity is impossible, confidentiality must be ensured (Keeney, Hasson, & McKenna, 2011; Polit & Beck, 2012). A promise of confidentiality is a pledge that any information participants provide will not be publicly reported in a manner that identifies them, and will not be accessible to others. This means that research data should not be shared with anyone, unless participants give explicit permission to do so. In this study, the PI ensured quasi-anonymity and confidentiality in the following ways: identifying information (only email addresses) was obtained from participants in order to send feedback from the first and second rounds; an identification (ID) number was assigned to each participant and attached to the actual data rather than other identifiers; all research data were maintained in a password-protected computer file in the PI’s locked office; access to identifying information was restricted only to the PI and the dissertation sponsor; identifying information was not entered onto computer files; research data were reported only in the aggregate, and identifying information will be destroyed, along with all data, at the conclusion of the study.

Participation in the Delphi Study lasted for the length of time it took to read the Delphi Study Recruitment Letter, agree to participate on the Delphi Study Consent Form, and complete the Delphi Study Demographic Questionnaire. This took approximately thirty minutes. It also included the length of time it took to complete each survey round which was approximately
thirty minutes for each of the two surveys. Overall participation in the Delphi Study took approximately one and a half hours. The timeline for the Delphi Study spanned a total of two months.

Data Collection and Data Analysis Procedures

Round I Data Collection and Data Analysis: The Delphi Study Round 1 Survey and the Delphi Study Survey Instructions (Round I) were provided in the first round of the Delphi Study. Panelists had two weeks to complete and score the Round I Survey according to the Delphi Study Survey Instructions. The main statistics used in the Delphi Method are measures of central tendency (mean, median and mode) and level of dispersion (standard deviation and inter-quartile range) in order to describe the consensus of the expert panel (Hasson, Keeney, McKenna, 2000). The use of the median is strongly favored to provide feedback to the expert panel (Hill & Fowles, 1975; Eckman, 1983; & Jacobs, 1996) and appears best suited to reflect the resultant convergence of opinion (Jacobs, 1996). Analysis of the survey data in the present study was performed in each round. Once the raw data were collected by the PI from all survey respondents, group responses were averaged to determine the overall level of consensus for each suggested competency which resulted in the final set of instructional competencies.

<table>
<thead>
<tr>
<th>Table 3.9: The Modified Delphi Study Survey Instructions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) REVIEW the suggested competencies;</td>
</tr>
<tr>
<td>(2) SCORE each suggested competency:</td>
</tr>
<tr>
<td>A). “Include as is,”</td>
</tr>
<tr>
<td>B). “Include with edits,” (and provide suggested edits),</td>
</tr>
<tr>
<td>C). “Drop” from the list;</td>
</tr>
<tr>
<td>(3) RECOMMEND clarifications, make comments on any</td>
</tr>
<tr>
<td>suggested competency, suggest competencies which initially</td>
</tr>
<tr>
<td>do not appear on the survey, or ask questions; AND</td>
</tr>
<tr>
<td>(4) RETURN this list to the specified SurveyMonkey web</td>
</tr>
<tr>
<td>site.</td>
</tr>
</tbody>
</table>

Using the online program SurveyMonkey®, panelists were instructed to decide whether each listed suggested competency should either be scored (A) “included as is,” (B) “included
Competencies that were scored (A), and reached at least 75% consensus became part of the final set of competencies. Competencies that did not reach at least 75% on any of the three possible scores (A/B/C) were reviewed by the PI.

Those competencies that were not dropped after review of panel members’ comments, and after discussion and approval with the PI’s dissertation sponsor, were revised according to the responses from the open-text field “include with edits.” These items were re-written in an attempt to reflect the suggestions and concerns of panelists regarding these suggested competencies. The goal of re-writing the item was to try to achieve the broadest consensus possible on item inclusion, or deletion, from the final set of competencies. These revisions were approved by the PI’s dissertation sponsor, and comprised the Round II Survey.

The Round I Survey also provided an open-text field for panelists to recommend clarifications, make comments on any suggested competency, suggest competencies which initially did not appear on the survey, or ask questions. Offering respondents the opportunity to flag items and suggest edits provided valuable feedback to the researcher, and also gave panelists an active voice in the process. This opportunity often helps move panelists closer to consensus (Keeney, Hasson, & McKenna, 2011).

Consensus is a characteristic of the Delphi Method. The definition of consensus is crucial to the trustworthiness of Delphi research (Butterworth & Bishop, 1995; Powell, 2003) yet no universal definition exists (Hasson, Keeney, & McKenna, 2000). The answer may lie with the importance of the research topic (Keeney, Hasson, & McKenna, 2006). Two points are important to defining consensus: how it is assessed and what threshold for consensus is selected when interpreting item ratings.
For this research, the consensus level was set at 75%, which strengthened the credibility of the study by using a high consensus level. Panelists scored each competency and were given the opportunity to make suggestions for editing survey items. Survey items with at least 75% consensus were included in the final set of competencies, and items with less than 75% consensus (agreement) were reviewed and rewritten to reflect the suggestions and concerns of all panel members. The dissertation sponsor reviewed and approved the revisions on the remaining suggested competencies, which became the Round II Survey. Controlled feedback is another characteristic of the Delphi Method. In this study, after the first round, the individual panelists’ scores for each item, the individual panel comments, and the group scores for each competency were sent to each panel member within two weeks of receipt of their response to the Round I Survey.

**Round II Data Collection and Data Analysis:** The Delphi Study Round II Survey (Appendix 25) and the Delphi Study Survey Instructions (Round II) (Appendix 24) were distributed in the second round of the Delphi Study. Survey Instructions were the same for both rounds. Again, panelists had two weeks to complete and score the Round II Survey according to the Delphi Study Survey Instructions (Round II). The PI sent two reminder emails to complete the round in order to enhance response rates (Appendix 26/27). These emails reminded participants that their participation in the study was important and appreciated. Reminders encourage interest, ownership, and active participation (Keeney, Hasson, & McKenna, 2011). Quick turnaround times in data collection (two weeks to complete and return the survey, and two weeks to receive the next survey) can also reduce non-response rates (Gordon, 1994). Panel members were again asked to indicate whether survey items should be: (A) “included as is,” (B) “included with edits,” or (C) “dropped.” The Round II Survey gave panelists the opportunity to
re-consider their responses from Round I. The Round II Survey also provided an open-text field for panelists to recommend clarifications, make comments on any suggested competency, suggest competencies which initially did not appear on the survey, or ask questions.

The process for data collection and data analysis for Round II was the same process as performed in Round I. After the second round, the individual panelists’ scores for each item, the individual panel comments, and the group scores for each competency were sent to each panel member who participated in the second round, within two weeks of receipt of their response to the Round II Survey. Because consensus was reached on all suggested competencies after the second round, there was no need for a third round.

The Delphi rounds spanned a period of two months. Delphi Study Participant Thank You Letters were sent to all Delphi Study participants (Appendix 30/31), as well as, the final results of the study (Instructional Competencies for Assessing and Managing Suicide Risk for Baccalaureate Nursing Education: Appendix 32). The final results, along with thank you letters, were also sent to those Delphi Study non-participants who requested such (Appendix 29), and to all focus group members (Appendix 28).

**Trustworthiness**

A characteristic of the Delphi Method is trustworthiness. Trustworthiness is the degree of confidence that qualitative researchers have in their data, and the criteria used to evaluate a study’s quality (Polit & Beck, 2012). Many Delphi researchers argue that trustworthiness is the standard for the Delphi Method rather than the criteria of validity and reliability used by quantitative researchers (Cornick, 2006; Polit & Beck, 2012). Trustworthiness is assessed using the criteria of credibility, transferability, dependability, and confirmability (Polit & Beck, 2012).
Credibility is the criterion for evaluating integrity and quality in qualitative studies, referring to confidence in the truth of the data; analogous to internal validity in quantitative research (Polit & Beck, 2012). Transferability is the extent to which qualitative findings can be transferred to other settings or groups; one of several models of generalizability (Polit & Beck, 2012). Dependability is a criterion for evaluating integrity in qualitative studies, referring to the stability of data over time and over conditions: analogous to reliability in quantitative research (Polit & Beck, 2012). Confirmability is a criterion for integrity in a qualitative inquiry, referring to the objectivity or neutrality of the data and interpretations (Polit & Beck, 2012).

In the present study, trustworthiness of the findings from the focus group was ensured (1) by having both the PI and the PI’s sponsor analyze the data to establish reliability (McDaniel & Bach, 1996; Higginbottom, 1998), and (2) the Round I Survey was provided to the focus group members for ‘member checking’ of its validity (Higginbottom, 1998) at the conclusion of the focus group. All focus group members confirmed by email receipt of the Round I Survey and approval of the Round I Survey.

Trustworthiness of the findings from the Delphi rounds was ensured by (1) a systematic and independent analysis of the content of the initial responses by both the PI and the PI’s sponsor of those remaining suggested competencies that did not reach at least 75% consensus for inclusion in the first round, and (2) the provision of an opportunity to review the interpretation of the initial data over a successive round of the Delphi method (Wilson, Ramelet, & Zuiderduyn, 2010) by the panel members. An audit trail (Rodgers & Cowles 1993), which is a clear decision trail of all key theoretical, methodological and analytical decisions made in the research from beginning to end (Koch, 1994), was captured in a journal by the PI. These attempts to ensure
trustworthiness and methodological rigor enhanced the quality of the study which is critical and contributed to a successful Delphi study.

**Chapter Summary**

This chapter provided an overview of the traditional Delphi Method and a description of the modified Delphi Method which was used to achieve consensus from a panel of nursing experts in the development of instructional competencies for assessing and managing suicide risk for baccalaureate nursing education. The Delphi Method is characterized by a number of factors which include: controlled feedback with statistical group response, consensus, and trustworthiness. A summary of the activities of both the focus group and the Delphi rounds is provided in the Modified Delphi Study Process Timeline.

A list of competencies for assessing and managing suicide risk from the NSSP Best Practice Registry were compiled with competencies suggested by a focus group of four nursing experts who were recruited from the PI’s professional network. Anonymity and confidentiality were ensured for the focus group members. After initially scoring these suggested competencies on the compiled list, an audio-recorded, teleconference focus group revised this list which became the Round 1 Survey for the modified Delphi Study.

The Delphi Study Recruitment Letter was then posted on APNA and ANA web sites which provided access to the Delphi Study Consent Form, the Delphi Study Demographic Questionnaire, and the Round I Survey and Delphi Study Survey Instructions (Round I). Panel experts were determined: ten psychiatric nursing faculty, ten psychiatric nurse clinicians, ten psychiatric nurse administrators, ten nursing faculty, ten nurse clinicians, and ten nurse administrators who were the first to respond and completed the Round I Survey became the Delphi Study panel members. Anonymity and confidentiality were ensured for Delphi Study
panel members. Data were collected during two rounds of the modified Delphi Study. Data were analyzed using a 75% consensus level to ensure the trustworthiness of the study, resulting in a final set of forty-two instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.
Chapter IV. PRESENTATION AND ANALYSIS OF DATA

Introduction

A modified Delphi Study was an effective method for achieving consensus amongst a panel of registered nurses regarding instructional competencies for assessing and managing suicide risk for baccalaureate nursing education. Initially, a two-part, four-member focus group was undertaken in order to develop suggested competencies for assessing and managing suicide risk for baccalaureate nursing education. The focus group consisted of a non-psychiatric nurse, a psychiatric nurse, an emergency department nurse, and a psychiatric emergency department nurse, all Master’s-prepared, with five years of experience in their specialty area, and with at least one experience with a patient who had expressed suicidal ideation.

Focus group individual member’s suggested competencies were compiled with suggested competencies from the Best Practice Registry of the National Strategy for Suicide Prevention (NSSP). For the first part of the focus group, focus group members scored this compiled list which was entitled the Focus Group Members’ and NSSP Suggested Competencies Compiled List according to the Focus Group Instructions: Part 1. The revised list was entitled the Focus Group Members’ and NSSP Suggested Competencies Revised List, which was the topic of discussion during the second part of the focus group; the audio-recorded, teleconference. After scoring the revised list according to the Focus Group Instructions: Part 2, forty-two of the forty-seven competencies were deemed suggested competencies for the Round I Survey, and two additional competencies were suggested and included in the Round I Survey.

The Delphi Rounds then commenced after recruitment of sixty panel members: ten nursing faculty, ten psychiatric nursing faculty, ten nurse clinicians, ten psychiatric nurse clinicians, ten nurse administrators, and ten psychiatric nurse administrators, all with five years
of experience in their specialty area, and with at least one experience with a patient who had expressed suicidal ideation. All sixty panel members completed the Round I Survey according to the Delphi Study Survey Instructions (Round I). The response rate was 100%. Thirty-four of the forty-four competencies first suggested by the focus group members were scored for inclusion in the set of instructional competencies. Ten suggested competencies did not reach 75% consensus for inclusion by the Round I panel members; two suggested competencies were dropped, and eight suggested competencies were revised in accordance with panel members’ comments. The Round II Survey was completed according to the Delphi Study Survey Instructions (Round II) by 34 panel members. The response rate was 57%. Overall, these forty-two items comprise the final set of instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

Focus Group

The inclusion criteria for the focus group members included: Master’s prepared Registered Nurses (RN), with at least five years of experience in a nursing specialty area, and experience with at least one patient expressing suicidal ideation. Similar experiences were noted among these nurses. RN 1 has provided direct patient care to a non-psychiatric population for at least five years. RN 2 has provided direct patient care to a psychiatric population for at least five years, to a non-psychiatric population in an emergency department for at least five years, and to a psychiatric population in a psychiatric emergency department for at least five years. RN 3 has provided direct patient care to a non-psychiatric population for at least five years, and to a non-psychiatric population in an emergency department for at least five years. RN 4 has provided direct patient care to a non-psychiatric population for at least five years, to a psychiatric
population for at least five years, and to a non-psychiatric population in an emergency department for at least five years.

Table 4.1: Focus Group Determination of Inclusion Criteria:

<table>
<thead>
<tr>
<th>INCLUSION CRITERIA</th>
<th>RN 1</th>
<th>RN 2</th>
<th>RN 3</th>
<th>RN 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maser’s-prepared (or above) RN</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>RN who has provided direct patient care to a non-psychiatric population for at least five years</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>RN who has provided direct patient care to a psychiatric population for at least five years</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>An emergency department RN who has provided direct patient care to a non-psychiatric population for at least five years</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>A psychiatric emergency department RN who has provided direct patient care to a psychiatric population for at least five years</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience with at least one patient expressing suicidal ideation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

The demographic data collected from the focus group members included gender, age, ethnicity, marital status, highest educational level, year of nursing program graduation, years of nursing practice, current job title, current place of employment, years at current job, and previous job titles. The focus group members included three females and one male, with an age range between 41 to over 60. All were white. Three were married, and one was widowed. The highest educational level was a Master’s degree. The years of nursing program graduation were: 1972, 1977, 1985, and 1996. The years of nursing practice ranged from 18-42 years. Current job titles were Clinical Nurse specialist/Nurse Practitioner, Associate/Director of Nursing, or “other.” The current place of employment was either a college/university or a hospital. Most respondents had more than ten years of experience in their current job, with one respondent having more than five years of experience. Previous job titles included: staff nurse, advanced practice registered nurse, professor, or “other.”
Table 4.2: Focus Group Demographic Characteristics:

<table>
<thead>
<tr>
<th></th>
<th>RN 1</th>
<th>RN 2</th>
<th>RN 3</th>
<th>RN 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Female</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Age</td>
<td>Over 60</td>
<td>Over 60</td>
<td>41-50</td>
<td>51-60</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White</td>
<td>White</td>
<td>White</td>
<td>White</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Married</td>
<td>Widowed</td>
<td>Married</td>
<td>Married</td>
</tr>
<tr>
<td>Highest Educational Level</td>
<td>MS Degree</td>
<td>MS Degree</td>
<td>MS Degree</td>
<td>MS Degree</td>
</tr>
<tr>
<td>Year RN Program Grad.</td>
<td>1977</td>
<td>1972</td>
<td>1996</td>
<td>1985</td>
</tr>
<tr>
<td>Years RN Practice</td>
<td>37 Years</td>
<td>42 Years</td>
<td>18 Years</td>
<td>29 Years</td>
</tr>
<tr>
<td>Current Job Title</td>
<td>CNS/NP</td>
<td>Other</td>
<td>AD/DON</td>
<td>Other</td>
</tr>
<tr>
<td>Current Place of Employ</td>
<td>College/Univ.</td>
<td>Hospital</td>
<td>Hospital</td>
<td>Hospital</td>
</tr>
<tr>
<td>Years at Current Job</td>
<td>&gt;10 Years</td>
<td>&gt;10 Years</td>
<td>&gt;5 Years</td>
<td>&gt;10 Years</td>
</tr>
<tr>
<td>Previous Job Titles</td>
<td>APRN/Staff RN</td>
<td>Staff RN</td>
<td>Other</td>
<td>Staff RN/Prof.</td>
</tr>
</tbody>
</table>

Eighteen competencies were suggested by the focus group members. Four of the suggested competencies were similar to the NSSP suggested competencies (good mental status assessment skills, assessment of risk factors, knowledge of all risk / protective factors for suicide / how to assess for, and determination of intent/means/lethality), therefore, fourteen of the focus group individual member’s suggested competencies were compiled with NSSP suggested competencies for assessing and managing suicide risk. The compiled list was emailed to all focus group members with the Focus Group Instructions: Part 1. Each listed suggested competency was scored (A) “include as is”, (B) “include with edits” (and provide edits) or (C), “drop” from the list. Competencies that were scored (A), and reached at least 75% consensus became part of the revised list. Competencies that did not reach at least 75% for inclusion were dropped from the revised list. After scoring by all focus group members, the results were:
<table>
<thead>
<tr>
<th>SUGGESTED COMPETENCIES</th>
<th>FINAL PERCENTAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrate knowledge of a definition of suicide</td>
<td>A)=100%</td>
</tr>
<tr>
<td>2. Demonstrate knowledge of the field of suicidology</td>
<td>A)=50%;B)=25%;C)=25%</td>
</tr>
<tr>
<td>3. Demonstrate knowledge of the suicide prevention movement</td>
<td>A)=25%;B)=25%;C)=50%</td>
</tr>
<tr>
<td>4. Demonstrate knowledge of suicide prevention resources</td>
<td>A)=100%</td>
</tr>
<tr>
<td>5. Demonstrate knowledge of community resources for individuals and families</td>
<td>A)=50%;B)=50%</td>
</tr>
<tr>
<td>6. Demonstrate knowledge of the prevalence of suicide</td>
<td>A)=75%;B)=25%</td>
</tr>
<tr>
<td>7. Demonstrate knowledge of the populations at risk</td>
<td>A)=100%</td>
</tr>
<tr>
<td>8. Demonstrate knowledge of the economic and emotional cost of suicide</td>
<td>A)=50%;B)=50%</td>
</tr>
<tr>
<td>9. Demonstrate knowledge of the myths vs. facts about suicide</td>
<td>A)=75%;B)=25%</td>
</tr>
<tr>
<td>10. Demonstrate knowledge of the risk factors for suicide</td>
<td>A)=100%</td>
</tr>
<tr>
<td>11. Demonstrate knowledge of other conditions that may affect suicide</td>
<td>A)=100%</td>
</tr>
<tr>
<td>12. Demonstrate knowledge of the warning signs of suicide</td>
<td>A)=75%;B)=25%</td>
</tr>
<tr>
<td>13. Demonstrate knowledge of the protective factors for suicide</td>
<td>A)=75%;C)=25%</td>
</tr>
<tr>
<td>14. Demonstrate knowledge of legal/ethical issues related to suicide</td>
<td>A)=75%;C)=25%</td>
</tr>
<tr>
<td>15. Demonstrate knowledge of cultural issues related to suicide</td>
<td>A)=75%;B)=25%</td>
</tr>
<tr>
<td>16. Demonstrate knowledge of issues related to documentation</td>
<td>A)=100%</td>
</tr>
<tr>
<td>17. Participate in a class journal club and select/present an article on suicide</td>
<td>A)=100%</td>
</tr>
<tr>
<td>18. Demonstrate ability to communicate openly about suicidal ideation</td>
<td>A)=100%</td>
</tr>
<tr>
<td>19. Demonstrate self-awareness in assessing and managing suicide risk</td>
<td>A)=100%</td>
</tr>
<tr>
<td>20. Demonstrate awareness of own verbal and nonverbal communication</td>
<td>A)=100%</td>
</tr>
<tr>
<td>21. Demonstrate awareness &amp; understanding of patient’s verbal and nonverbal communication</td>
<td>A)=100%</td>
</tr>
<tr>
<td>22. Demonstrate good observational skill of behavioral clues</td>
<td>A)=75%;C)=25%</td>
</tr>
<tr>
<td>23. Demonstrate effective triage/interviewing skills</td>
<td>A)=100%</td>
</tr>
<tr>
<td>24. Demonstrate use of therapeutic nonverbal and verbal communication</td>
<td>A)=100%</td>
</tr>
<tr>
<td>25. Complete a physical assessment</td>
<td>A)=75%;B)=25%</td>
</tr>
<tr>
<td>26. Complete a Mental Status Examination</td>
<td>A)=100%</td>
</tr>
<tr>
<td>27. Demonstrate behavioral health competency</td>
<td>A)=100%</td>
</tr>
<tr>
<td>28. Elicit suicidal ideation</td>
<td>A)=75%;C)=25%</td>
</tr>
<tr>
<td>29. Elicit risk factors for suicide</td>
<td>A)=100%</td>
</tr>
<tr>
<td>30. Elicit warning signs for suicide</td>
<td>A)=100%</td>
</tr>
<tr>
<td>31. Elicit protective factors for suicide</td>
<td>A)=75%;C)=25%</td>
</tr>
<tr>
<td>32. Complete intent/means/lethality assessment</td>
<td>A)=75%;C)=25%</td>
</tr>
<tr>
<td>33. Develop an assessment tool including asking the right questions</td>
<td>A)=75%;C)=25%</td>
</tr>
<tr>
<td>34. Follow organization’s policies and procedures for suicide</td>
<td>A)=100%</td>
</tr>
<tr>
<td>35. Communicate and coordinate with the interdisciplinary team</td>
<td>A)=100%</td>
</tr>
<tr>
<td>36. Determine level of care needed</td>
<td>A)=100%</td>
</tr>
<tr>
<td>37. Communicate assertively to intervene</td>
<td>A)=75%;C)=25%</td>
</tr>
<tr>
<td>38. Demonstrate ability to maintain the safety of the patient and the health care team</td>
<td>A)=100%</td>
</tr>
<tr>
<td>39. Collaborate with patient regarding plan of care in order to ensure the patient’s safety</td>
<td>A)=75%; B)=25%</td>
</tr>
<tr>
<td>40. Demonstrate use of nonviolent crisis intervention</td>
<td>A)=50%;B)=25%;C)=25%</td>
</tr>
<tr>
<td>41. Arrange for 1to1 observation if necessary</td>
<td>A)=75%;B)=25%</td>
</tr>
<tr>
<td>42. Demonstrate therapeutic verbal and nonverbal communication during one-to-one observation</td>
<td>A)=75%;C)=25%</td>
</tr>
<tr>
<td>43. Arrange for psychiatric evaluation if necessary</td>
<td>A)=7%;B)=25%</td>
</tr>
<tr>
<td>44. Obtain information and records from collateral sources as appropriate</td>
<td>A)=75%; B)=25%</td>
</tr>
<tr>
<td>45. Document the assessment and management of suicide risk</td>
<td>A)=100%</td>
</tr>
<tr>
<td>46. Demonstrate an ability to assess and manage suicide risk through role play</td>
<td>A)=100%</td>
</tr>
<tr>
<td>47. Demonstrate an ability to assess and manage suicide risk through simulation and debriefing</td>
<td>A)=100%</td>
</tr>
</tbody>
</table>
Five suggested competencies did not meet at least 75% consensus for inclusion, and were therefore, dropped from the revised list.

Table 4.4: Focus Group Part 1: Dropped Competencies / Comments / Percentages

<table>
<thead>
<tr>
<th>DROPPED COMPETENCIES/COMMENTS/PERCENTAGES:</th>
<th>(A) %</th>
<th>(B) %</th>
<th>(C) %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Demonstrates knowledge of the field of suicidology</td>
<td>50%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>“Who are experts (what types of professions) in the field?”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Demonstrates knowledge of the suicide prevention movement</td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
</tr>
<tr>
<td>“Include who is behind the suicide movement.”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Demonstrate knowledge of community resources for individuals and families</td>
<td>50%</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>“Identify 1 resource in your community, and for LGBT population.”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Demonstrate knowledge of the economic and emotional cost of suicide</td>
<td>50%</td>
<td>0%</td>
<td>50%</td>
</tr>
<tr>
<td>40. Demonstrate use of nonviolent crisis intervention</td>
<td>50%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>“Specific to suicide assessment.”</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Feedback of the individual member’s scores, the individual member’s comments, and the group scores were sent to each individual via email, along with the revised list and the Focus Group Instructions: Part 2. The Focus Group Members’ and NSSP Suggested Competencies Revised List was discussed and scored during the second part of the focus group: the audi-taped, teleconference. Competencies that were scored (A) “include as is”, and reached at least 75% consensus became part of the Round I Survey. Competencies that were scored (B) “include with edits,” and reached at least 75% consensus were revised by the focus group members during the teleconference. No competencies were dropped during the teleconference because no competencies reached 75% consensus with a score of (C). After scoring by all focus group members, the results were:
<table>
<thead>
<tr>
<th>SUGGESTED COMPETENCIES:</th>
<th>FINAL PERCENTAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrate knowledge of a definition of suicide</td>
<td>A) = 100 %</td>
</tr>
<tr>
<td>2. Demonstrate knowledge of suicide prevention resources</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>3. Demonstrate knowledge of the prevalence of suicide</td>
<td>B) = 100%</td>
</tr>
<tr>
<td>4. Demonstrate knowledge of the populations at risk</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>5. Demonstrate knowledge of the myths vs. facts about suicide</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>6. Demonstrate knowledge of the risk factors for suicide</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>7. Demonstrate knowledge of other conditions that may affect suicide</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>8. Demonstrate knowledge of the warning signs of suicide</td>
<td>B) = 100%</td>
</tr>
<tr>
<td>9. Demonstrate knowledge of the protective factors for suicide</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>10. Demonstrate knowledge of legal/ethical issues related to suicide</td>
<td>A) = 75%; C) = 25%</td>
</tr>
<tr>
<td>11. Demonstrate knowledge of cultural issues related to suicide</td>
<td>A) = 25%; B) = 75% *</td>
</tr>
<tr>
<td>12. Demonstrate knowledge of issues related to documentation</td>
<td>B) = 100%; *</td>
</tr>
<tr>
<td>13. Participate in a class journal club and select/present an article on</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>14. Demonstrate ability to communicate openly about suicidal ideation</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>15. Demonstrate self-awareness in assessing and managing suicide risk</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>16. Demonstrate awareness of own verbal and nonverbal communication</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>17. Demonstrate awareness &amp; understanding of patient’s verbal and nonverbal communication</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>18. Demonstrate good observational skill of behavioral clues</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>19. Demonstrate effective triage/interviewing skills</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>20. Demonstrate use of therapeutic nonverbal and verbal communication</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>21. Complete a physical assessment</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>22. Complete a Mental Status Examination</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>23. Demonstrate behavioral health competency</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>24. Elicit suicidal ideation</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>25. Elicit risk factors for suicide</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>26. Elicit warning signs for suicide</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>27. Elicit protective factors for suicide</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>28. Complete intent/means/lethality assessment</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>29. Develop an assessment tool including asking the right questions</td>
<td>A) = 75%; C) = 25%</td>
</tr>
<tr>
<td>30. Follow organization’s policies and procedures for suicide</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>31. Communicate and coordinate with the interdisciplinary team</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>32. Determine level of care needed</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>33. Communicate assertively to intervene</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>34. Demonstrate ability to maintain the safety of the patient and the health care team</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>35. Collaborate with patient regarding plan of care in order to ensure the patient’s safety</td>
<td>B) = 100% *</td>
</tr>
<tr>
<td>36. Arrange for 1to1 observation if necessary</td>
<td>B) = 100%; *</td>
</tr>
<tr>
<td>37. Demonstrate therapeutic verbal and nonverbal communication during one-to-one observation</td>
<td>A) = 75%; C) = 25%</td>
</tr>
<tr>
<td>38. Arrange for psychiatric evaluation if necessary</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>39. Obtain information and records from collateral sources as appropriate</td>
<td>B) = 100%; *</td>
</tr>
<tr>
<td>40. Document the assessment and management of suicide risk</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>41. Demonstrate an ability to assess and manage suicide risk through role play</td>
<td>A) = 100%</td>
</tr>
<tr>
<td>42. Demonstrate an ability to assess and manage suicide risk through simulation and debriefing</td>
<td>A) = 100%</td>
</tr>
</tbody>
</table>
Thirty-five competencies were scored (A) “include as is.” Seven* suggested competencies were scored (B) “include with edits. These edits were discussed, revised during the focus group, and scored for inclusion by all focus group members.

Table 4.6: Focus Group Part 2 Competency Revisions *

<table>
<thead>
<tr>
<th>Initial Competency</th>
<th>Revised Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>#3. Demonstrate knowledge of the prevalence of suicide. Comment: “with breakdown by ethnicity, religion, sex, and background.”</td>
<td>#3. Demonstrate knowledge of the prevalence of suicide with breakdown by ethnicity, religion, sex, and background.</td>
</tr>
<tr>
<td>#8. Demonstrate knowledge of the warning signs of suicide. Comment: “especially psychiatric diagnosis and/or substance abuse issues.”</td>
<td>#8. Demonstrate knowledge of the warning signs of suicide especially psychiatric diagnosis and/or substance abuse issues.</td>
</tr>
<tr>
<td>#35. Collaborate with patient regarding plan of care in order to ensure the patient’s safety. Comment: “collaborate with patient, family, significant other, and treatment team…”</td>
<td>#35. Collaborate with patient, family, significant other, and treatment team regarding the plan of care in order to ensure the patient’s safety.</td>
</tr>
<tr>
<td>#36. Arrange for 1to1 observation if necessary. Comment: “include observation of patient and environment”</td>
<td>#36. Arrange for 1to1 observation if necessary, including observation of the patient and environment.</td>
</tr>
<tr>
<td>#39. Obtain information and records from collateral sources as appropriate. Comment: “while maintaining confidentiality.”</td>
<td>#39. Obtain information and records from collateral sources as appropriate while maintaining confidentiality.</td>
</tr>
</tbody>
</table>

Two competencies were suggested during the FG: Demonstrate knowledge of suicide risk assessment for an ED patient vs. an inpatient suicide risk assessment, and demonstrate suicide risk assessment for different age populations: child, adolescent, and adult. Both these
additional competencies were scored for inclusion by all focus group members. One clarification was sought by a focus group member regarding the meaning of ‘protective factors’ for suicide, and clarification was provided. The outcome of the Focus Group: Part 2 was the Round I Survey.

**Delphi Study: Round I**

The Delphi Study panel members for the first round were sixty Registered Nurses with experience with at least one patient expressing suicidal ideation. They included: ten “nursing faculty” – doctorally prepared registered nurses who hold a faculty appointment at a school or college of nursing for at least five years; ten “psychiatric nursing faculty” – doctorally prepared registered nurses who hold a faculty appointment at a school or college of nursing for at least five years; ten “nurse clinicians” – Master’s-prepared (or above) registered nurses who have clinical expertise as a nurse practitioner or as a clinical nurse specialist who have been providing direct patient care to a general medical population for at least five years; ten “psychiatric nurse clinicians” – Master’s-prepared (or above) registered nurses who have clinical expertise as a psychiatric nurse practitioner or as a clinical nurse specialist who have been providing direct patient care to a psychiatric population for at least five years; ten “nursing administrators” – Master’s-prepared (or above) registered nurses who hold an administrative title in a non-psychiatric hospital, organization, or agency, for at least five years; and ten “psychiatric nursing administrators” – Master’s-prepared (or above) registered nurses who hold an administrative title in a psychiatric hospital, organization, or agency, for at least five years. Similar experiences were also noted among these nurses. Nursing faculty also listed experience as nurse clinician and/or nurse administrator; Psychiatric nursing faculty also listed experience as psychiatric clinical nurse specialist/nurse practitioner and /or nurse administrator.
Table 4.7: Delphi Study Round I Panel Members:

<table>
<thead>
<tr>
<th>Professional Designation</th>
<th>%</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing faculty</td>
<td>31.67%</td>
<td>19</td>
</tr>
<tr>
<td>Psychiatric nursing faculty</td>
<td>26.67%</td>
<td>16</td>
</tr>
<tr>
<td>Nurse clinician</td>
<td>38.33%</td>
<td>23</td>
</tr>
<tr>
<td>Psychiatric nurse clinician</td>
<td>41.67%</td>
<td>25</td>
</tr>
<tr>
<td>Nursing administrator</td>
<td>20.00%</td>
<td>12</td>
</tr>
<tr>
<td>Psychiatric nursing administrator</td>
<td>16.67%</td>
<td>10</td>
</tr>
</tbody>
</table>

Demographic Characteristics of the Delphi Study Round I Panel Members:

The Delphi Study Round I Panel Members included 53 (89.83%) females and 6 (10.17%) males. The age range was between 21 – over 60, with the majority of respondents between 51-60 years old (50.85%). The major ethnicity of the Delphi Study Round I Panel Members was White (73.33%), and the majority was married (65.00%). Nearly half of the respondents had Master’s degrees (46.67%), while more than half of the respondents had doctoral degrees (51.67%). Nursing program graduation years ranged from 1960 – 2007, with most respondents graduating between the years 1970 – 1990. The years of nursing practice ranged from five years to forty-eight years, with 31.09 years of nursing practice on average.

The majority of respondents were professors (43.33%). The current place of employment for most respondents was either a college/university (50.85%) or a hospital (32.20%). Most respondents (56.57%) had more than ten years of experience in their current job. Many respondents had previous experiences as a staff nurse (44.07%), clinical nurse specialist/nurse practitioner (45.76%), and/or professor (45.76%). The response rate for the first round was 100%.
Table 4.8: Round I Participant Demographics

<table>
<thead>
<tr>
<th></th>
<th>%</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GENDER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>89.83%</td>
<td>53</td>
</tr>
<tr>
<td>Male</td>
<td>10.17%</td>
<td>6</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>59*</td>
</tr>
<tr>
<td><strong>AGE RANGE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 21</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>21 - 30</td>
<td>1.69%</td>
<td>1</td>
</tr>
<tr>
<td>31 - 40</td>
<td>3.39%</td>
<td>2</td>
</tr>
<tr>
<td>41 - 50</td>
<td>8.47%</td>
<td>5</td>
</tr>
<tr>
<td>51 - 60</td>
<td>50.85%</td>
<td>30</td>
</tr>
<tr>
<td>Over 61</td>
<td>35.59%</td>
<td>21</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>59*</td>
</tr>
<tr>
<td><strong>ETHNICITY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Asian/Native Hawaiian/Other Pacific Islander</td>
<td>6.67%</td>
<td>4</td>
</tr>
<tr>
<td>Black or African American</td>
<td>18.33%</td>
<td>11</td>
</tr>
<tr>
<td>Hispanic or Latina</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>White</td>
<td>73.33%</td>
<td>44</td>
</tr>
<tr>
<td>Other</td>
<td>1.67%</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>60</td>
</tr>
<tr>
<td><strong>MARITAL STATUS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>6.67%</td>
<td>4</td>
</tr>
<tr>
<td>Single, living with partner</td>
<td>5.00%</td>
<td>3</td>
</tr>
<tr>
<td>Married</td>
<td>65.00%</td>
<td>39</td>
</tr>
<tr>
<td>Separated</td>
<td>1.67%</td>
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</tr>
<tr>
<td>Divorced</td>
<td>18.33%</td>
<td>11</td>
</tr>
<tr>
<td>Widowed</td>
<td>3.33%</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>60</td>
</tr>
<tr>
<td><strong>HIGHEST EDUCATIONAL LEVEL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associate degree</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Baccalaureate degree</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Master's degree</td>
<td>46.67%</td>
<td>28</td>
</tr>
<tr>
<td>Doctoral degree</td>
<td>51.67%</td>
<td>31</td>
</tr>
<tr>
<td>Other</td>
<td>1.67%</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>60</td>
</tr>
<tr>
<td><strong>YEAR RN PROGRAM GRADUATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1960 - 1969</td>
<td>8.33%</td>
<td>5</td>
</tr>
<tr>
<td>1970 - 1979</td>
<td>43.33%</td>
<td>26</td>
</tr>
<tr>
<td>1980 - 1989</td>
<td>33.90%</td>
<td>20</td>
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<tr>
<td>1990 - 1999</td>
<td>6.67%</td>
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</tr>
<tr>
<td>2000 - 2009</td>
<td>6.67%</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>59*</td>
</tr>
</tbody>
</table>

(* One respondent skipped this question).
### Table 4.8: Round I Participant Demographics (Continued)

<table>
<thead>
<tr>
<th>YEARS RN PRACTICE</th>
<th>TOTAL YEARS</th>
<th>AVERAGE YEARS / PER RN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Faculty</td>
<td>332</td>
<td>33.20</td>
</tr>
<tr>
<td>Psychiatric Nursing Faculty</td>
<td>375</td>
<td>37.50</td>
</tr>
<tr>
<td>Nurse Clinicians</td>
<td>287</td>
<td>31.88*</td>
</tr>
<tr>
<td>Psychiatric Nurse Clinicians</td>
<td>284</td>
<td>28.40</td>
</tr>
<tr>
<td>Nurse Administrators</td>
<td>285</td>
<td>28.50</td>
</tr>
<tr>
<td>Psychiatric Nurse Administrators</td>
<td>271</td>
<td>27.10</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,834</td>
<td>31.09</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CURRENT JOB TITLE</th>
<th>%</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff nurse</td>
<td>6.67%</td>
<td>4</td>
</tr>
<tr>
<td>Advanced practice nurse</td>
<td>8.33%</td>
<td>5</td>
</tr>
<tr>
<td>Clinical nurse specialist/nurse practitioner</td>
<td>15.00%</td>
<td>9</td>
</tr>
<tr>
<td>Professor</td>
<td>43.33%</td>
<td>26</td>
</tr>
<tr>
<td>Associate Director/Director of Nursing</td>
<td>10.00%</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>16.67%</td>
<td>10</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>60</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CURRENT PLACE OF EMPLOY</th>
<th>%</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>32.20%</td>
<td>19</td>
</tr>
<tr>
<td>Clinic</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Elementary/High School</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>College/University</td>
<td>50.85%</td>
<td>30</td>
</tr>
<tr>
<td>Organization</td>
<td>3.39%</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>13.56%</td>
<td>8</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>60</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YEARS AT CURRENT JOB</th>
<th>%</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than one year</td>
<td>6.67%</td>
<td>4</td>
</tr>
<tr>
<td>1-3 years</td>
<td>6.67%</td>
<td>4</td>
</tr>
<tr>
<td>Less than 5 years</td>
<td>11.67%</td>
<td>7</td>
</tr>
<tr>
<td>5 years</td>
<td>1.67%</td>
<td>1</td>
</tr>
<tr>
<td>Less than 10 years</td>
<td>16.67%</td>
<td>10</td>
</tr>
<tr>
<td>More than 10 years</td>
<td>56.57%</td>
<td>34</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>60</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PREVIOUS JOB TITLES</th>
<th>%</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff nurse</td>
<td>44.07%</td>
<td>26</td>
</tr>
<tr>
<td>Advanced practice nurse</td>
<td>20.34%</td>
<td>12</td>
</tr>
<tr>
<td>Clinical Nurse Specialist/Nurse Practitioner</td>
<td>45.76%</td>
<td>27</td>
</tr>
<tr>
<td>Professor</td>
<td>45.76%</td>
<td>27</td>
</tr>
<tr>
<td>Associate/Director of Nursing</td>
<td>32.20%</td>
<td>19</td>
</tr>
<tr>
<td>Other</td>
<td>15.25%</td>
<td>9</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>59*</td>
</tr>
</tbody>
</table>
The Delphi Study Round I Survey was scored according to the Delphi Study Survey Instructions (Round I). Each listed suggested competency was scored (A) “include as is”, (B) “include with edits” (and provide edits) or (C) “drop” from the list. Competencies that were scored (A), and reached at least 75% consensus became part of the final set of competencies. Competencies that did not reach at least 75% on any of the three possible scores (A/B/C) were reviewed by the PI. After scoring by all Delphi Study Panel Members, the results were:

Table 4.9: Results of Round I Survey

<table>
<thead>
<tr>
<th>Suggested Competency</th>
<th>(A) %</th>
<th>(B) %</th>
<th>(C) %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrate knowledge of a definition of suicide.</td>
<td>86.67</td>
<td>13.33</td>
<td>0</td>
</tr>
<tr>
<td>2. Demonstrate knowledge of suicide prevention resources.</td>
<td>91.23</td>
<td>8.77</td>
<td>0</td>
</tr>
<tr>
<td>3. Demonstrate knowledge of the prevalence of suicide with breakdown by ethnicity, religion, sex, and background.</td>
<td>61.67</td>
<td>35.</td>
<td>3.33</td>
</tr>
<tr>
<td>4. Demonstrate knowledge of the populations at risk.</td>
<td>85.</td>
<td>15.</td>
<td>0</td>
</tr>
<tr>
<td>5. Demonstrate knowledge of the myths vs. facts about suicide.</td>
<td>90.</td>
<td>5.</td>
<td>5.</td>
</tr>
<tr>
<td>6. Demonstrate knowledge of the risk factors for suicide.</td>
<td>88.33</td>
<td>10.</td>
<td>1.67</td>
</tr>
<tr>
<td>7. Demonstrate knowledge of other conditions that may affect suicide.</td>
<td>79.66</td>
<td>16.95</td>
<td>3.39</td>
</tr>
<tr>
<td>8. Demonstrate knowledge of the warning signs of suicide especially psychiatric diagnosis and/or substance abuse issues.</td>
<td>76.27</td>
<td>20.34</td>
<td>3.39</td>
</tr>
<tr>
<td>9. Demonstrate knowledge of the protective factors for suicide.</td>
<td>79.66</td>
<td>20.34</td>
<td>0</td>
</tr>
<tr>
<td>10. Demonstrate knowledge of legal/ethical issues related to suicide.</td>
<td>86.21</td>
<td>10.34</td>
<td>3.45</td>
</tr>
<tr>
<td>11. Demonstrate knowledge of cultural issues related to suicide including demographics, ethnicity, religion, and background.</td>
<td>65.</td>
<td>30.</td>
<td>5.</td>
</tr>
<tr>
<td>12. Demonstrate knowledge of suicide risk assessment for different age populations: child / adolescent / adult.</td>
<td>79.66</td>
<td>18.64</td>
<td>1.69</td>
</tr>
<tr>
<td>13. Demonstrate knowledge of suicide risk assessment for an ED patient vs. an inpatient.</td>
<td>73.33</td>
<td>16.67</td>
<td>10</td>
</tr>
<tr>
<td>14. Demonstrate knowledge of issues related to nursing documentation.</td>
<td>75.86</td>
<td>20.69</td>
<td>3.45</td>
</tr>
<tr>
<td>15. Participate in a class journal club and select/present an article on suicide.</td>
<td>54.24</td>
<td>18.64</td>
<td>27.12</td>
</tr>
<tr>
<td>16. Demonstrate ability to communicate openly about suicidal ideation.</td>
<td>83.33</td>
<td>15.</td>
<td>1.67</td>
</tr>
<tr>
<td>17. Demonstrate self-awareness in assessing and managing suicide risk.</td>
<td>84.75</td>
<td>10.17</td>
<td>5.08</td>
</tr>
<tr>
<td>18. Demonstrate awareness of own verbal and nonverbal communication.</td>
<td>72.88</td>
<td>22.03</td>
<td>5.08</td>
</tr>
<tr>
<td>19. Demonstrate awareness and understanding of patient’s verbal and nonverbal communication.</td>
<td>86.67</td>
<td>11.67</td>
<td>1.67</td>
</tr>
<tr>
<td>20. Demonstrate good observational skill of behavioral clues.</td>
<td>74.58</td>
<td>23.73</td>
<td>1.69</td>
</tr>
<tr>
<td>21. Demonstrate effective triage/interviewing skills.</td>
<td>86.67</td>
<td>11.67</td>
<td>1.67</td>
</tr>
<tr>
<td>22. Demonstrate use of therapeutic verbal and nonverbal communication.</td>
<td>90.</td>
<td>6.67</td>
<td>3.33</td>
</tr>
<tr>
<td>23. Complete a physical examination.</td>
<td>70.</td>
<td>10.</td>
<td>20.</td>
</tr>
<tr>
<td>24. Complete a Mental Status Examination.</td>
<td>93.33</td>
<td>3.33</td>
<td>3.33</td>
</tr>
<tr>
<td>25. Demonstrate behavioral health competency.</td>
<td>57.63</td>
<td>16.95</td>
<td>25.42</td>
</tr>
<tr>
<td>26. Elicit suicidal ideation.</td>
<td>66.10</td>
<td>20.34</td>
<td>13.56</td>
</tr>
<tr>
<td>27. Elicit risk factors for suicide.</td>
<td>77.59</td>
<td>17.24</td>
<td>5.17</td>
</tr>
<tr>
<td>28. Elicit warning signs for suicide.</td>
<td>83.05</td>
<td>13.56</td>
<td>3.39</td>
</tr>
<tr>
<td>29. Elicit protective factors for suicide.</td>
<td>81.36</td>
<td>13.56</td>
<td>5.08</td>
</tr>
<tr>
<td>30. Complete intent/means/lethality assessment.</td>
<td>90.</td>
<td>8.33</td>
<td>1.67</td>
</tr>
<tr>
<td>31. Develop an assessment tool including asking the right questions.</td>
<td>52.63</td>
<td>21.05</td>
<td>26.32</td>
</tr>
<tr>
<td>32. Follow organization’s policies and procedures for suicide.</td>
<td>86.21</td>
<td>10.34</td>
<td>3.45</td>
</tr>
<tr>
<td>33. Communicate assertively to intervene.</td>
<td>75.86</td>
<td>18.97</td>
<td>5.17</td>
</tr>
<tr>
<td>34. Communicate and coordinate with the interdisciplinary team.</td>
<td>92.98</td>
<td>7.02</td>
<td>0</td>
</tr>
<tr>
<td>35. Determine level of care needed.</td>
<td>80.70</td>
<td>14.04</td>
<td>5.26</td>
</tr>
<tr>
<td>36. Arrange for psychiatric evaluation if necessary.</td>
<td>86.44</td>
<td>8.47</td>
<td>5.08</td>
</tr>
<tr>
<td>37. Collaborate with patient, family, significant other, and treatment team regarding the plan of care in order to ensure patient’s safety.</td>
<td>94.92</td>
<td>5.08</td>
<td>0</td>
</tr>
<tr>
<td>38. Demonstrate ability to maintain the safety of the patient and the health care team.</td>
<td>88.14</td>
<td>10.17</td>
<td>1.69</td>
</tr>
<tr>
<td>39. Arrange for 1to1 observation if necessary, including observation of the patient and the environment.</td>
<td>89.83</td>
<td>8.47</td>
<td>1.69</td>
</tr>
<tr>
<td>40. Demonstrate therapeutic verbal and nonverbal communication during one-to-one observation.</td>
<td>93.22</td>
<td>3.39</td>
<td>3.39</td>
</tr>
<tr>
<td>41. Obtain information and records from collateral sources as appropriate while maintaining confidentiality.</td>
<td>89.83</td>
<td>6.78</td>
<td>3.39</td>
</tr>
<tr>
<td>42. Document the assessment and management of suicide risk.</td>
<td>96.61</td>
<td>3.39</td>
<td>0</td>
</tr>
<tr>
<td>43. Demonstrate an ability to assess and manage suicide risk through role play.</td>
<td>84.48</td>
<td>5.17</td>
<td>10.34</td>
</tr>
<tr>
<td>44. Demonstrate an ability to assess and manage suicide risk through simulation and debriefing.</td>
<td>89.66</td>
<td>3.45</td>
<td>6.90</td>
</tr>
</tbody>
</table>

Thirty-four of the forty-four competencies reached at least 75% consensus for inclusion in the final set of competencies. Ten suggested competencies did not reach that consensus level.

After discussion and approval with the PI’s dissertation sponsor, two competencies were
dropped: Competency # 15: Participate in a class journal club and select/present an article on suicide, which was determined to be a class assignment; and Competency # 25: Demonstrate behavioral health competency, which encompasses a broad array of competencies in order to determine one's mental health. The remaining eight competencies were revised according to the suggested edits by panel members, approved by the PI’s dissertation sponsor, and comprised the Round II Survey.

Suggested edits by panel members were:

---

**Initial Competency #3. Demonstrate knowledge of the prevalence of suicide with breakdown by ethnicity, religion, sex, and background.**

“Suicide needs to be more specifically defined - ideation, attempt, completed?” / “Diversity within the specified ethnic groups/ Age, sociopolitical environment” / “this should be at the analysis level”/ “add age”/ “I think "demonstrate" is the wrong qualifier- how would student demonstrate this? Also I think using sex as identifier is important but would you miss other cultural issues or identifiers such as transgendered youth who have a high prevalence of suicide. And what exactly is meant by "background"?" / “Demonstrate knowledge of social, medical, and demographic factors associated with suicide prevalence” / “Age is also an important factor” / “Demonstrate knowledge of the prevalence of suicide with breakdown by ethnicity, religion, gender” / “I do not know what 'background' means here. Demographics should be added” / ”This one should be included in the cultural diversity courses in order to provide more in depth training” / “Circumstances” / “Not sure a baccalaureate nurse will be able to evaluate "background", unless this refers to a prior history of suicidal behavior or a diagnosis of mental illness”/ “Gender not sex, sextant preferences” /"gender vs sex.”/ “What is meant by
Revised Competency #3. Demonstrate knowledge of the incidence/prevalence of suicidal ideation, suicide attempt, and suicide completion among persons related to demographic characteristics (age, gender, sexual orientation, religion, ethnicity, culture, educational level, employment, marital status, geographic location, sociopolitical environment, socioeconomic factors), personal and family history.

Initial Competency #11. Demonstrate knowledge of cultural issues related to suicide including demographics, ethnicity, religion, and background.

“Suicidal ideation /background” / “Analyze cultural issues related to suicide...”/ “Seems like duplicate of one of above questions?”/ “Include age. Also, what is meant by background?” / “This one and item 3 sound similar so maybe combine and spell it out clearly??” / “Remove demographics, ethnicity, religion, and background”/ “Update as necessary”/ “Demonstrate knowledge of socioeconomic and cultural factors related to suicide including demographics, ethnicity, religion, and geographical location /sexual orientation” / “Background is too vague” / “Does background encompass education, marital status, employment, financial or social resources or life circumstances?” / “drop the background piece, needs to be more specific.”

Revised Competency #11. Demonstrate knowledge of cultural issues related to suicidal ideation, suicide attempt, and suicide completion.

Initial Competency #13. Demonstrate knowledge of suicide risk assessments for an ED patient vs. an inpatient.

“Would include hometcare, provider office visit” / “I think you mean Emergency department here but would use language maybe more inclusive without abbrev? i.e. acute setting such as emergency department, crisis evaluation center??” / “Demonstrate knowledge of suicide risk assessment for an Emergency Department patient vs. an inpatient/ in outpatient and inpatient settings” / “Include out-patient” / “This perhaps should encompass any outpatient arena outside of inpatient (clinics, ED, schools, clubs)”

Revised Competency #13. Demonstrate knowledge of suicide risk assessments for all patients: emergency department patients, inpatients, and outpatients.
**Initial Competency #18.** Demonstrate awareness of own verbal and nonverbal communication.

“Nonverbal and verbal as it relates to cultural diversity” / “Demonstrate competency in verbal and nonverbal communication (note: this is an assessment skill at the baccalaureate level...not therapy for undergrad students/ please clarify information /of one's own /How to demonstrate?” / “In general or related to suicide assessment?” / “There is some ambiguity in this question”/ “communication about suicide” / “measured?” / “personal instead of own?” / ”Add patterns or style and their impact” / “Need more specific objective. What is demonstrate?”/ "self awareness" how will it be measured?”

**Revised Competency #18.** Demonstrate awareness of personal verbal (sound, words, speaking, and language) and nonverbal (the environment, body language, prosodic and paralinguistic features of voice) communication related to suicide assessment.

**Initial Competency #20.** Demonstrate good observational skill of behavioral clues.

“Delete good (too vague)” / “behavioral cues?” / “Good is subjective; a better adjective that can be measured is suggested” / “In general or related to suicide assessment?” / “demonstrate ability to interpret behavioral clues” / “as evidenced by charting of client status and updates” / “what does good mean?”/ “how will it be measured /be more concrete, what is good observational skill?” / “Demonstrate specific observational skill for behavioral clues of patient with actual or potential suicide idea/plan” / “The term 'good' should be removed - how do you measure this?” “Demonstrate understanding of behavioral clues” / “Again, I think this one is too broad. What do you want to observe, specifically?” / “of presence of OR increased suicidal risk?” / “demonstrate competence?”/ “drop the "good"

**Revised Competency #20.** Demonstrate ability to observe and interpret verbal and nonverbal clues of patient at risk for suicide.

**Initial Competency #23.** Complete a physical assessment.

“Not clear...which components of physical assessment?” / “More specific to this area /I would definitely specify this may not always be appropriate to the role of the APRN -is setting dependent”/ “I have a private practice and do not do physical exams on my patients”/ “with documentation of evidence of prior self-harm if any exists” / “how is this relevant?”/ “This should be covered elsewhere”/ “Let's not overwhelm the student with too many expectations. Include this elsewhere in the education”

**Revised Competency #23.** Complete a nursing assessment including baccalaureate-level physical and psychosocial assessments.
Initial Competency #26. Elicit suicidal ideation.

“Redundant...assessment skills above include this” /"Assess for suicidal ideation” /"demonstrate ability to elicit suicidal ideation” /"Describe what that means” / “Demonstrate ability to effectively interview an individual regarding suicidal ideation” / “Seems too vague. How to measure this one also?” / “unclear what the expectation is” / “Demonstrate the ability to use therapeutic communication skills to elicit.....” / “fits under the broad category of interview skills”/ “Ask client about suicidal ideations” / “many clients do not divulge” / “ask directly about” / “I don't understand this question. If a student successfully does a suicide risk assessment these will be covered” / “Or contradictions that suggest it in face of outward denial by client”

Revised Competency #26. Demonstrate ability to use therapeutic communication skills to elicit suicidal ideation.

Initial Competency #31. Develop an assessment tool including asking the right questions.

“Appropriate questions /Use evidence based tools - Columbia /these exist...should be provided to students...don't make students re-invent the wheel” / “Complete the suicide assessment instrument (there should already be one in place at each facility)” / “interviewing should replace asking the right questions” / “Rather than develop I would have them research and find a tool”/ “Developing a tool I see as a master's competency”/ “Have knowledge re available suicide assessment tools” / “Too high level I think” / “Think developing an assessment tool would be very helpful”/ “Giving specific detailed ways to ask questions and documentation” / “what would the assessment tool be for? What patient population?”/ “have no idea what this means beyond what has already been listed as competencies” / “I really like this one!” / “Too advanced for baccalaureate students...would suggest Demonstrate ability to apply an assessment tool” /"there will be loads - see the ASIST training” / “Not sure what this means, too vague” / “Develop a screening instrument for suicide assessment with specific questions” / “At the baccalaureate level I believe identifying existing assessment tools that have strong reliability and validity is appropriate” / “There are excellent resources available” / “A new tool wouldn't be established as reliable and its validity probably would be in question” / “This is an unrealistic expectation, have them demonstrate knowledge in using already developed assessment tools” / “for what?” / “Each student will develop an assessment tool? Use of standardized or best practice tools”

Revised Competency #31. Demonstrate ability to complete a reliable and valid suicide assessment instrument.
After the first round, the individual panelists’ scores for each item, the individual panel comments, and the group scores for each competency (Results of Round I Survey: Table 18) were sent to each panel member within two weeks of receipt of their response to the Round I Survey. The Delphi Study Round II Survey and the Delphi Study Survey Instructions (Round II) were distributed in the second round of the Delphi Study. Again, panelists had two weeks to complete and score the Round II Survey according to the Delphi Study Survey Instructions (Round II).

**Delphi Study: Round II**

Thirty-four panel members responded to the second round of the Delphi Study; five nursing faculty, eight psychiatric nursing faculty, six nurse clinicians, five psychiatric nurse clinicians, four nurse administrators, and six psychiatric nurse administrators. Two reminders to complete the survey provided a 57% response rate. A response rate needed for consensus for a Delphi study is usually within 50%- 80% (Edwards, 2002) for each round. In general, questionnaire research has notoriously low response rates, typically less than 50% (Polit & Beck, 2012), and a problem related to the iterative process within Delphi studies is the potential for experts to withdraw after the first round (Evans, 1997).

**Table 4.10: Delphi Study Round II Panel Members:**

<table>
<thead>
<tr>
<th>Professional Designation</th>
<th>%</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing faculty</td>
<td>29.41%</td>
<td>10</td>
</tr>
<tr>
<td>Psychiatric nursing faculty</td>
<td>32.35%</td>
<td>11</td>
</tr>
<tr>
<td>Nurse clinician</td>
<td>38.23%</td>
<td>13</td>
</tr>
<tr>
<td>Psychiatric nurse clinician</td>
<td>41.17%</td>
<td>14</td>
</tr>
<tr>
<td>Nursing administrator</td>
<td>14.70%</td>
<td>5</td>
</tr>
<tr>
<td>Psychiatric nursing administrator</td>
<td>17.64%</td>
<td>6</td>
</tr>
</tbody>
</table>
Demographic Characteristics of the Delphi Study Round II Panel Members:

The Delphi Study Round II Panel Members included 29 (85.30%) females and 5 (14.70%) males. Examination of the demographic characteristics of the Delphi Study Round II panel members show a similar demographic to the Delphi Study Round I panel members. Therefore, no differential attrition rate was noted.

The age range of the Round II panel members was between 21 – over 60, with the majority of respondents between 51-60 years old (55.88%). The major ethnicity of the Delphi Study Round II Panel Members was White (76.47%), and the majority was married (50.00%). Nearly half of the respondents had Master’s degrees (47.05%), while half of the respondents had doctoral degrees (50%). Nursing program graduation years ranged from 1960 – 2007, with most respondents graduating between the years 1970 – 1990. The years of nursing practice ranged from nine years to forty-three years, with 30.15 years of nursing practice on average.

The majority of respondents were professors (44.11%). The current place of employment for most respondents was either a college/university (57.57%) or a hospital (27.27%). Most respondents (63.63%) had more than ten years of experience in their current job. Many respondents had previous experiences as a staff nurse (38.23%), clinical nurse specialist/nurse practitioner (50.00%), and/or professor (50.00%). Similarities in all demographic characteristics were noted between the Delphi Study Round I panel members and the Delphi Study Round II panel members.
Table 4.11 Round II Participant Demographics

<table>
<thead>
<tr>
<th>GENDER</th>
<th>%</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>85.30%</td>
<td>29</td>
</tr>
<tr>
<td>Male</td>
<td>14.70%</td>
<td>5</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>34</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AGE RANGE</th>
<th>%</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 21</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>21 - 30</td>
<td>2.94%</td>
<td>1</td>
</tr>
<tr>
<td>31 - 40</td>
<td>2.94%</td>
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</tr>
<tr>
<td>41 - 50</td>
<td>8.82%</td>
<td>3</td>
</tr>
<tr>
<td>51 - 60</td>
<td>55.88%</td>
<td>19</td>
</tr>
<tr>
<td>Over 61</td>
<td>29.41%</td>
<td>10</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>34</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>ETHNICITY</th>
<th>%</th>
<th>#</th>
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</thead>
<tbody>
<tr>
<td>American Indian or Alaska Native</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Asian/Native Hawaiian/Other Pacific Islander</td>
<td>5.88%</td>
<td>2</td>
</tr>
<tr>
<td>Black or African American</td>
<td>14.70%</td>
<td>5</td>
</tr>
<tr>
<td>Hispanic or Latina</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>White</td>
<td>76.47%</td>
<td>26</td>
</tr>
<tr>
<td>Other</td>
<td>2.94%</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>34</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MARITAL STATUS</th>
<th>%</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>11.76%</td>
<td>4</td>
</tr>
<tr>
<td>Single, living with partner</td>
<td>5.88%</td>
<td>2</td>
</tr>
<tr>
<td>Married</td>
<td>50.00%</td>
<td>17</td>
</tr>
<tr>
<td>Separated</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Divorced</td>
<td>14.70%</td>
<td>5</td>
</tr>
<tr>
<td>Widowed</td>
<td>17.64%</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>34</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HIGHEST EDUCATIONAL LEVEL</th>
<th>%</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate degree</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Baccalaureate degree</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Master's degree</td>
<td>47.05%</td>
<td>16</td>
</tr>
<tr>
<td>Doctoral degree</td>
<td>50.00%</td>
<td>17</td>
</tr>
<tr>
<td>Other</td>
<td>2.94%</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>34</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YEAR RN PROGRAM GRADUATION</th>
<th>%</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960 - 1969</td>
<td>9.09%</td>
<td>3</td>
</tr>
<tr>
<td>1970 - 1979</td>
<td>39.39%</td>
<td>13</td>
</tr>
<tr>
<td>1980 - 1989</td>
<td>36.36%</td>
<td>12</td>
</tr>
<tr>
<td>1990 - 1999</td>
<td>9.09%</td>
<td>3</td>
</tr>
<tr>
<td>2000 - 2009</td>
<td>6.06%</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>33*</td>
</tr>
</tbody>
</table>
Table 4.11  Round II Participant Demographics (Continued)

<table>
<thead>
<tr>
<th>YEARS RN PRACTICE</th>
<th>TOTAL YEARS</th>
<th>AVERAGE YEARS/PER RN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Faculty</td>
<td>145</td>
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</tr>
<tr>
<td>Psychiatric Nursing Faculty</td>
<td>298</td>
<td>37.25</td>
</tr>
<tr>
<td>Nurse Clinicians</td>
<td>152</td>
<td>30.04</td>
</tr>
<tr>
<td>Psychiatric Nurse Clinicians</td>
<td>135</td>
<td>27.00</td>
</tr>
<tr>
<td>Nurse Administrators</td>
<td>109</td>
<td>27.25</td>
</tr>
<tr>
<td>Psychiatric Nurse Administrators</td>
<td>156</td>
<td>26.00</td>
</tr>
<tr>
<td>TOTAL</td>
<td>995</td>
<td>30.15</td>
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</table>

<table>
<thead>
<tr>
<th>CURRENT JOB TITLE</th>
<th>%</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff nurse</td>
<td>8.82%</td>
<td>3</td>
</tr>
<tr>
<td>Advanced practice nurse</td>
<td>8.82%</td>
<td>3</td>
</tr>
<tr>
<td>Clinical nurse specialist/nurse practitioner</td>
<td>17.64%</td>
<td>6</td>
</tr>
<tr>
<td>Professor</td>
<td>44.11%</td>
<td>15</td>
</tr>
<tr>
<td>Associate Director/Director of Nursing</td>
<td>2.94%</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>17.64%</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>34</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CURRENT PLACE OF EMPLOY</th>
<th>%</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>27.27%</td>
<td>9</td>
</tr>
<tr>
<td>Clinic</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Elementary/High School</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>College/University</td>
<td>57.57%</td>
<td>19</td>
</tr>
<tr>
<td>Organization</td>
<td>3.03%</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>12.12%</td>
<td>4</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>33*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YEARS AT CURRENT JOB</th>
<th>%</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than one year</td>
<td>9.09%</td>
<td>3</td>
</tr>
<tr>
<td>1-3 years</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Less than 5 years</td>
<td>15.15%</td>
<td>5</td>
</tr>
<tr>
<td>5 years</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Less than 10 years</td>
<td>11.76%</td>
<td>4</td>
</tr>
<tr>
<td>More than 10 years</td>
<td>63.63%</td>
<td>21</td>
</tr>
<tr>
<td>TOTAL</td>
<td>33*</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PREVIOUS JOB TITLES</th>
<th>%</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff nurse</td>
<td>38.23%</td>
<td>13</td>
</tr>
<tr>
<td>Advanced practice nurse</td>
<td>20.58%</td>
<td>7</td>
</tr>
<tr>
<td>Clinical Nurse Specialist/Nurse Practitioner</td>
<td>50.00%</td>
<td>17</td>
</tr>
<tr>
<td>Professor</td>
<td>50.00%</td>
<td>17</td>
</tr>
<tr>
<td>Associate/Director of Nursing</td>
<td>29.41%</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td>14.70%</td>
<td>5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>34</td>
<td></td>
</tr>
</tbody>
</table>

(* One respondent skipped this question).
The Delphi Study Round II Survey was scored according to the Delphi Study Survey (Round II) Instructions. Each listed suggested competency was scored (A) “*include as is,*” (B) “*include with edits*” (and provide edits) or (C) “*drop*” from the list. Competencies that were scored (A), and reached at least 75% consensus became part of the final set of competencies. The response rate for the second round was 57%. After scoring by all Delphi Study Panel Members, the results were:

**Table 4.12: Results of Round II Survey**

<table>
<thead>
<tr>
<th>Suggested Competency:</th>
<th>(A) %</th>
<th>(B) %</th>
<th>(C) %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. (3). Demonstrate knowledge of the incidence/prevalence of suicidal ideation, suicide attempt, and suicide completion among persons related to demographic characteristics (age, gender, sexual orientation, religion, ethnicity, culture, educational level, employment, marital status, geographic location, sociopolitical environment, socioeconomic factors), personal and family history.</td>
<td>94.12</td>
<td>5.88</td>
<td>0.00</td>
</tr>
<tr>
<td>2. (11). Demonstrate knowledge of cultural issues related to suicidal ideation, suicide attempt, and suicide completion.</td>
<td>88.24</td>
<td>5.88</td>
<td>5.88</td>
</tr>
<tr>
<td>3. (13). Demonstrate knowledge of suicide risk assessments for all patients in all settings including: emergency department patients, inpatients, and outpatients.</td>
<td>84.85</td>
<td>15.15</td>
<td>0.00</td>
</tr>
<tr>
<td>4. (18). Demonstrate awareness of personal verbal (sound, words, speaking, and language) and nonverbal (the environment, body language, prosodic and paralinguistic features of voice) communication related to suicide assessment.</td>
<td>78.79</td>
<td>12.12</td>
<td>9.09</td>
</tr>
<tr>
<td>5. (20). Demonstrate ability to observe and interpret verbal and nonverbal clues of a patient at risk for suicide.</td>
<td>90.91</td>
<td>3.03</td>
<td>6.06</td>
</tr>
<tr>
<td>6. (23). Complete a nursing assessment including baccalaureate-level physical and psychosocial assessments.</td>
<td>88.24</td>
<td>8.82</td>
<td>2.94</td>
</tr>
<tr>
<td>7. (26). Demonstrate ability to use therapeutic communication skills to elicit suicidal ideation.</td>
<td>90.91</td>
<td>9.09</td>
<td>0.00</td>
</tr>
<tr>
<td>8. (31). Demonstrate ability to complete a reliable and valid suicide assessment instrument.</td>
<td>94.12</td>
<td>0.00</td>
<td>5.88</td>
</tr>
</tbody>
</table>
Changes in group scores from the Round I Survey were noted after revisions of the remaining suggested competencies on the Round II Survey.

Table 4.13: Changes in Consensus Level from Round I Survey to Round II Survey

<table>
<thead>
<tr>
<th>INITIAL COMPETENCY</th>
<th>(A)</th>
<th>(B)</th>
<th>(C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Demonstrate knowledge of the prevalence of suicide with breakdown by ethnicity, religion, sex, and background.</td>
<td>61.67</td>
<td>35.00</td>
<td>3.33</td>
</tr>
<tr>
<td>REVISED COMPETENCY</td>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
</tr>
<tr>
<td>3. Demonstrate knowledge of the incidence/prevalence of suicidal ideation, suicide attempt, and suicide completion among persons related to demographic characteristics (age, gender, sexual orientation, religion, ethnicity, culture, educational level, employment, marital status, geographic location, sociopolitical environment, socioeconomic factors), personal and family history.</td>
<td>94.12</td>
<td>5.88</td>
<td>0.00</td>
</tr>
<tr>
<td>INITIAL COMPETENCY</td>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
</tr>
<tr>
<td>11. Demonstrate knowledge of cultural issues related to suicide including demographics, ethnicity, religion, and background.</td>
<td>65.00</td>
<td>30.00</td>
<td>5.00</td>
</tr>
<tr>
<td>REVISED COMPETENCY</td>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
</tr>
<tr>
<td>11. Demonstrate knowledge of cultural issues related to suicidal ideation, suicide attempt, and suicide completion.</td>
<td>88.24</td>
<td>5.88</td>
<td>5.88</td>
</tr>
<tr>
<td>INITIAL COMPETENCY</td>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
</tr>
<tr>
<td>13. Demonstrate knowledge of suicide risk assessment for an ED patient vs. an inpatient.</td>
<td>73.33</td>
<td>16.67</td>
<td>10.00</td>
</tr>
<tr>
<td>REVISED COMPETENCY</td>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
</tr>
<tr>
<td>13. Demonstrate knowledge of suicide risk assessments for all patients in all settings including: emergency department patients, inpatients, and outpatients.</td>
<td>84.85</td>
<td>15.15</td>
<td>0.00</td>
</tr>
<tr>
<td>INITIAL COMPETENCY</td>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
</tr>
<tr>
<td>18. Demonstrate awareness of own verbal and nonverbal communication.</td>
<td>72.88</td>
<td>22.03</td>
<td>5.08</td>
</tr>
<tr>
<td>REVISED COMPETENCY</td>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
</tr>
<tr>
<td>18. Demonstrate awareness of personal verbal (sound, words, speaking, and language) and nonverbal (the environment, body language, prosodic and paralinguistic features of voice) communication related to suicide assessment.</td>
<td>78.79</td>
<td>12.12</td>
<td>9.09</td>
</tr>
<tr>
<td>INITIAL COMPETENCY</td>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
</tr>
<tr>
<td>20. Demonstrate good observational skill of behavioral clues.</td>
<td>74.58</td>
<td>23.73</td>
<td>1.69</td>
</tr>
<tr>
<td>REVISED COMPETENCY</td>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
</tr>
<tr>
<td>20. Demonstrate ability to observe and interpret verbal and nonverbal clues of a patient at risk for suicide.</td>
<td>90.91</td>
<td>3.03</td>
<td>6.06</td>
</tr>
<tr>
<td>INITIAL COMPETENCY</td>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
</tr>
<tr>
<td>23. Complete a physical examination.</td>
<td>70.00</td>
<td>10.00</td>
<td>20.00</td>
</tr>
<tr>
<td>REVISED COMPETENCY</td>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
</tr>
<tr>
<td>23. Complete a nursing assessment including baccalaureate-level physical and psychosocial assessments.</td>
<td>88.24</td>
<td>8.82</td>
<td>2.94</td>
</tr>
<tr>
<td>INITIAL COMPETENCY</td>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
</tr>
<tr>
<td>26. Elicit suicidal ideation.</td>
<td>66.10</td>
<td>20.34</td>
<td>13.56</td>
</tr>
<tr>
<td>REVISED COMPETENCY</td>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
</tr>
<tr>
<td>26. Demonstrate ability to use therapeutic communication skills to elicit suicidal ideation.</td>
<td>90.91</td>
<td>9.09</td>
<td>0.00</td>
</tr>
<tr>
<td>INITIAL COMPETENCY</td>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
</tr>
<tr>
<td>31. Develop an assessment tool including asking the right questions.</td>
<td>52.63</td>
<td>21.05</td>
<td>26.32</td>
</tr>
<tr>
<td>REVISED COMPETENCY</td>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
</tr>
<tr>
<td>31. Demonstrate ability to complete a reliable and valid suicide assessment instrument.</td>
<td>94.12</td>
<td>0.00</td>
<td>5.88</td>
</tr>
</tbody>
</table>
Because consensus was reached on all suggested competencies after the second round, there was no need for a third round. There are no strict guidelines on the correct number of rounds, but typically Delphi studies use between two and three rounds (Proctor & Hunt, 1994; Beech, 1997; Green et al., 1999).

**Chapter Summary**

Initially, this study began with a two-part, four member focus group. A list of NSSP competencies were compiled with suggested competencies from focus group members. The compiled list included forty-seven competencies which were scored in part 1 of the focus group. After scoring the compiled list, five suggested competencies were dropped resulting in forty-two competencies on the revised list. After scoring the revised list during the audio-recorded teleconference, all competencies were scored to be included in the first round survey. Two additional competencies were suggested and scored for inclusion. The Round I Survey, therefore, included forty-four competencies.

After the sixty Delphi Study panel members scored the Round I Survey, thirty-four competencies were scored for inclusion in the final set of instructional competencies, and of the remaining ten suggested competencies, two suggested competencies were dropped, and eight suggested competencies were revised with approval of the PI’s dissertation sponsor. After thirty-four Delphi Study panel members scored the second round, all eight remaining suggested competencies were scored for inclusion resulting in forty-two instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.
Chapter V. DISCUSSION, IMPLICATIONS, RECOMMENDATIONS, SUMMAR Y and CONCLUSIONS

Discussion of the Findings

Sample Population

This study used a modified Delphi method with nursing experts to develop a set of instructional competencies for assessing and managing suicide risk for baccalaureate nursing education. The research included a focus group and a two-round Delphi Study. The four focus group members were a non-psychiatric nurse, a psychiatric nurse, an emergency department nurse, and a psychiatric emergency department nurse, all Master’s-prepared, with five years of experience in their specialty area, and with at least one experience with a patient who had expressed suicidal ideation. The Delphi Study Round I (RIS) panel members consisted of: ten non-psychiatric nursing faculty, ten psychiatric nursing faculty, ten nurse clinicians, ten psychiatric nurse clinicians, ten nurse administrators, and ten psychiatric nurse administrators. The Delphi Study Round II (RIIS) panel members included the five nursing faculty, eight psychiatric nursing faculty, six nurse clinicians, five psychiatric nurse clinicians, four nurse administrators, and six psychiatric nurse administrators who completed the second round survey.

Similarities in all demographic characteristics, including gender, age, ethnicity, marital status, highest educational level, year of nursing program graduation, years of nursing practice, current job title, current place of employment, years at current job, and previous job titles, were noted among the focus group members, the Delphi Study Round I panel members, and the Delphi Study Round II panel members. The demographics of all study participants were similar to the demographic characteristics, regarding gender, ethnicity, and marital status, of nurses
throughout the United States today (USDHHS, 2010). Therefore, the sample population of this study appears to be a representative sample of nurses in the United States today except for age.

Because the inclusion criteria for this study called for nurses with advanced degrees, the age range of the panel members was older than nurses in general. Oftentimes, it is the older nurse who returns to school for advanced education (USDHHS, 2010), and this is reflected in the age range of the nurses who participated in this study. Nurses with graduate degrees are also likely to be faculty, clinicians, and/or administrators which were the targeted nursing experts for this study.

| Table 5.1: A Comparison of Demographic Characteristics of Nurses Nationwide, Focus Group (FG) Members, Delphi Study – Round I (DS-RIS) Panel Members, and Delphi Study – Round II (DS – RIIS) Panel Members: |
|-----------------|---------------|---------------|---------------|
| GENDER          | NATIONWIDE    | FG            | DS - RIS      | DS- RIIS      |
| FEMALE          | 84.20%        | 75%           | 89.83%        | 85.30%        |
| MALE            | 15.80%        | 25%           | 10.17%        | 14.70%        |
| AGE*            | NATIONWIDE    | FG            | DS - RIS      | DS- RIIS      |
| < 50 years      | 55.30%        | 25%           | 13.39%        | 14.70%        |
| > 50 years      | 44.70%        | 75%           | 86.44%        | 85.29%        |
| ETHNICITY       | NATIONWIDE    | FG            | DS - RIS      | DS- RIIS      |
| WHITE           | 83.20%        | 100%          | 73.33%        | 76.47%        |
| NON-WHITE       | 16.80%        | 0%            | 26.67%        | 23.53%        |
| M/ STATUS       | NATIONWIDE    | FG            | DS - RIS      | DS- RIIS      |
| MARRIED         | 74%           | 75%           | 65%           | 50%           |
| OTHER           | 26%           | 25%           | 35%           | 50%           |

Discussion of Results

A set of instructional competencies for assessing and managing suicide risk for baccalaureate nursing education is offered as a framework to help address some of the challenges nursing students face in ensuring the provision of effective suicide risk assessment and management of patients upon graduation. Pre-assessment, assessment and management competencies for assessing and managing suicide risk for baccalaureate nursing education were developed. Throughout the study, the level of agreement was quite high not only by the focus
group members, but also by the Delphi Study Round I and Round II panel members. This high level of agreement may have been due to the fact that the candidate competencies suggested for this study were from recognized suicide prevention programs (NSSP, 2012). The overall findings from the scoring process during the first and second parts of the Focus Group, and during the first and second rounds of the Delphi study are presented in Table 5.2. The complete list of competencies can be found in Appendices 11, 16, 18, and 25.

<table>
<thead>
<tr>
<th>Table 5.2: Overall Findings from the Focus Group and the Delphi Rounds:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus Group Part 1: Compiled List Scored through SurveyMonkey:</strong></td>
</tr>
<tr>
<td>47 competencies</td>
</tr>
<tr>
<td>42 scored for inclusion</td>
</tr>
<tr>
<td><strong>Focus Group Part 2: Revised List Scored through Teleconference:</strong></td>
</tr>
<tr>
<td>42 competencies</td>
</tr>
<tr>
<td>35 scored for inclusion</td>
</tr>
<tr>
<td><strong>Round I Survey: Scored through SurveyMonkey:</strong></td>
</tr>
<tr>
<td>44 competencies</td>
</tr>
<tr>
<td>34 scored for inclusion</td>
</tr>
<tr>
<td><strong>Round II Survey: Scored through SurveyMonkey:</strong></td>
</tr>
<tr>
<td>8 competencies</td>
</tr>
<tr>
<td>8 scored for inclusion</td>
</tr>
<tr>
<td><strong>Final Set of Instructional Competencies</strong></td>
</tr>
<tr>
<td>42 competencies</td>
</tr>
</tbody>
</table>

During the first part of the focus group, forty-two of the forty-seven candidate competencies were scored for inclusion by at least 75% consensus of the members (Table 4.3). Five competency items were dropped:

<table>
<thead>
<tr>
<th>Table 5.3: Dropped Competencies from the Focus Group: Part I:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Demonstrates knowledge of the field of suicidology.</td>
</tr>
<tr>
<td>3. Demonstrates knowledge of the suicide prevention movement.</td>
</tr>
<tr>
<td>5. Demonstrate knowledge of community resources for individuals and families.</td>
</tr>
<tr>
<td>8. Demonstrate knowledge of the economic and emotional cost of suicide.</td>
</tr>
<tr>
<td>40. Demonstrate use of nonviolent crisis intervention.</td>
</tr>
</tbody>
</table>

“Demonstrating knowledge of the field of suicidology, the suicide prevention movement, and the economic and emotional cost of suicide,” may be interesting information, but is not
necessary to be competent in assessing and managing suicide risk. “Demonstrating knowledge of community resources for individuals and families” was a competency quite similar to an item that was scored for inclusion: (#2). “Demonstrate knowledge of suicide prevention resources.” “Demonstrating use of nonviolent crisis intervention” was a competency quite similar to an item that was scored for inclusion: (#20). “Demonstrate effective triage/interviewing skills.”

During the second part of the focus group, thirty-five of the forty-two candidate competencies were scored for inclusion by at least 75% consensus of the members (Table 4.5). The remaining seven competency items were revised by adding members’ comments which provided clarity to the suggested items. After these revisions, all focus group members scored the revised competencies for inclusion.

<table>
<thead>
<tr>
<th>Table 5.4: Initial/Revised Competencies from the Focus Group: Part 2:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Competency #3.</strong> Demonstrate knowledge of the prevalence of suicide.</td>
</tr>
<tr>
<td><strong>Initial Competency #8.</strong> Demonstrate knowledge of the warning signs of suicide.</td>
</tr>
<tr>
<td><strong>Initial Competency #11.</strong> Demonstrate knowledge of cultural issues related to suicide.</td>
</tr>
<tr>
<td><strong>Initial Competency #12.</strong> Demonstrate knowledge of issues related to documentation.</td>
</tr>
<tr>
<td><strong>Initial Competency #35.</strong> Collaborate with patient regarding plan of care in order to ensure the patient’s safety.</td>
</tr>
<tr>
<td><strong>Initial Competency #36.</strong> Arrange for 1to1 observation if necessary.</td>
</tr>
<tr>
<td><strong>Initial Competency #39.</strong> Obtain information and records from collateral sources as appropriate.</td>
</tr>
</tbody>
</table>
Additional competencies were suggested which seemed to indicate that focus group members had a concern for nursing students to be knowledgeable in assessing and managing suicide risk for all patients in different settings. All focus group members scored these for inclusion which resulted in the final Round I Survey composed of forty-four candidate competencies.

<table>
<thead>
<tr>
<th>Table 5.5: Additional Competencies suggested during the Focus Group: Part 2:</th>
</tr>
</thead>
<tbody>
<tr>
<td>43. (13.) Demonstrate knowledge of suicide risk assessment for an ED patient vs. an inpatient suicide risk assessment.</td>
</tr>
<tr>
<td>44. (12.) Demonstrate suicide risk assessment for different age populations: child, adolescent, and adult.</td>
</tr>
</tbody>
</table>

During Round I of the modified Delphi Study, thirty-four of the forty-four candidate competencies were scored for inclusion by at least 75% consensus of the members (Table 4.9). The remaining ten competency items were reviewed by the PI. Two competencies were dropped.

<table>
<thead>
<tr>
<th>Table 5.6: Dropped Competencies from Round I:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(15). Participate in a class journal club and select/present an article on suicide.</td>
</tr>
<tr>
<td>(25). Demonstrate behavioral health competency.</td>
</tr>
</tbody>
</table>

Competency #15 was determined to be a class assignment, and received only 54.24% agreement. Competency #25 encompasses a broad array of competencies in order to determine one's mental health, and received only 57.63% agreement. Eight candidate competencies were revised by adding members’ comments which provided clarity to the suggested items.

Six candidate competencies were revised for the first time.
<table>
<thead>
<tr>
<th>Initial Competency</th>
<th>Revised Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>#13. Demonstrate knowledge of suicide risk assessments for emergency department patients and inpatients.</td>
<td>#13. Demonstrate knowledge of suicide risk assessments for all patients: emergency department patients, inpatients, and outpatients.</td>
</tr>
<tr>
<td>#18. Demonstrate awareness and understanding of patient’s verbal and nonverbal communication.</td>
<td>#18. Demonstrate awareness of personal verbal (sound, words, speaking, and language) and nonverbal (the environment, body language, prosodic and paralinguistic features of voice) communication related to suicide assessment.</td>
</tr>
<tr>
<td>#20. Demonstrate good observational skill of behavioral clues.</td>
<td>#20. Demonstrate ability to observe and interpret verbal and nonverbal clues of patient at risk for suicide.</td>
</tr>
<tr>
<td>#23. Complete a physical assessment.</td>
<td>#23. Complete a nursing assessment including baccalaureate-level physical and psychosocial assessments.</td>
</tr>
<tr>
<td>#26. Elicit suicidal ideation.</td>
<td>#26. Demonstrate ability to use therapeutic communication skills to elicit suicidal ideation.</td>
</tr>
<tr>
<td>#31. Develop an assessment tool including asking the right questions.</td>
<td>#31. Demonstrate ability to complete a reliable and valid suicide assessment instrument.</td>
</tr>
</tbody>
</table>

The revision to Competency #13 reflected a change to be more inclusive of all patient settings. The revision to Competency #18 reflected a clearer definition of verbal and nonverbal communication. The revision to Competency #20 reflected a change to not only observe but also interpret. The word, “good,” was described as being subjective and unmeasureable, and was therefore, dropped. The revision to Competency #23 reflected a suggestion that this needed to be clarified as a nursing physical assessment. The revision to Competency #26 reflected the need to use therapeutic communication in eliciting suicidal ideation. The revision to Competency #31 reflected a change from developing an assessment tool to using evidenced-based instruments. Developing an assessment tool was described as being a competency for a nurse at the Master’s degree level.

Two of the eight candidate competencies were revised for a second time.
Table 5.8: Initial/First Revision/Second Revision Competencies from Round I:

<table>
<thead>
<tr>
<th>Initial Competency 3</th>
<th>First Revision Competency 3</th>
<th>Second Revision Competency 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competency 3</td>
<td>Demonstrate knowledge of the prevalence of suicide.</td>
<td>Demonstrate knowledge of the prevalence of suicide with breakdown by ethnicity, religion, sex, and background.</td>
</tr>
<tr>
<td>Competency 11</td>
<td>Demonstrate knowledge of cultural issues related to suicide.</td>
<td>Demonstrate knowledge of cultural issues related to suicide including demographics, ethnicity, religion, and background.</td>
</tr>
</tbody>
</table>

After these revisions, at least 75% of the Round II panel members scored these for inclusion (Table 4.12). This demonstrates the importance of panel members’ comments on the revision of the original competency. The result was a final set of instructional competencies for assessing and managing suicide risk for baccalaureate nursing education comprised of forty-two competencies.

Closer scrutiny of Competencies #3, Competency #7, Competency #41, and Competency #42 was warranted. Competency #3 was twice revised during the study due to participants’ suggested edits resulting in an all-encompassing statement. Similarities are noted in components within competencies: #4, #6, #8, #11, #12, and #13. During testing of these competencies, it may become evident that competency #3 is too broad, and a more concise competency would be advisable.
Table 5.9: Similarities noted between Competency 3 and Competencies: 4, 6, 8, 11, 12, & 13.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(3)</td>
<td>Demonstrate knowledge of the incidence/prevalence of suicidal ideation, suicide attempt, and suicide completion among persons related to demographic characteristics (age, gender, sexual orientation, religion, ethnicity, culture, educational level, employment, marital status, geographic location, sociopolitical environment, socioeconomic factors), personal and family history.</td>
</tr>
<tr>
<td>(4)</td>
<td>Demonstrate knowledge of the populations at risk.</td>
</tr>
<tr>
<td>(6)</td>
<td>Demonstrate knowledge of the risk factors for suicide.</td>
</tr>
<tr>
<td>(8)</td>
<td>Demonstrate knowledge of the warning signs of suicide especially psychiatric diagnosis and/or substance abuse issues.</td>
</tr>
<tr>
<td>(11)</td>
<td>Demonstrate knowledge of cultural issues related to suicidal ideation, suicide attempt, and suicide completion.</td>
</tr>
<tr>
<td>(13)</td>
<td>Demonstrate knowledge of suicide risk assessments for all patients in all settings including: emergency department patients, inpatients, and outpatients.</td>
</tr>
</tbody>
</table>

Competency #7 was offered during the first part of the focus group:

**Competency #7:** Demonstrate knowledge of other conditions that may affect suicide.

“Other conditions” were described as “medical conditions” by a focus group member.

According to the literature, risk factors for suicide are typically thought of as ongoing patient characteristics that increase risk (Granello & Granello, 2007), and can be divided into four categories: demographic factors, psychosocial factors, disease factors, and associating factors.

Table 5.10: Risk Factors for Suicide:

<table>
<thead>
<tr>
<th>Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demographic risk factors include: male gender, increasing age, White race, unmarried, unemployed, and a lack of a spiritual connection (American Psychiatric Association, (APA), 2003; Granello &amp; Granello, 2007; Cooke et al, 2013);</td>
</tr>
<tr>
<td>2. Psychosocial risk factors include: history of childhood abuse, lack of social support and isolation, recent stressful life event, impending incarceration, sexual orientation issues, military service (Langhinrichsen-Rohling et al, 2011), history of a suicide attempt, suicidal ideation / intent, self-injurious behavior, access to means, and a family history of suicide;</td>
</tr>
<tr>
<td>3. Disease risk factors include: co-occurring psychiatric illnesses, such as, depression, schizophrenia, substance abuse, personality disorder, and anxiety disorder, and co-occurring medical illness, such as, cancer, dementia, disfigurement, loss of mobility, and chronic pain (Sadock &amp; Sadock, 2008);</td>
</tr>
<tr>
<td>4. Associated factors include: low frustration tolerance, hopelessness, impulsivity, and aggressiveness. Risk factors are typically thought of as ongoing patient characteristics that increase risk (Granello &amp; Granello, 2007).</td>
</tr>
</tbody>
</table>
Therefore, because these “other conditions” fall within the generally-accepted risk factors, it seems redundant to retain competency #7, when competency #6 encompasses risk factors.

**Competency #6:** Demonstrate knowledge of risk factors for suicide.

In addition, competencies #41 and #42 are ways to implement the instructional competencies, rather than actual instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

<table>
<thead>
<tr>
<th>Table 5.11: Instructional Competencies #41 and #42:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(41). Demonstrate an ability to assess and manage suicide risk through role play.</td>
</tr>
<tr>
<td>(42). Demonstrate an ability to assess and manage suicide risk through simulation and debriefing.</td>
</tr>
</tbody>
</table>

Continued investigation of all the instructional competencies will help to validate their usefulness in teaching nursing students to be competent in assessing and managing suicide risk.

**Implications for Nursing**

The findings of this study have important implications for baccalaureate nursing education, and point to needed curricular changes which will improve nursing students’ attitudes and competence in assessing and managing suicide risk. Ultimately, these changes may lead to an improvement in care for suicidal individuals and improved health outcomes. The development of a set of instructional competencies for assessing and managing suicide risk for baccalaureate nursing education, therefore, has many implications for nursing.

Nursing faculty, nurse clinicians, and nurse administrators must first focus on attitudes of nursing students and nurses toward patients expressing suicidal ideation. Nurses have reported feeling angry, uncomfortable, and frustrated when caring for patients at risk for suicide (Valente, 2004). They have expressed an inability to care appropriately for, and a lack of confidence in
intervening with patients at risk for suicide (McAllister et al, 2009). In turn, nursing care received by patients expressing suicidal ideation has been described as “second rate, ineffective, and impersonal” (Cutcliffe & Stevenson, 2008, p. 951). These barriers to effective intervention must be addressed in academic, clinical, and organizational settings. Within these settings, nurses must be aware that suicidality is a mental health problem and patients deserve quality care. Competence of nurses in assessing and managing suicide risk must begin in baccalaureate nursing education because workforce competence will only result if individual competence is established first (Miner et al, 2005).

Nursing faculty must ensure that nursing students are aware that patient safety is their primary goal with patients, and a potential aspect of caring for any and all patients is the possibility of suicide. To accomplish this, baccalaureate nursing curricula should be changed to incorporate instructional competencies for assessing and managing suicide risk. A central piece of the MACH Model (Miner et al, 2005), which is the theoretical framework that guides this study, is the curriculum process. Through the cyclical interaction among the five components of the curriculum process: assessment, planning, development, delivery, and evaluation, a structure is in place by which individual needs can be targeted resulting in individual competence.

A workgroup of psychiatric nursing faculty and other nursing faculty, interested in and knowledgeable about suicide prevention, should convene in order to review the competency-based curriculum, based on the findings from this study, which will include the instructional competencies and measurable outcomes. After review and revision, this curriculum should be added to the existing psychiatric nursing curriculum. This competency-based curriculum will be student-centered (Candela, 2006) with a focus on the development of critical thinking and clinical judgment. These are essential skills that new graduate nurses must possess in order to be

Because students need experiences both in and out of the classroom to help them attain competence (Candela, 2006), opportunities to engage in critical thinking and clinical judgment will be provided, not only during the educational component, but also, with the use of simulation and vignettes focused on effective intervention with patients at risk for suicide. The use of patient simulators (human and/or computerized) and standardized patient case studies with patients expressing suicidal ideation will provide an opportunity for students and faculty to discuss their own experiences and attitudes about providing care to patients expressing suicidal ideation (Instructional Competency #16), and enhance faculty and student competence in caring for patients at risk for suicide (Hermanns, Lilly & Crawley, 2011; Campbell & Daley, 2013). For example, during psychiatric-mental health nursing theory class, nursing students could demonstrate knowledge of the warning signs of suicide (Instructional Competency # 8) through class discussion and testing. Through simulated experiences and vignettes, nursing students could demonstrate their ability to elicit the warning signs of suicide (Instructional Competency #26).

Evaluating these competencies should be an ongoing process throughout both the theory classes and the clinical practicums. Evidence that students can demonstrate the knowledge and skills necessary for attaining competence will be assessed in the classroom and the clinical area through a newly-designed evaluation tool, created based on the findings from this study, which will assess student progress toward achieving competence in each instructional competency. Careful instruction in competencies necessary to assess and manage suicide risk will likely help nursing students to carry this competence into their practice as graduate nurses.
Moreover, the competencies could also be used by practicing nurses and nurse clinicians who did not have instruction in suicide prevention. Hospital- or community based nurse educators could use the competencies in their orientation programs to assist nurses to identify patients expressing suicidal ideation and ensure those patients’ safety within the health care environment. These instructional competencies could provide a valuable framework to review the nurse’s competence in clinical cases of patients who expressed suicidal ideation. Discussion of clinical cases by nurse managers can include identification of competencies that may have been overlooked in the care of patients who expressed suicidal ideation, attempted suicide, or died by suicide, and lead to the identification of problems with competence within the pre-assessment, the assessment, and/or the management phase of patient care. In addition, root cause analysis, which is a structured method to analyze serious adverse events using a systems approach (Williams, 2001), could also use the instructional competencies as a retrospective method for detecting safety hazards in the event of a patient suicide. Widespread use of these competencies may result in overall improved competence in assessing and managing suicide risk.

Nurse administrators must acknowledge the need for a competent workforce, and be responsible for providing instruction in competencies necessary for assessing and managing suicide risk, if such was not provided during nurses’ undergraduate education. There is a reciprocal relationship between individual performance and organizational performance, with an underlying assumption that once enhanced individual performance is achieved, organizational performance will improve (Miner et al, 2005). Therefore, the education of nurses is an investment in the quality and safety of the organization for the improvement of workforce
capacity. In addition, the competencies could be used as a means of increasing nurse’s interest in developing improved expertise in this area through the credentialing and accreditation processes.

Credentialing, which offers consistent recognition of worker abilities and provides a structure that supports ongoing workforce development (Miner et al, 2005), may be offered to nurses who demonstrate competence in assessing and managing suicide risk. After licensure as a registered nurse, many nurses seek certification in a clinical specialty, such as oncology or critical care, or in a functional specialty, such as case management or legal consulting. Nurses could seek certification in the assessment and management of suicide risk. Many organizations offer certification after completing an education/training program, specified clinical practicum hours, and/or passing a national test. Currently, forty-eight organizations offer certification in nursing (Yoder-Wise, 2009). The American Nurses Credentialing Center (ANCC), a subunit of the ANA, is the largest organization to offer certification (AACN, 2008). Often, certification is effective for 3-5 years, and must be renewed within a predetermined time. In an effort to create uniformity in the numerous nursing certification programs, the ANCC with other certification boards, formed the American Board of Nursing Specialities (ABNS) in 1991, with the aim of promoting standards of excellence in nursing (Chitty & Black, 2011). It is an ongoing challenge to unify the certification process within nursing. A certification in assessing and managing suicide risk could be offered through the ANCC.

Accreditation, which allows for organizations to be evaluated against standardized and consistent criteria and held accountable for their performance (Miner et al, 2005) may in the future, be dependent on its health care workers’ competence in assessing and managing suicide risk. This may become a factor considered in accreditation. Investment in nursing education within the organization is likely to enhance quality care and patient safety.
The findings of this study can challenge nursing faculty, nurse clinicians, and nurse administrators to reflect on how they are helping nursing students, and graduate nurses to be competent in assessing and managing suicide risk in patients expressing suicidal ideation. Disseminating the results of this study in peer-reviewed journals and at professional conferences can provide an initial framework of instructional competencies necessary for baccalaureate nursing education which would be useful for nursing faculty, nurse clinicians, and nurse administrators. Disseminating these findings widely may cause them to be endorsed by academic and healthcare facilities which could then adopt these instructional competencies in order to ensure patient safety and to improve nursing students’ and nurses’ attitudes and competence in caring for patients at risk for suicide. Certainly, it would benefit health care institutions, not only financially but also ethically, to decrease the incidence of suicide in their institutions.

**Recommendations for Further Research**

The development of instructional competencies for assessing and managing suicide risk for baccalaureate nursing education is a first step toward helping nursing students develop competence in assessing and managing suicide risk during undergraduate nursing education. These instructional competencies should be used as a framework to help guide curricular development in baccalaureate schools of nursing as they strive to ensure graduate nurses are competent in assessing and managing suicide risk in the health care environment. An evaluation program should be designed and implemented within baccalaureate nursing education in order to investigate whether nursing students become competent in assessing and managing suicide risk as a result of these instructional competencies. A pilot study should be conducted in order to
investigate if nursing students’ attitudes change and competence improves after involvement in the competency-based curriculum in assessing and managing suicide risk.

Given the difficulties of including new content in already heavily content-laden nursing curricula, prioritizing the instructional competencies should be investigated in order to determine which instructional competencies are most important, moderately important, and least important in intervening with patients expressing suicide risk. Curricula could then focus on the highest priority issues. Ongoing testing including feasibility studies followed by outcomes evaluation would then be called for and further refinement made as needed.

Other technologies could be incorporated within the educational program, and investigations could determine which technologies are most effective in improving competence. Strategies from effective suicide prevention programs could also be incorporated and evaluated. Follow-up studies should be conducted with nursing students who receive instruction in assessing and managing suicide risk during their undergraduate nursing education in order to determine the long term effects of the instruction, and whether competence is maintained. The goal is that nursing students will continuously be able to assess and manage suicide risk competently, and upon graduation, be able to transfer that competence to practice with any patient population in any health care setting.

These instructional competencies should also be investigated with registered nurses within the health care environment, as it is likely that they have not have had instruction in assessing and managing suicide risk during their undergraduate nursing education. Investigation of the instructional competencies needs to be conducted with a broad range of nursing students and nurses, in different educational settings.
In addition to quantitative research, qualitative studies should also be undertaken to explore faculty’s attitudes towards patients expressing suicidal ideation. Nurses have reported feeling angry and uncomfortable when caring for patients at risk for suicide (Valente, 2004). They have reported feeling a lack of confidence and a feeling of frustration due to their inability to intervene appropriately with patients at risk for suicide (McAllister et al, 2009). These attitudes have influenced their suicide risk assessment and management skills (Anderson & Standen, 2007; Brunero et al, 2008; & Sun et al, 2011). Nursing faculty may have similar attitudes. Therefore, an investigation of nursing faculty attitudes is warranted. In addition, it is important to access the impact these have on educators’ ability to teach suicide risk assessment and management to nursing students. Nursing students’ attitudes could also be investigated in order to determine the impact these have on students’ ability to learn.

Due to the multidimensional aspects of the term, competency, a clear definition of competency in nursing does not exist at the present time, and there is no officially agreed upon theoretical or operational definition of competency among nurses, educators, employers, regulating bodies, government, and patients (Axley, 2008). Competency development is, therefore, a complex and imprecise process (Tilley, 2008). Continued research into defining and measuring competency in nursing is imperative. Instrument development and testing are necessary in order to establish both reliability and validity of competency measurement. The continued testing and investigation of the instructional competencies for assessing and managing suicide risk may result in the development of more specific and measurable competencies. Validating and clarifying the proposed instructional competencies with nursing experts with experience in competency development could result in the development of more specific and measurable competencies. With continued investigation of the impact of the instructional
competencies, it is likely that they will evolve resulting in increased competence of nursing students in assessing and managing suicide risk during baccalaureate nursing education, and increased competence of nurses in the health care environment.

**Summary and Conclusions of the Study**

This study developed a set of forty-two instructional competencies for assessing and managing suicide risk for baccalaureate nursing education based on expert opinion. Suicide is a leading cause of death throughout the world with approximately one million people dying by suicide each year worldwide (Centers for Disease Control and Prevention, [CDC], 2010a; American Foundation for Suicide Prevention, [AFSP], 2010). Nations across the globe have launched initiatives for suicide prevention and reforming health professional education has been identified as a primary goal for suicide prevention (United States Public Health Service, [USPHS], 1999; National Strategy for Suicide Prevention (NSSP), 2001; New Freedom Commission on Mental Health (NFCMH), 2003; and Institute of Medicine (IOM), 2002). Although nursing education is being reformed because of deficiencies in the quality of care and patient safety vis a vis suicide prevention (American Nurses Association (ANA) (2012); National League for Nursing (NLN) (2003); American Association of Colleges of Nursing (AACN) (2008), instructional competencies for assessing and managing suicide risk are absent in baccalaureate nursing education (American Association of Colleges of Nursing (AACN), 2008; Cronenwett et al., 2007). The purpose of this study was to develop a set of instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

The significance of the study is that nurses are the largest group of health care providers in the United States, numbering more than 3 million (ANA, 2008), and people who are feeling suicidal often make contact with health care professionals prior to completing the act of suicide.
Although nurses are among the many key people who come into contact with those at risk for suicide, they frequently lack the competence necessary to assess and manage suicide risk (Kalafat, 2006; Brunero et al, 2008; Chan, Chien, & Tso, 2009a; McAllister et al, 2009; Aflague & Ferszt, 2010). This may be due, in part, to serious gaps in nursing education programs (Puntil et al, 2013).

The MACH Model provided the framework for the study which represents a systematic process for identifying and meeting training and educational needs of individuals that ultimately meet organizational needs (Minor et al, 2005). Using a modified Delphi Method (Dalkey et al, 1972), which is a systematic polling of the opinions of an expert panel knowledgeable on a given topic through iterative questionnaires in an attempt to reach group consensus, this study began with a two-part focus group consisting of four nursing experts. The focus group members suggested competencies which were compiled with suggested competencies from the National Strategy for Suicide Prevention (NSSP, 2012). After an initial scoring of these competencies, the revised list was scored during an audio-recorded teleconference. The resulting list became the Round I Survey for the Delphi Study. The Delphi Study panel members consisted of sixty nursing experts who scored the Round I Survey. The Round II Survey was scored by thirty-four of the original sixty panel members who responded to the second round. The result of the modified Delphi Study was the development of instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

In conclusion, achieving an effective health care system rests in large part on the future of nursing (IOM, 2011), and preparing nurses to practice in the 21st century requires a commitment of all nursing faculty, nurse clinicians, and nurse administrators to recognize the inherent importance of competency in the practice of nursing. Competency is essential to the profession
of nursing in order to provide quality care, ensure patient safety, and maintain the credibility of nurses. Standards of competency must be established and adhered to. Because most suicides are preventable (Jones, 2010), competent assessment and management of suicide risk is crucial. The instructional competencies for assessing and managing suicide risk for baccalaureate nursing education is offered therefore, as a framework to help address this challenging task, and steps for assessment and further refinement are provided.
Appendices

Appendix 1: Focus Group Email to Professional Contacts

October 10, 2014

Dear Professional Contact:

For my doctoral research at the Graduate Center of the City University of New York, I am conducting a study in order to develop instructional competencies for assessing and managing suicide risk for baccalaureate nursing education. I will be doing a modified Delphi Method beginning with a focus group of four Master’s prepared nursing professionals with five years of direct nursing experience, and at least one experience with a patient expressing suicidal ideation. I intend to recruit one non-psychiatric nurse, a psychiatric nurse, an emergency department nurse, and a psychiatric emergency department nurse for a one-hour, audio-recorded teleconference focus group.

As an experienced nursing professional who is interested in suicide and suicide prevention, I am requesting your assistance in obtaining these four nursing professionals. Could you please provide me with the names and email addresses of one non-psychiatric nurse, a psychiatric nurse, an emergency department nurse, and a psychiatric emergency department nurse who fit the aforementioned inclusion criteria who would be interested in participating in the focus group by 10/20/14 by clicking the SurveyMonkey link below.

Here is the link to the survey: https://www.research.net/s.aspx

I look forward to your assistance in this important effort. If you have any questions, please contact me at (516) 972-8868 or at: akotowski@gc.cuny.edu.

Thank you.
Sincerely,
Abigail Kotowski, RN, PMHCNS-BC, PhD (c)

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list: https://www.research.net/optout.aspx
Appendix 2: Focus Group Professional Contacts’ Thank You Letter

October 20, 2014

Dear Professional Contact,

You recently provided referrals of nurses who may be interested in participating in a focus group to determine instructional competencies for assessing and managing suicide risk for baccalaureate nursing education. I would like to express my appreciation, and thank you for your assistance.

If you have any questions, please contact me at: akotowski@gc.cuny.edu.

Sincerely,

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)
Appendix 3: Focus Group Recruitment Letter

October 20, 2014

You have been identified as an experienced nursing professional who is interested in suicide and suicide prevention. I am requesting your participation in a research project that I am conducting for my doctoral dissertation entitled, Development of Instructional Competencies for Assessing and Managing Suicide Risk for Baccalaureate Nursing Education, at the Graduate Center of the City University of New York. My research project involves a focus group which will determine suggested competencies for assessing and managing suicide risk for baccalaureate nursing education, followed by a modified Delphi Study which will determine instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

You are being asked to participate in a one-hour, audio-recorded, teleconference focus group, consisting of four nursing experts, to determine specific competency requirements for effective suicide prevention. An agreed-upon date and time for the focus group will be arranged, and I will provide contact information. All focus group members will remain anonymous to the other focus group members, and all data collected will remain confidential.

If you are interested in being a member of the focus group, here is a link to the Focus Group Consent Form, which will provide more information: https://www.research.net/s.aspx

The Focus Group Demographic Questionnaire and the Focus Group Individual Members’ Suggested Competencies will become available if you consent to participate in the focus group. Please return all these documents by 10/30/14.

I look forward to your assistance in this important effort. If you have any questions, please contact me at (516) 972-8868 or at: akotowski@gc.cuny.edu.

Sincerely,

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list: https://www.research.net/optout.aspx
Appendix 4: Focus Group Consent Form

THE CITY UNIVERSITY OF NEW YORK
Hunter College
Nursing

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Title of Research Study: Development of Instructional Competencies for Assessing and Managing Suicide Risk for Baccalaureate Nursing Education

Principal Investigator: Abigail Kotowski, RN, PMHCNS-BC, Ph.D. (c)
CUNY doctoral student

Faculty Advisor: Carol Roye, Ed.D, RN, CPNP
Professor of Nursing

Research Sponsor: This research is being funded with a Doctoral Student Research Grant awarded by the Graduate Center of the City University of New York.

You are being asked to participate in a one-hour audiotaped teleconference focus group in a modified Delphi Study, which is a systematic polling of the opinions of an expert panel knowledgeable on a given topic through iterative surveys, in an attempt to reach group consensus on a given topic. The goal of this study is the development of instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

You were selected as a possible participant in this study because you have been identified as an experienced nursing professional interested in suicide prevention who fits one of the following criteria: (1). A Master's-prepared non-psychiatric nurse - a registered nurse who has been providing direct patient care to a non-psychiatric population for at least five years, and has had at least one experience with a patient who has expressed suicidal ideation; (2). A Master's-prepared psychiatric nurse – a registered nurse who has been providing direct patient care to a psychiatric population for at least five years, and has had at least one experience with a patient who has expressed suicidal ideation; (3). A Master's-prepared emergency department nurse - a registered nurse who has been providing direct patient care to a non-psychiatric population for at least five years in a non-psychiatric emergency department, and has had at least one experience with a patient who has expressed suicidal ideation; or (4). A Master's-prepared psychiatric emergency department nurse - a registered nurse who has been providing direct patient care to a psychiatric population for at least five years in a psychiatric emergency department, and has had at least one experience with a patient who has expressed suicidal ideation.

Purpose:
The purpose of this research study is to develop instructional competencies for assessing and managing suicide risk for baccalaureate nursing education. Reference to suicide
Prevention education is absent in documents critical for curricula development in baccalaureate nursing programs. As one of many key people who come into contact with those at risk for suicide, nurses frequently lack the competence necessary to assess and manage suicide risk due to serious gaps in nursing education programs. This study aims to develop instructional competencies for assessing and managing suicide risk for use in baccalaureate nursing education.

**Procedures:**
If you volunteer to participate in the four-member focus group (FG) for this modified Delphi Study, we will ask you to do the following:

1. Read the FG Recruitment Letter, consent to participate if you are interested after reading the FG Consent Form, complete the FG Demographic Questionnaire, and the FG Individual Member’s Suggested Competencies List, and return these within 2 weeks to the specified SurveyMonkey web site.

2. If you are either the first non-psychiatric nurse, psychiatric nurse, emergency room nurse, or psychiatric emergency room nurse, who fits the inclusion criteria and who returns the aforementioned forms to the specified SurveyMonkey web site, you will be asked to you will be asked to participate as a member of the focus group.

3. Two weeks later, you will be asked to review the suggested competencies for suicide prevention from all focus group members and the National Strategy for Suicide Prevention (NSSP), score these competencies according to the Focus Group Instructions, and return this list within two weeks of receipt to the specified SurveyMonkey web site listed on the document.

4. Participate in a one-hour audiotaped teleconference focus group during which a revised list of suggested competencies will be reviewed, and each competency will again be scored. The goal of the focus group is the development of the Round I Survey for the modified Delphi Study.

**Time Commitment:**
Your participation in the focus group will last for the length of time it takes to consent to participate if you are interested after reading the FG Consent Form, and complete the Focus Group Demographic Questionnaire and the Individual Focus Group Member’s Suggested Competencies List. This is expected to take approximately one hour. It will also include the length of time it takes to review the Focus Group Members’ and NSSP Suggested Competencies List and score these competencies according to the Focus Group Instructions before the focus group. This is also expected to take approximately one hour. Participation in the focus group will take approximately one hour. Overall participation in the focus group will take approximately three hours. The timeline for the focus group will span a total of two months.

**Potential Risks or Discomforts:**
The risks associated with participation in this study are minimal. If you decide to discontinue your participation in the study, you can choose to do so by clicking the SurveyMonkey link asking you to be removed from the mailing list. If you should feel uncomfortable during the one-
hour audiotaped teleconference focus group, you can discontinue study participation at any time without repercussions. During the focus group, you will be identified only by your middle name to other focus group members. If you inadvertently use your full name during the focus group, your full name will be de-identified during tape transcription by an IRB-approved transcription service. The audio-tape recording will only be available to the Principal Investigator (PI) and the dissertation sponsor. Your middle name will be associated with your email address which will be kept in a log that will be stored in a password-protected computer file, along with all research data, in the PI’s office available only to the PI and the dissertation sponsor.

**Potential Benefits:**
There are no direct benefits to participants. However, they will have the opportunity to make a contribution to nursing education. On a societal level, the unique knowledge gathered from this study will enhance suicide prevention efforts, by elucidating competencies for assessing and managing suicide risk that are necessary for instruction during baccalaureate nursing education.

**Payment for Participation:**
You will not receive any payment for participating in this research study.

**Confidentiality:**
We will make our best efforts to maintain confidentiality of any information that is collected during this research study, and that can identify you. We will disclose this information only with your permission or as required by law.

We will protect your confidentiality by ensuring that there will be no identifying information on any of the data from the focus group. You will be identified only by your middle name to other focus group members. Your middle name will be associated with your email address which will be kept in a log that will be stored in a password-protected computer file in the PI’s office available only to the PI and the dissertation sponsor.

All data collected will remain confidential. There will be privacy in gathering, storing and handling data. Only the PI and the dissertation sponsor will have access to the audio-tapes. The audiotapes will be transcribed by an IRB-approved transcription service. If your name is inadvertently used by the focus group members during the group, it will be de-identified during tape transcription. The data will be kept by the PI for three years. After that, all materials will be destroyed.

The research team, authorized CUNY staff, Dr. Carol Roye, the dissertation sponsor, and government agencies that oversee this type of research may have access to research data and records in order to monitor the research. Research records provided to authorized, non-CUNY individuals will not contain identifiable information about you. Publications and/or presentations that result from this study will not identify you by name.

**Participants’ Rights:**
Your participation in this research study is entirely voluntary. If you decide not to participate, there will be no penalty to you, and you will not lose any benefits to which you
are otherwise entitled. You can decide to withdraw your consent and stop participating in the research at any time, without any penalty.

Questions, Comments or Concerns:
If you have any questions, comments or concerns about the research, you can talk to one of the following researchers:

Abigail Kotowski: akotowski@gc.cuny.edu

Dr. Carol Roye: croye@hunter.cuny.edu

If you have questions about your rights as a research participant, or you have comments or concerns that you would like to discuss with someone other than the researchers, please call the CUNY Research Compliance Administrator at 646-664-8918. Alternatively, you can write to:

CUNY Office of the Vice Chancellor for Research
Attn: Research Compliance Administrator
205 East 42nd Street
New York, NY 10017

The Focus Group Consent Form is an internet consent form which will allow respondents to either consent to participate in the study or to not consent to participate in the study. If you click NO and choose not to participate in the study, you will be disqualified from continuing. If you click YES and consent to participate in the study, you will automatically continue to participate in the study.

Do you consent to participate in this research study?

_____ YES

_____ NO

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list: https://www.research.net/optout.aspx
Appendix 5: Focus Group Demographic Questionnaire

Focus Group Demographic Questionnaire

1) Please indicate any and all options that pertain to you:
   _____ A Master’s-prepared (or above) Registered Nurse/
   _____ A Nurse who has provided direct patient care to a non-psychiatric population for at least five years/
   _____ A Nurse who has provided direct patient care to a psychiatric population for at least five years/
   _____ An emergency department nurse who has provided direct patient care to a non-psychiatric population for at least five years/
   _____ A psychiatric emergency department nurse who has provided direct patient care to a psychiatric population for at least five years/
   _____ Experience with at least one patient expressing suicidal ideation.

2) What is your gender? _____ Female/ _____ Male.


4) What option best describes your ethnicity? _____ American Indian or Alaska Native/ _____ Asian / Native Hawaiian / Other Pacific Islander (non-Hispanic)/ _____ Black or African American (non-Hispanic)/ _____ Hispanic or Latino/ _____ White (non-Hispanic)/ _____ Other.


6) What is your highest level of education? _____ Associate degree _____ Baccalaureate degree _____ Master’s degree _____ Doctorate degree ________________ Other.

7) What year did you graduate from your baccalaureate nursing program? _____.

8) What is the number of years that you have practiced as a registered nurse? _____.


11) Which option best describes your years of current employment? _____ less than 1 year/ _____ 1-3 years/ _____ less than 5 years/ _____ 5 years/ _____ less than 10 years/ _____ more than 10 years.
Appendix 6: Focus Group Individual Member’s Suggested Competencies List

Please list five competencies for assessing and managing suicide risk that you think are necessary for baccalaureate nursing students:

1.

2.

3.

4.

5.

Thank you.

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)
Appendix 7: Focus Group Non-Participant Thank You Letter

October 30, 2014

Dear RN - 5,

You recently expressed an interest in participating in a focus group to determine instructional competencies for assessing and managing suicide risk for baccalaureate nursing education. I would like to thank you for your interest, but members for the focus group have been determined.

If you have any questions, please contact me at: akotowski@gc.cuny.edu.

Sincerely,

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)
Appendix 8: Focus Group Members’ Suggested Competencies List

RN 1:
Suggestion # 1: Develop an assessment tool including asking the right questions.
Suggestion # 2: Plan a simulation with the students and have a debriefing with the group
Suggestion # 3: Class journal club: students select an article on suicide / present to the group.
Suggestion # 4: Role play

RN 2:
Suggestion # 1: good mental status assessment skill
Suggestion # 2: assessment of risk factors
Suggestion # 3: knowledge of other conditions that may affect suicide
Suggestion # 4: good observational skill of behavioral clues
Suggestion # 5: ability to communicate openly about suicidal ideation

RN 3:
Suggestion # 1: Triage/ interviewing skills
Suggestion # 2: Behavioral health competency
Suggestion # 3: Non-violent crisis intervention
Suggestion # 4: safety of the patients and care team

RN 4:
Suggestion # 1: Knowledge of all risk / protective factors for suicide / how to assess for
Suggestion # 2: Determination of intent/means/lethality
Suggestion # 3: Ability to communicate assertively to intervene
Suggestion # 4: How to be therapeutic during one to one observation
Suggestion # 5: Knowledge of community resources for individuals, families
Appendix 9: Focus Group NSSP Suggested Competencies List

Pre-assessment competencies:
1. Demonstrates knowledge of a definition of suicide.
2. Demonstrates knowledge of the field of suicidology.
3. Demonstrates knowledge of the suicide prevention movement.
4. Demonstrates knowledge of suicide prevention resources.
5. Demonstrates knowledge of the prevalence of suicide.
6. Demonstrates knowledge of the populations at risk.
7. Demonstrates knowledge of the economic and emotional cost of suicide.
8. Demonstrates knowledge of the myths vs. facts about suicide.
9. Demonstrates knowledge of the risk factors for suicide.
10. Demonstrates knowledge of the warning signs of suicide.
11. Demonstrates knowledge of the protective factors for suicide.
12. Demonstrates knowledge of legal/ethical issues related to suicide.
13. Demonstrates knowledge of cultural issues related to suicide.
14. Demonstrates knowledge of issues related to documentation.

Assessment competencies:
16. Demonstrates awareness of own verbal and nonverbal communication.
17. Demonstrates awareness & understanding of patient’s verbal and nonverbal communication.
18. Uses therapeutic nonverbal and verbal communication.
19. Completes a physical assessment.
20. Completes a mental status examination.
22. Elicits risk factors for suicide.
23. Elicits warning signs for suicide.

Management competencies:
26. Communicates and coordinates with the interdisciplinary team.
27. Determines level of care needed.
28. Collaborates with patient regarding plan of care in order to ensure the patient’s safety.
29. Arranges for 1-to-1 observation if necessary.
30. Arranges for psychiatric evaluation if necessary.
31. Obtains information and records from collateral sources as appropriate.
32. Follows organization’s policies and procedures for suicide.
33. Documents the assessment and management of suicide risk.
Appendix 10: Focus Group Instructions: Part 1

November 1, 2014

Dear Focus Group Member,

Thank you for agreeing to participate in a one-hour, audio-recorded, teleconference focus group in order to identify competencies needed by nurses to respond effectively when a person is at risk for suicide. This focus group is part of a modified Delphi Study that I am conducting for my doctoral dissertation entitled, Development of Instructional Competencies for Assessing and Managing Suicide Risk for Baccalaureate Nursing Education, at the Graduate Center of the City University of New York. This research is being funded with a Doctoral Student Research Grant awarded by the Graduate Center of the City University of New York.

You, along with the three other focus group members, recently provided suggested competencies for assessing and managing suicide risk for baccalaureate nursing education. These suggested competencies were compiled into one list, along with suggested competencies from suicide prevention programs recognized by the National Strategy for Suicide Prevention now entitled the Focus Group Members’ and NSSP Suggested Competencies Compiled List.

Before the focus group, you are asked to:

• REVIEW the suggested competencies;
• SCORE each suggested competency:
  A). “include as is,”
  B). “include with edits,” (and provide suggested edits), or
  C). “drop” from the list;
• RECOMMEND clarifications, make comments on any suggested competency, suggest competencies which initially do not appear on the survey, or ask questions; AND
• RETURN this list to the specified SurveyMonkey web site by 11/10/14.

I will then revise the list based on the scores suggested by all focus group members regarding each competency. Those competencies that are scored “A) Include as is,” and reach 75% consensus by focus group members will be included in the revised list. Those competencies that are scored “C) Drop,” and reach 75% consensus by focus group members will be dropped. Those competencies that are scored “B) Include with edits,” and reach 75% consensus by focus group members will be included with all edits. The revised list will now be entitled the Focus Group Members’ and NSSP Suggested Competencies Revised List.

The Focus Group Members’ and NSSP Suggested Competencies Revised List will be sent to you within two weeks, allowing each member to see all other members’ responses prior to the actual focus group. The Focus Group Members’ and NSSP Suggested Competencies Revised List will be the topic of discussion during the focus group.

All data collected will remain confidential. There will be privacy in gathering, storing and handling the data. Only I and my dissertation sponsor will have access to the data. All data will
be stored in a password-protected computer file in my office available only to me and my dissertation sponsor. All data will be destroyed at the conclusion of the study. The results of the research project will be made available to you at the completion of the study.

Here is a link to the Focus Group Members’ and NSSP Suggested Competencies Compiled List: https://www.research.net/s.aspx

Please follow the instructions as outlined above, and return this by 11/10/14.

I look forward to your continued assistance in this important effort. If you have any questions, please contact me at (516) 972-8868 or at: akotowski@gc.cuny.edu.

Sincerely,

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list: https://www.research.net/optout.aspx
Appendix 11: Focus Group Members’ and NSSP Suggested Competencies Compiled List

The following survey items describe pre-assessment, assessment, and management competencies for assessing and managing suicide risk. Survey items # 1-17 describe pre-assessment competencies. Please indicate by clicking on the appropriate circle, whether you feel the following survey items should be considered instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

Please indicate if the following competencies should be scored:

A) Included as is, in the competency model
B) Included with edits, in the competency model (Please use suggested edits box)
C) Dropped, and not included in the competency model

1. Demonstrate knowledge of a definition of suicide

   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

2. Demonstrate knowledge of the field of suicidology

   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

3. Demonstrate knowledge of suicide prevention movement

   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

4. Demonstrate knowledge of suicide prevention resources

   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:
5. **Demonstrate knowledge of community resources for individuals and families**
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

6. **Demonstrate knowledge of the prevalence of suicide**
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

7. **Demonstrate knowledge of the populations at risk**
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

8. **Demonstrate knowledge of the economic and emotional cost of suicide**
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

9. **Demonstrate knowledge of the myths vs. facts about suicide**
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

10. **Demonstrate knowledge of the risk factors for suicide**
    A) Include as is
    B) Include with edits
    C) Drop
Suggested edits:

11. Demonstrate knowledge of other conditions that may affect suicide
   A) Include as is
   B) Include with edits
   C) Drop

Suggested edits:

12. Demonstrate knowledge of the warning signs of suicide
   A) Include as is
   B) Include with edits
   C) Drop

Suggested edits:

13. Demonstrate knowledge of the protective factors for suicide
   A) Include as is
   B) Include with edits
   C) Drop

Suggested edits:

14. Demonstrate knowledge of legal/ethical issues related to suicide
   A) Include as is
   B) Include with edits
   C) Drop

Suggested edits:

15. Demonstrate knowledge of cultural issues related to suicide
   A) Include as is
   B) Include with edits
   C) Drop

Suggested edits:

16. Demonstrate knowledge of issues related to documentation
   A) Include as is
   B) Include with edits
17. Participate in a class journal club and select/present an article on suicide

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

The following survey items, # 18 – 33, describe assessment competencies for assessing and managing suicide risk. Please indicate by clicking on the appropriate circle, whether you feel the following survey items should be considered instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

Please indicate if the following competencies should be scored:

A) Included as is, in the competency model
B) Included with edits, in the competency model (Please use suggested edits box)
C) Dropped, and not included in the competency model

18. Demonstrate ability to communicate openly about suicidal ideation

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

19. Demonstrate self-awareness in assessing and managing suicide risk

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

20. Demonstrate awareness of own verbal and nonverbal communication

A) Include as is
B) Include with edits
C) Drop

Suggested edits:
21. Demonstrate awareness & understanding of patient’s verbal and nonverbal communication

   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

22. Demonstrate good observational skill of behavioral clues

   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

23. Demonstrate effective triage/interviewing skills

   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

24. Demonstrate use of therapeutic verbal and nonverbal communication

   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

25. Complete a physical assessment

   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

26. Complete a Mental Status Examination

   A) Include as is
   B) Include with edits
27. Demonstrate behavioral health competency
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

28. Elicit suicidal ideation
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

29. Elicit risk factors for suicide
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

30. Elicit warning signs for suicide
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

31. Elicit protective factors for suicide
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

32. Complete intent/means/lethality assessment
A) Include as is  
B) Include with edits  
C) Drop  

Suggested edits:  

33. Develop an assessment tool including asking the right questions  

A) Include as is  
B) Include with edits  
C) Drop  

Suggested edits:  

The following survey items, # 34 – 47, describe management competencies for assessing and managing suicide risk. Please indicate by clicking on the appropriate circle, whether you feel the following survey items should be considered instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.  

Please indicate if the following competencies should be scored:  

A) Included as is, in the competency model  
B) Included with edits, in the competency model (Please use suggested edits box)  
C) Dropped, and not included in the competency model  

34. Follow organization’s policies and procedures for suicide  

A) Include as is  
B) Include with edits  
C) Drop  

Suggested edits:  

35. Communicate and coordinate with the interdisciplinary team  

A) Include as is  
B) Include with edits  
C) Drop  

Suggested edits:  

36. Determine level of care needed  

A) Include as is  
B) Include with edits  
C) Drop
Suggested edits:

37. Communicate assertively to intervene

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

38. Demonstrate ability to maintain the safety of the patient and the health care team

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

39. Collaborate with patient regarding plan of care in order to ensure the patient’s safety

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

40. Demonstrate use of non-violent crisis intervention

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

41. Arrange for 1to1 observation if necessary

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

42. Demonstrate therapeutic verbal and nonverbal communication during one-to-one observation

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

43. Arrange for psychiatric evaluation if necessary

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

44. Obtain information and records from collateral sources as appropriate

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

45. Document the assessment and management of suicide risk

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

46. Demonstrate an ability to assess and manage suicide risk through role play

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

47. Demonstrate an ability to assess and manage suicide risk through simulation and debriefing

A) Include as is
B) Include with edits
C) Drop

Suggested edits:
48. Please recommend clarifications, make comments on any suggested competency, suggest competencies which do not appear on the survey, or ask questions in the space provided below.

Thank you so much for scoring the Focus Group Members’ and NSSP suggested competencies Compiled List. Once you click on the “Done” button, you will have successfully completed this survey.

Within two weeks, you will receive the anonymous results (in aggregate) from this survey. Results will include your responses as well as the responses of the other focus group members.

You will also receive the Focus Group Members’ and NSSP Suggested Competencies Revised List. This list will be the topic of discussion for the audio-recorded, teleconference focus group.

A list of possible dates / times and the contact phone number for the focus group will soon be sent to you. You will be asked to indicate on that list the dates / times that you will be available to participate in the teleconference. A date and time agreed upon by all focus group members will then be determined and you will be notified.

I thank you again for your assistance in this important effort.

Sincerely,

Abigail Kotowski, RN, PMHCNS – BC, PhD (c)

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list: https://www.research.net/optout.aspx
Appendix 12: Focus Group Teleconference Initial Scheduling

November 10, 2014

Dear Focus Group Members:

Thank you very much for your participation in this focus group aimed to develop suggested competencies for assessing and managing suicide risk for baccalaureate nursing education.

You recently received feedback regarding your individual scores and group scores from the Focus Group Members' and NSSP Suggested Competencies Compiled List. You also received the Focus Group Members' and NSSP Suggested Competencies Revised List and Focus Group Instructions: Part 2, which will be the topic of discussion during the focus group.

This is the last step in your participation in this research study: the one-hour, teleconference focus group. First, please confirm that you received your individual and group scores from the compiled list, and that you received the revised list and instructions for the second part of the focus group. Please also provide the following information: the name you will use during the focus group, a phone number where you can be reached for the focus group, and any and all dates and times (from the list provided) that you will be available for the one-hour focus group. Please provide this information by 11/20/14.

Please click this link in order to provide this information: https://www.research.net/s.aspx

Again, thank you very much for your participation in this research study!

Sincerely,

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list: https://www.research.net/optout.aspx
Appendix 13: Focus Group Teleconference Final Scheduling

November 20, 2014

Dear Focus Group Members:

Thank you very much for your participation in this focus group aimed to develop suggested competencies for assessing and managing suicide risk for baccalaureate nursing education.

This is a reminder to return the Focus Group Teleconference Scheduling email that you recently received. Other focus group members have indicated their availability as follows:

Monday, 12/1 - 1-2pm;
Monday, 12/1 - 2-3pm;
Wednesday, 12/3 - 3-4pm.

Please indicate on the Focus Group Teleconference Scheduling email sent through SurveyMonkey, any and all availability on these above dates.

Your response would be greatly appreciated by 11/25/14.

Please click this link in order to provide this information: https://www.research.net/s.aspx

Again, thank you very much for your participation in this research study! This is the last step in your participation in this research study.

Sincerely,

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list: https://www.research.net/optout.aspx
Appendix 14: Reminder regarding the Teleconference Focus Group

November 25, 2014

Dear Focus Group Members:

Thank you very much for your participation in this focus group aimed to develop suggested competencies for assessing and managing suicide risk for baccalaureate nursing education.

This is a reminder that the audio-recorded, teleconference focus group is 12/1. Please call (teleconference phone number) promptly at 1pm. Please let me know that you received this reminder by 11/30.

Again, thank you very much for your participation in this research study! This is the last step in your participation in this research study.

Sincerely,

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list: https://www.research.net/optout.aspx
Appendix 15: Focus Group Instructions: Part 2

November 25, 2014

Dear Focus Group Member,

Thank you for agreeing to participate in a one-hour, audio-recorded, teleconference focus group on 12/1/14 at 1pm in order to identify competencies needed by nurses to respond effectively when a person is at risk for suicide. This focus group is part of a modified Delphi Study that I am conducting for my doctoral dissertation entitled, Development of Instructional Competencies for Assessing and Managing Suicide Risk for Baccalaureate Nursing Education, at the Graduate Center of the City University of New York. This research is being funded with a Doctoral Student Research Grant awarded by the Graduate Center of the City University of New York.

You, along with the three other focus group members, recently provided suggested competencies for assessing and managing suicide risk for baccalaureate nursing education. These suggested competencies were compiled into one list, along with suggested competencies from suicide prevention programs recognized by the National Strategy for Suicide Prevention entitled the Focus Group Members’ and NSSP Suggested Competencies Compiled List. You reviewed and scored the suggested competencies. You may have also recommended clarifications, made comments on any suggested competency, suggested competencies which initially did not appear on the survey, or asked questions. Your input resulted in the Focus Group Members’ and NSSP Suggested Competencies Revised List, which will be the topic of discussion during the focus group.

During the focus group discussion, the focus group ground rules will be: you must state your identifier (middle name) each time you speak, and allow others to speak. You can stop the discussion at any time if you wish. You are asked not to share information with other focus group members, or to others outside of the group once the focus group ends. An opportunity for questions will be afforded prior to commencing the group.

The process of the focus group will begin by listing those competencies that:

- Scored (A) (“include as is”) by at least 75% agreement of the members, indicating that those competencies will now constitute part of the Round 1 Survey for the Delphi Study;
- Scored (B) (“include with edits”) that reached at least 75% agreement, allowing each member to provide suggestions for how the competency should be edited. Suggested competencies that reach 75% agreement once edited will constitute the Round 1 Survey.
- Scored (C) (“delete”) by at least 75% agreement of the members, indicating that those competencies will not be part of the Round 1 Survey for the Delphi Study;

I will allow time for clarification and questions. The final goal of the focus group will be the development of the Round 1 Survey.

All data collected will remain confidential. There will be privacy in gathering, storing and handling the data. Only the principal investigator (PI) and the dissertation sponsor will have access to the audio-tapes. If names are inadvertently used by focus group members during the
group, they will be de-identified during tape transcription. All data will be stored in a password-protected computer file in the PI’s office available only to the PI and the dissertation sponsor. All data will be destroyed at the conclusion of the study. The results of the research project will be made available to you at the completion of the study.

Attached you will find the Focus Group Members’ and NSSP Suggested Competencies Revised List, which will be the topic of discussion during the focus group. Please review this list. We will score each competency during the focus group.

I would like to remind you that the focus group will be on December 1, 2014. Please call (the teleconference phone number) promptly at 1pm, at which time you will be connected to the focus group.

I look forward to your continued assistance in this important effort. If you have any questions, please contact me at (516) 972-8868 or at: akotowski@gc.cuny.edu.

Sincerely,

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list: https://www.research.net/optout.aspx
Appendix 16: Focus Group Members’ and NSSP Suggested Competencies Revised List

1. Demonstrate knowledge of a definition of suicide
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

2. Demonstrate knowledge of suicide prevention resources
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

3. Demonstrate knowledge of the prevalence of suicide
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

4. Demonstrate knowledge of the populations at risk
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

5. Demonstrate knowledge of the myths vs. facts about suicide
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

6. Demonstrate knowledge of the risk factors for suicide
   A) Include as is
   B) Include with edits
C) Drop

Suggested edits:

7. Demonstrate knowledge of other conditions that may affect suicide
   A) Include as is
   B) Include with edits
   C) Drop

Suggested edits:

8. Demonstrate knowledge of the warning signs of suicide
   A) Include as is
   B) Include with edits
   C) Drop

Suggested edits:

9. Demonstrate knowledge of the protective factors for suicide
   A) Include as is
   B) Include with edits
   C) Drop

Suggested edits:

10. Demonstrate knowledge of legal/ethical issues related to suicide
    A) Include as is
    B) Include with edits
    C) Drop

Suggested edits:

11. Demonstrate knowledge of cultural issues related to suicide
    A) Include as is
    B) Include with edits
    C) Drop

Suggested edits:

12. Demonstrate knowledge of issues related to documentation
A) Include as is
B) Include with edits
C) Drop

Suggested edits:

13. Participate in a class journal club and select/present an article on suicide

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

14. Demonstrate ability to communicate openly about suicidal ideation

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

15. Demonstrate self-awareness in assessing and managing suicide risk

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

16. Demonstrate awareness of own verbal and nonverbal communication

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

17. Demonstrate awareness & understanding of patient’s verbal and nonverbal communication

A) Include as is
B) Include with edits
C) Drop

Suggested edits:
18. Demonstrate good observational skill of behavioral clues
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

19. Demonstrate effective triage/interviewing skills
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

20. Demonstrate use of therapeutic nonverbal and verbal communication
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

21. Complete a physical assessment
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

22. Complete a Mental Status Examination
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

23. Demonstrate behavioral health competency
   A) Include as is
   B) Include with edits
   C) Drop
Suggested edits:

24. Elicit suicidal ideation
   A) Include as is
   B) Include with edits
   C) Drop

Suggested edits:

25. Elicit risk factors for suicide
   A) Include as is
   B) Include with edits
   C) Drop

Suggested edits:

26. Elicit warning signs for suicide
   A) Include as is
   B) Include with edits
   C) Drop

Suggested edits:

27. Elicit protective factors for suicide
   A) Include as is
   B) Include with edits
   C) Drop

Suggested edits:

28. Complete intent/means/lethality assessment
   A) Include as is
   B) Include with edits
   C) Drop

Suggested edits:

29. Develop an assessment tool including asking the right questions
   A) Include as is
   B) Include with edits
C) Drop

Suggested edits:

30. Follow organization’s policies and procedures for suicide

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

31. Communicate and coordinate with the interdisciplinary team

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

32. Determine level of care needed

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

33. Communicate assertively to intervene

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

34. Demonstrate ability to maintain the safety of the patient and the health care team

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

35. Collaborate with patient regarding plan of care in order to ensure the patient’s safety
A) Include as is  
B) Include with edits  
C) Drop  

Suggested edits:

36. **Arrange for 1to1 observation if necessary**

A) Include as is  
B) Include with edits  
C) Drop  

Suggested edits:

37. **Demonstrate therapeutic verbal and nonverbal communication during one-to-one observation**

A) Include as is  
B) Include with edits  
C) Drop  

Suggested edits:

38. **Arrange for psychiatric evaluation if necessary**

A) Include as is  
B) Include with edits  
C) Drop  

Suggested edits:

39. **Obtain information and records from collateral sources as appropriate**

A) Include as is  
B) Include with edits  
C) Drop  

Suggested edits:

40. **Document the assessment and management of suicide risk**

A) Include as is  
B) Include with edits  
C) Drop  

Suggested edits:
41. Demonstrate an ability to assess and manage suicide risk through role play

   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

42. Demonstrate an ability to assess and manage suicide risk through simulation and debriefing

   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:
Appendix 17: Focus Group Participant Thank You Letter

December 2, 2014

Dear Focus Group Member:

You recently participated in a focus group to determine suggested competencies for assessing and managing suicide risk for baccalaureate nursing education. Attached you will find the results of the focus group which constitute the Round 1 Survey for the Delphi Study. Please confirm by email receipt and approval of the Round I Survey. The final results of the research project will be made available to you at the completion of the study.

I would like to thank you for your participation in the focus group.

If you have any questions, please contact me at (516) 972-8868 or at: akotowski@gc.cuny.edu.

Sincerely,

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)
Appendix 18: Round I Survey

The following survey items describe pre-assessment, assessment, and management competencies for assessing and managing suicide risk. Survey items #1-15 describe pre-assessment competencies. Please indicate by clicking on the appropriate circle, whether you feel the following survey items should be considered instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

Please indicate if the following competencies should be scored:

A) Included as is, in the competency model
B) Included with edits, in the competency model (Please use suggested edits box)
C) Dropped, and not included in the competency model

1. Demonstrate knowledge of a definition of suicide

   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

2. Demonstrate knowledge of suicide prevention resources

   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

3. Demonstrate knowledge of the prevalence of suicide with breakdown by ethnicity, religion, sex, and background

   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

4. Demonstrate knowledge of the populations at risk

   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:
5. Demonstrate knowledge of the myths vs. facts about suicide

   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

6. Demonstrate knowledge of the risk factors for suicide

   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

7. Demonstrate knowledge of other conditions that may affect suicide

   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

8. Demonstrate knowledge of the warning signs of suicide especially psychiatric diagnosis and/or substance abuse

   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

9. Demonstrate knowledge of the protective factors for suicide

   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

10. Demonstrate knowledge of legal/ethical issues related to suicide

    A) Include as is
    B) Include with edits
C) Drop

Suggested edits:

11. Demonstrate knowledge of cultural issues related to suicide including demographics, ethnicity, religion, and background

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

12. Demonstrate knowledge of suicide risk assessment for different age populations: child/adolescent/adult

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

13. Demonstrate knowledge of suicide risk assessment for an ED patient vs. an inpatient

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

14. Demonstrate knowledge of issues related to nursing documentation

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

15. Participate in a class journal club and select/present an article on suicide

A) Include as is
B) Include with edits
C) Drop

Suggested edits:
The following survey items, #16 – 31, describe assessment competencies for assessing and managing suicide risk. Please indicate by clicking on the appropriate circle, whether you feel the following survey items should be considered instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

Please indicate if the following competencies should be scored:

A) Included as is, in the competency model
B) Included with edits, in the competency model (Please use suggested edits box)
C) Dropped, and not included in the competency model

16. Demonstrate ability to communicate openly about suicidal ideation

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

17. Demonstrate self-awareness in assessing and managing suicide risk

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

18. Demonstrate awareness of own verbal and nonverbal communication

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

19. Demonstrate awareness & understanding of patient’s verbal and nonverbal communication

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

20. Demonstrate good observational skill of behavioral clues
21. Demonstrate effective triage/interviewing skills

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

22. Demonstrate use of therapeutic verbal and nonverbal communication

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

23. Complete a physical assessment

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

24. Complete a Mental Status Examination

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

25. Demonstrate behavioral health competency

A) Include as is
B) Include with edits
C) Drop

Suggested edits:
26. Elicit suicidal ideation
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

27. Elicit risk factors for suicide
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

28. Elicit warning signs for suicide
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

29. Elicit protective factors for suicide
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

30. Complete intent/means/lethality assessment
   A) Include as is
   B) Include with edits
   C) Drop

   Suggested edits:

31. Develop an assessment tool including asking the right questions
   A) Include as is
   B) Include with edits
   C) Drop
The following survey items, # 32 – 44, describe management competencies for assessing and managing suicide risk. Please indicate by clicking on the appropriate circle, whether you feel the following survey items should be considered instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

Please indicate if the following competencies should be scored:

A) Included as is, in the competency model
B) Included with edits, in the competency model (Please use suggested edits box)
C) Dropped, and not included in the competency model

32. Follow organization’s policies and procedures for suicide
   A) Include as is
   B) Include with edits
   C) Drop

Suggested edits:

33. Communicate assertively to intervene
   A) Include as is
   B) Include with edits
   C) Drop

Suggested edits:

34. Communicate and coordinate with the interdisciplinary team
   A) Include as is
   B) Include with edits
   C) Drop

Suggested edits:

35. Determine level of care needed
   A) Include as is
   B) Include with edits
   C) Drop

Suggested edits:

36. Arrange for psychiatric evaluation if necessary
   A) Include as is
B) Include with edits
C) Drop

Suggested edits:

37. Collaborate with patient, family, significant other, and treatment team regarding plan of care in order to ensure the patient’s safety

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

38. Demonstrate ability to maintain the safety of the patient and the health care team

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

39. Arrange for 1to1 observation if necessary, including observation of the patient and environment

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

40. Demonstrate therapeutic verbal and nonverbal communication during one-to-one observation

A) Include as is
B) Include with edits
C) Drop

Suggested edits:

41. Obtain information and records from collateral sources as appropriate while maintaining confidentiality

A) Include as is
B) Include with edits
C) Drop
Suggested edits:

42. Document the assessment and management of suicide risk
   A) Include as is
   B) Include with edits
   C) Drop

Suggested edits:

43. Demonstrate an ability to assess and manage suicide risk through role play
   A) Include as is
   B) Include with edits
   C) Drop

Suggested edits:

44. Demonstrate an ability to assess and manage suicide risk through simulation and debriefing
   A) Include as is
   B) Include with edits
   C) Drop

Suggested edits:

45. Please recommend clarifications, make comments on any suggested competency, suggest competencies which do not appear on the survey, or ask questions in the space provided below.

Thank you so much for your participation in Round I of the Delphi Study.

Within two weeks, you will receive an analysis of the feedback from all panel members of the Delphi Study. You will also receive the revised Round I Survey based on this feedback, which will be entitled the Round II Survey, and the Delphi Study Instructions (Round II).

Please provide your email address in order to receive your individual scores, and the group scores from the Round I Survey, and to receive the Round II Survey and the Survey Instructions.
I look forward to your continued assistance in this important effort. I think you will find the process interesting and the final results of the study will be made available to you at the conclusion of the study.

If you have any questions, please contact me at (516) 972-8868 or at: akotowski@gc.cuny.edu.

Thank you.

Sincerely,

Abigail Kotowski, RN, PMHCNS – BC, PhD (c)

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list: https://www.research.net/optout.aspx
Appendix 19: Delphi Study Recruitment Letter

December 3, 2014

I am conducting a research study for my doctoral dissertation entitled, Development of Instructional Competencies for Assessing and Managing Suicide Risk for Baccalaureate Nursing Education, at the Graduate Center of the City University of New York.

Suicide is a leading cause of death throughout the world, and deficiencies in the quality of care and patient safety have been noted, as well as, a gap in baccalaureate nursing education concerning student nurses’ competence in intervening in suicidal crisis. In response to the need for competent graduate nurses, I am conducting a study to develop instructional competencies for assessing and managing suicide risk for use in baccalaureate nursing programs.

A focus group was recently conducted which determined suggested competencies for assessing and managing suicide risk for baccalaureate nursing education. A three-round, modified Delphi Study will now determine instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

I am requesting your participation in this research study. I look forward to your assistance in this important effort. I think you will find the process interesting and the final results of the research study will be made available to you at the conclusion of the study.

If you are interested in being a panel member of the Delphi Study, here is a link to the Delphi Study Consent Form, which will provide more information:

https://www.research.net/s/3XK8QHD

The Delphi Study Demographic Questionnaire, the Delphi Study Instructions, and the Delphi Study Round I Survey will become immediately available once you consent to participate in the Delphi Study, and click NEXT after each document. Please return all these documents by 12/17/14 by clicking DONE at the bottom of the Round I Survey.

Please note: If the above link is not hyperlinked, please copy and paste the link into the address bar. The address bar is not the google search bar. It is the bar above that where www.google.com would be typed.

If you have any questions, please contact me at (516) 972-8868 or at: akotowski@gc.cuny.edu.

Sincerely,

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list: https://www.research.net/optout.aspx
Appendix 20: Delphi Study Consent Form

THE CITY UNIVERSITY OF NEW YORK
Hunter College
Nursing

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Title of Research Study: Development of Instructional Competencies for Assessing and Managing Suicide Risk for Baccalaureate Nursing Education

Principal Investigator: Abigail Kotowski, RN, PMHCNS-BC, PhD (c)
CUNY doctoral student

Faculty Advisor: Carol Roye, Ed.D, RN, CPNP
Professor of Nursing

Research Sponsor: This research is being funded with a Doctoral Student Research Grant awarded by the Graduate Center of the City University of New York.

You are being asked to participate in a modified Delphi Study which is a systematic polling of the opinions of an expert panel knowledgeable on a given topic through iterative surveys in an attempt to reach group consensus on a given topic. The goal of this modified Delphi Study is the development of instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

You were selected as a possible participant in this study because you have been identified as an experienced nursing professional interested in suicide prevention who fits one (or more) of the following criteria: 1) A “psychiatric nursing faculty” – a doctorally prepared registered nurse who holds a faculty appointment at a school or college of nursing for at least five years, and has had at least one experience with a patient who has expressed suicidal ideation; 2) A “psychiatric nurse clinician” – a Master’s-prepared (or above) registered nurse who has clinical expertise as a psychiatric nurse practitioner or as a clinical nurse specialist who has been providing direct patient care to a psychiatric population for at least five years; and has had at least one experience with a patient who has expressed suicidal ideation; or 3) A “psychiatric nursing administrator” – a Master’s-prepared (or above) registered nurse who holds an administrative title in a psychiatric hospital, organization, or agency, for at least five years, and has had at least one experience with a patient who has expressed suicidal ideation; 4) A “non-psychiatric nursing faculty” – a doctorally prepared registered nurse who holds a faculty appointment at a school or college of nursing for at least five years, and has had at least one experience with a patient who has expressed suicidal ideation; 5) A “nurse clinician” – a Master’s-prepared (or above) registered nurse who has clinical expertise as a nurse practitioner or as a clinical nurse specialist who has been providing direct patient care to a general medical population for at least five years, and has had at least one experience with a patient who has expressed suicidal ideation; and/or 6) A
“nursing administrator” – a Master’s-prepared (or above) registered nurse who holds an administrative title in a non-psychiatric hospital, organization, or agency, for at least five years, and has had at least one experience with a patient who has expressed suicidal ideation.

**Purpose:**
The purpose of this research study is to develop instructional competencies for assessing and managing suicide risk for baccalaureate nursing education. Reference to suicide prevention education is absent in documents critical for curricula development in baccalaureate nursing programs. As one of many key people who come into contact with those at risk for suicide, nurses frequently lack the competence necessary to assess and manage suicide risk due to serious gaps in nursing education programs. This study aims to develop instructional competencies for assessing and managing suicide risk for use in baccalaureate nursing education.

**Procedures:**
If you volunteer to participate in this sixty-member Delphi Study (DS), we will ask you to do the following:

(1.) Read the DS Recruitment Letter, consent to participate after reading the DS Consent Form, complete the DS Demographic Questionnaire, score the Round I Survey according to the Delphi Study Survey Instructions, and submit these to the specified SurveyMonkey web site within two weeks of the initial invitation email.

(2.) If you are one of the first ten psychiatric nursing faculty, the first ten psychiatric nursing clinicians, or the first ten psychiatric nursing administrators, or the first ten nursing faculty, the first ten nursing clinicians, or the first ten nursing administrators, who return the aforementioned forms to the specified SurveyMonkey web site, you will be asked to participate as a panel member in this Delphi Study.

(3.) Two weeks later, you will receive the Round II Survey which you will score according to the Delphi Study Survey Instructions, and submit this to the specified SurveyMonkey web site within two weeks or receipt.

(4.) Two weeks later, you will receive the Round III Survey which you will score according to the Delphi Study Survey Instructions, and submit this to the specified SurveyMonkey web site within two weeks or receipt. Within two weeks, you will receive the final set of instructional competencies for assessing and managing suicide risk for baccalaureate nursing education that was developed as a result of this study.

**Time Commitment:**
Your participation in the Delphi Study will last for the length of time it takes to consent to participate after reading the Delphi Study Consent Form and complete the Delphi Study Demographic Questionnaire. This is expected to take approximately thirty minutes. It will also include the length of time it takes to complete each survey round which will be approximately thirty minutes for each of the three surveys. Overall participation in the Delphi Study will take approximately two hours. The timeline for the Delphi Study will span a total of three months.
**Potential Risks or Discomforts:**
The risks associated with participation in this study are minimal. If you should feel uncomfortable about participating in the Delphi Study, you can discontinue study participation at any time without repercussions by clicking the SurveyMonkey link asking you to be removed from the mailing list. All data collected will be stored in a password-protected computer file in the Principal Investigator’s (PI) office available only to the PI and the dissertation sponsor.

**Potential Benefits:**
There are no direct benefits to participants. However, they will have the opportunity to make a contribution to nursing education. On a societal level, the unique knowledge gathered from this study will enhance suicide prevention efforts, by elucidating competencies for assessing and managing suicide risk that are necessary for instruction during baccalaureate nursing education.

**Payment for Participation:**
You will not receive any payment for participating in this research study.

**Confidentiality:**
We will make our best efforts to maintain confidentiality of any information that is collected during this research study, and that can identify you. We will disclose this information only with your permission or as required by law.

We will protect your confidentiality by ensuring that there will be no identifying information on any of the data from the Delphi Study. You will be identified by a study ID number. Your study ID number will be associated with your email address which will be kept in a log that will be stored in a password-protected computer file available only to the PI and the dissertation sponsor. You will need to be contacted by the PI via your email address during the study if you do not respond during the requested time frame between each Delphi round. All data collected will remain confidential. There will be privacy in gathering, storing and handling data. The data will be kept by the PI for three years. After that, all materials will be destroyed.

The research team, authorized CUNY staff, Dr. Carol Roye, the dissertation sponsor, and government agencies that oversee this type of research may have access to research data and records in order to monitor the research. Research records provided to authorized, non-CUNY individuals will not contain identifiable information about you. Publications and/or presentations that result from this study will not identify you by name.

**Participants’ Rights:**
Your participation in this research study is entirely voluntary. If you decide not to participate, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled. You can decide to withdraw your consent and stop participating in the research at any time, without any penalty.

**Questions, Comments or Concerns:**
If you have any questions, comments or concerns about the research, you can talk to one of the following researchers:

Abigail Kotowski:  akotowski@gc.cuny.edu

Dr. Carol Roye:  croye@hunter.cuny.edu

If you have questions about your rights as a research participant, or you have comments or concerns that you would like to discuss with someone other than the researchers, please call the CUNY Research Compliance Administrator at 646-664-8918. Alternately, you can write to:

CUNY Office of the Vice Chancellor for Research
Attn: Research Compliance Administrator
205 East 42nd Street
New York, NY 10017

The Delphi Study Consent Form is an internet consent form which will allow respondents to either consent to participate in the study or to not consent to participate in the study. If you click NO and choose not to participate in the study, you will be disqualified from continuing. If you click YES and consent to participate in the study, you will automatically continue to participate in the study.

Here is the link:

Do you consent to participate in this research study?
_____ YES
_____ NO

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list:  https://www.research.net/optout.aspx
Appendix 21: Delphi Study Demographic Questionnaire

Delphi Study Demographic Questionnaire

1) Please indicate any and all options that pertain to you:
   _____ A Master’s prepared (or above) Registered Nurse/
   _____ A “psychiatric nursing faculty” – a doctorally prepared registered nurse who holds a faculty appointment at a school or college of nursing for at least five years/
   _____ A “psychiatric nurse clinician” – a Master’s-prepared (or above) registered nurse who has clinical expertise as a psychiatric nurse practitioner or as a clinical nurse specialist who has been providing direct patient care to a psychiatric population for at least five years;
   _____ A “psychiatric nursing administrator” – a Master’s-prepared (or above) registered nurse who holds an administrative title in a psychiatric hospital, organization, or agency, for at least five years/
   _____ A “non-psychiatric nursing faculty” – a doctorally prepared registered nurse who holds a faculty appointment at a school or college of nursing for at least five years/
   _____ A “nurse clinician” – a Master’s-prepared (or above) registered nurse who has clinical expertise as a nurse practitioner or as a clinical nurse specialist who has been providing direct patient care to a general medical population for at least five years/
   _____ A “nursing administrator” – a Master’s-prepared (or above) registered nurse who holds an administrative title in a non-psychiatric hospital, organization, or agency, for at least five years/
   _____ Experience with at least one patient expressing suicidal ideation.

2) What is your gender? _____ Female/ _____ Male.


4) What option best describes your ethnicity? _____ American Indian or Alaska Native/ _____ Asian / Native Hawaiian / Other Pacific Islander (non-Hispanic)/ _____ Black or African American (non-Hispanic)/ _____ Hispanic or Latino/ _____ White (non-Hispanic)/ _____ Other.


6) What is your highest level of education? _____ Associate degree _____ Baccalaureate degree _____ Master’s degree _____ Doctorate degree _________________ Other.

7) What year did you graduate from your baccalaureate nursing program? _____.

8) What is the number of years that you have practiced as a registered nurse? _____.


11) Which option best describes your years of current employment? _____ less than 1 year/ _____ 1-3 years/ _____ less than 5 years/ _____ 5 years/ _____ less than 10 years/ _____ more than 10 years.

Appendix 22: Delphi Study Survey Instructions (Round I)

Dear Delphi Study panel member,

Thank you for agreeing to participate in a three-round Delphi Study in order to identify competencies needed by nurses to respond effectively when a person is at risk for suicide. I am conducting this study for my doctoral dissertation entitled, Development of Instructional Competencies for Assessing and Managing Suicide Risk for Baccalaureate Nursing Education, at the Graduate Center of the City University of New York. This research is being funded with a Doctoral Student Research Grant awarded by the Graduate Center of the City University of New York.

The Delphi Study Survey Instructions are:

- REVIEW the suggested competencies;
- SCORE each suggested competency:
  - A). “Include as is,”
  - B). “Include with edits,” (and provide suggested edits), or
  - C). “Drop” from the list;
- RECOMMEND clarifications, make comments on any suggested competency, suggest competencies which initially do not appear on the survey, or ask questions; AND
- RETURN this list to the specified SurveyMonkey web site by 12/17/14.

Within two weeks of receipt, you will receive an analysis of the feedback from all panel members of the Delphi Study. You will also receive the revised Round I Survey based on this feedback, which is now entitled the Round II Survey, and the Delphi Study Survey Instructions.

I look forward to your assistance in this important effort. I think you will find the process interesting and the final results of this study will be made available to you at the conclusion of the study.

If you have any questions, please contact me at (516) 972-8868 or at: akotowski@gc.cuny.edu. Sincerely,

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)
Appendix 23: Delphi Study Non-Participant Thank You Letter

December 17, 2015

You recently completed a Round I Survey, part of a modified Delphi Study, aimed to develop instructional competencies for assessing and managing suicide risk for baccalaureate nursing education. The response to the survey was overwhelming, and the first sixty respondents who were either nursing faculty, nursing clinicians, or nursing administrators and who fit the inclusion criteria, are now the panel members for the Delphi Study.

I would like to thank you therefore for your time completing the survey, and I would like to offer to send you the final results at the conclusion of the study. Please click this link: https://www.research.net/s.aspx and indicate whether you would like to receive the final results or not.

Again, I thank you.

Sincerely,

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list: https://www.research.net/optout.aspx
Appendix 24: Delphi Study Survey Instructions (Round II)

January 1, 2015

Dear Delphi Study Panel Member,

Thank you for scoring the first round of this three-round Delphi Study in order to identify competencies needed by nurses to respond effectively when a person is at risk for suicide. Thirty-four of the forty-four competencies reached at least 75% consensus for inclusion in the final set of instructional competencies. Two competencies were dropped: Competency # 15: Participate in a class journal club and select/present an article on suicide, which has been determined to be a class assignment; and Competency # 25: Demonstrate behavioral health competency, which encompasses a broad array of competencies in order to determine one's mental health. The remaining eight competencies have been revised according to the suggested edits by all panel members, and are listed on the Round II Survey.

The Delphi Study Survey Instructions are:

- REVIEW the suggested competencies;
- SCORE each suggested competency:
  A). “Include as is,”
  B). “Include with edits,” (and provide suggested edits), or
  C). “Drop” from the list;
- RECOMMEND clarifications, make comments on any suggested competency, suggest competencies which initially do not appear on the survey, or ask questions; AND
- RETURN this list to the specified SurveyMonkey web site by 1/15/15.

Please click this link in order to complete the Round II Survey: https://www.research.net/s.aspx

Within two weeks of receipt, you will receive an analysis of the feedback from Round II from all panel members of the Delphi Study. You will also receive the revised Round II Survey based on this feedback, now entitled the Round III Survey, which will be the final survey, and the Delphi Study Survey Instructions.

I look forward to your continued assistance in this important effort. The final results of this study will be made available to you at the conclusion of the study.

If you have any questions, please contact me at (516) 972-8868 or at: akotowski@gc.cuny.edu.

Sincerely,

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list: https://www.research.net/optout.aspx
Appendix 25: Delphi Study Round II Survey

Dear Delphi Study panel member,

On the Round I Survey, thirty-four of the forty-four suggested competencies reached at least 75% consensus for inclusion in the instructional competency model for assessing and managing suicide risk for baccalaureate nursing education. Two competencies were dropped: Competency #15: Participate in a class journal club and select/present an article on suicide, which has been determined to be a class assignment; and Competency #25: Demonstrate behavioral health competency, which encompasses a broad array of competencies in order to determine one's mental health.

The remaining eight competencies have been revised according to the suggested edits by all panel members, and now constitute the Round II Survey. These suggested competencies are listed below and they describe pre-assessment, assessment, and management competencies for assessing and managing suicide risk. Please indicate by clicking on the appropriate circle, whether you feel the following survey items should be considered instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

Please indicate if the following competencies should be scored:

A) Included as is, in the competency model
B) Included with edits, in the competency model (Please use suggested edits box)
C) Dropped, and not included in the competency model

1. (3). Demonstrate knowledge of the incidence/prevalence of suicidal ideation, suicide attempt, and suicide completion among persons related to demographic characteristics (age, gender, sexual orientation, religion, ethnicity, culture, educational level, employment, marital status, geographic location, sociopolitical environment, socioeconomic factors), personal and family history.

2. (11). Demonstrate knowledge of cultural issues related to suicidal ideation, suicide attempt, and suicide completion.

3. (13). Demonstrate knowledge of suicide risk assessments for all patients in all settings including: emergency department patients, inpatients, and outpatients.

4. (18). Demonstrate awareness of personal verbal (sound, words, speaking, and language) and nonverbal (the environment, body language, prosodic and paralinguistic features of voice) communication related to suicide assessment.

5. (20). Demonstrate ability to observe and interpret verbal and nonverbal clues of a patient at risk for suicide.
6. (23). Complete a nursing assessment including baccalaureate-level physical and psychosocial assessments.

7. (26). Demonstrate ability to use therapeutic communication skills to elicit suicidal ideation.

8. (31). Demonstrate ability to complete a reliable and valid suicide assessment instrument.

Thank you for completing the Round II Survey.

Within two weeks of receipt, you will receive an analysis of the feedback from Round II from all panel members of the Delphi Study. You will also receive the revised Round II Survey based on this feedback, now entitled the Round III Survey, which will be the final survey, and the Delphi Study Survey Instructions.

I look forward to your continued assistance in this important effort. The final results of this study will be made available to you at the conclusion of the study.

If you have any questions, please contact me at (516) 972-8868 or at: akotowski@gc.cuny.edu.
Sincerely,

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list:
https://www.research.net/optout.aspx
Appendix 26: Delphi Study First Reminder to Complete the Round II Survey

January 10, 2015

Dear Delphi Study Panel Member,

This is a reminder to complete the Round II Survey for the Delphi Study aimed to develop instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

Please click this link in order to complete the Round II Survey by 1/15/15:
https://www.research.net/s.aspx

Within two weeks of receipt, you will receive an analysis of the feedback from Round II from all panel members of the Delphi Study. You will also receive the revised Round II Survey based on this feedback, now entitled the Round III Survey, which will be the final survey, and the Delphi Study Survey Instructions.

I look forward to your continued assistance in this important effort. The final results of this study will be made available to you at the conclusion of the study.

If you have any questions, please contact me at (516) 972-8868 or at: akotowski@gc.cuny.edu. Sincerely,

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list: https://www.research.net/optout.aspx
Appendix 27: Delphi Study Second Reminder to Complete the Round II Survey

January 15, 2015

Dear Delphi Study Panel Member,

This is a second reminder to complete the Round II Survey for the Delphi Study aimed to develop instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

Please click this link in order to complete the Round II Survey by 1/20/15: https://www.research.net/s.aspx

Within two weeks of receipt, you will receive an analysis of the feedback from Round II from all panel members of the Delphi Study. You will also receive the revised Round II Survey based on this feedback, now entitled the Round III Survey, which will be the final survey, and the Delphi Study Survey Instructions.

I look forward to your continued assistance in this important effort. The final results of this study will be made available to you at the conclusion of the study.

If you have any questions, please contact me at (516) 972-8868 or at: akotowski@gc.cuny.edu. Sincerely,

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list: https://www.research.net/optout.aspx
Appendix 28: Focus Group Participant Thank You Letter

January 21, 2015

Dear Focus Group Member:

You recently participated in a focus group to determine suggested competencies for assessing and managing suicide risk for baccalaureate nursing education. Attached you will find the results of the two-round Delphi Study which determined the instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

I would like to thank you for your participation in this research project, and inform you that these research findings will be published and presentations of the instructional competencies for assessing and managing suicide risk will be presented at nursing research conferences, and will likely inform individual faculty and schools of nursing to address these competencies in their classrooms.

Again, I thank you.

Sincerely,

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)
Appendix 29: Delphi Study Non-Participant Thank You Letter

January 21, 2015

You recently completed a Round I Survey, part of a modified Delphi Study, aimed to develop instructional competencies for assessing and managing suicide risk for baccalaureate nursing education. The first sixty respondents who were nursing faculty, nursing clinicians, or nursing administrators, who fit the inclusion criteria, became the panel members for the Delphi Study. Although I was unable to offer you participation in the study, I would like to thank you again for your time completing the survey, and I have attached the final results of the study as per your request.

Again, I thank you.

Sincerely,

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)
Appendix 30: Delphi Study Participant Thank You Letter (one round)

January 21, 2015

Dear Delphi Study Panel Member,

You recently participated in one round of a modified Delphi Study to determine instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

A second round determined that all remaining competencies suggested reached at least 75% consensus by the Delphi Study panel members who participated in the second round. A third round, therefore, is not necessary. Attached is the final result of the study: the instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

I would like to thank you for your participation in this research project, and inform you that these research findings will be published and presentations of the instructional competencies for assessing and managing suicide risk for baccalaureate nursing education will be presented at nursing research conferences, and will likely inform individual faculty and schools of nursing to address these competencies in their classrooms. This could not have been possible without your participation.

If you have any questions, please contact me at (516) 972-8868 or at: akotowski@gc.cuny.edu.

Sincerely,

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)
Appendix 31: Delphi Study Participant Thank You Letter (two rounds)

January 21, 2015

Dear Delphi Study Panel Member,

You recently participated in a two-round, modified Delphi Study to determine instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

Attached you will find your individual scores and the group scores from the second round. A third round is not necessary because all remaining competencies suggested reached at least 75% consensus by the Delphi Study panel members who participated in the second round. Also attached is the final result of the study: the instructional competencies for assessing and managing suicide risk for baccalaureate nursing education.

I would like to thank you for your participation in this research project, and inform you that these research findings will be published and presentations of the instructional competencies for assessing and managing suicide risk for baccalaureate nursing education will be presented at nursing research conferences, and will likely inform individual faculty and schools of nursing to address these competencies in their classrooms. This could not have been possible without your participation.

If you have any questions, please contact me at (516) 972-8868 or at: akotowski@gc.cuny.edu.

Sincerely,

Abigail Kotowski, RN, PMHCNS-BC, PhD (c)
Appendix 32: Instructional Competencies for Assessing and Managing Suicide Risk for Baccalaureate Nursing Education

Pre-assessment Competencies:
1. Demonstrate knowledge of a definition of suicide.
2. Demonstrate knowledge of suicide prevention resources.
3. Demonstrate knowledge of the incidence/prevalence of suicidal ideation, suicide attempt, and suicide completion among persons related to demographic characteristics (age, gender, sexual orientation, religion, ethnicity, culture, educational level, employment, marital status, geographic location, sociopolitical environment, socioeconomic factors), personal and family history.
4. Demonstrate knowledge of the populations at risk.
5. Demonstrate knowledge of the myths vs. facts about suicide.
6. Demonstrate knowledge of the risk factors for suicide.
7. Demonstrate knowledge of other conditions that may affect suicide.
8. Demonstrate knowledge of the warning signs of suicide especially psychiatric diagnosis and/or substance abuse issues.
9. Demonstrate knowledge of the protective factors for suicide.
10. Demonstrate knowledge of legal/ethical issues related to suicide.
11. Demonstrate knowledge of cultural issues related to suicidal ideation, suicide attempt, and suicide completion.
13. Demonstrate knowledge of suicide risk assessments for all patients in all settings including: emergency department patients, inpatients, and outpatients.
14. Demonstrate knowledge of issues related to nursing documentation.

Assessment Competencies:
15. Demonstrate ability to communicate openly about suicidal ideation.
17. Demonstrate awareness of personal verbal (sound, words, speaking, and language) and nonverbal (the environment, body language, prosodic and paralinguistic features of voice) communication related to suicide assessment.
18. Demonstrate awareness & understanding of patient’s verbal and nonverbal communication.
19. Demonstrate ability to observe and interpret verbal and nonverbal clues of a patient at risk for suicide.
20. Demonstrate effective triage/interviewing skills.
21. Demonstrate use of therapeutic verbal and nonverbal communication.
22. Complete a nursing assessment including baccalaureate-level physical and psychosocial assessments.
23. Complete a Mental Status Examination.
24. Demonstrate ability to use therapeutic communication skills to elicit suicidal ideation.
27. Elicit protective factors for suicide.
29. Demonstrate ability to complete a reliable and valid suicide assessment instrument.
Management Competencies:
30. Follow organization’s policies and procedures for suicide.
31. Communicate assertively to intervene.
32. Communicate and coordinate with the interdisciplinary team.
33. Determine level of care needed.
34. Arrange for psychiatric evaluation if necessary.
35. Collaborate with patient, family, significant other, and treatment team regarding the plan of care in order to ensure the patient’s safety.
36. Demonstrate ability to maintain the safety of the patient and the health care team.
37. Arrange for 1to1 observation if necessary, including observation of the patient and environment.
38. Demonstrate therapeutic verbal and nonverbal communication during one-to-one observation.
39. Obtain information and records from collateral sources as appropriate while maintaining confidentiality.
41. Demonstrate an ability to assess and manage suicide risk through role play.
42. Demonstrate an ability to assess and manage suicide risk through simulation and debriefing.
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