# Assessing for Occult Suicidality at Triage: Experiences of Emergency Nurses

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**Contribution to Emergency Nursing Practice**

- Screening for suicidality is a critical function of triage nursing.
- Screening is a process that involves recognition and interpretation of verbal and nonverbal cues.
- Future efforts to improve triage assessment of suicide risk should include screening tools that are deployed continuously through the ED visit.

**Abstract**

**Introduction:** Screening for suicidality is a critical nursing function at the initial ED encounter. Suicide is the tenth leading cause of death in the United States, and a substantial percentage of people who die by suicide present for health care in the year before their deaths. The emergency department provides health care professionals with a critical opportunity to identify patients at risk for suicide and intervene appropriately.

**Methods:** Qualitative exploratory study using focus-group data.

**Findings:** Effective and accurate suicidality assessment occurs not by asking a single question but also with the assessment of patient behaviors and presentation (appearance, hygiene, etc). When emergency nurses suspected occult suicidality, additional actions (finding private space, keeping patients safe, and passing on information), took priority.

**Discussion:** The Joint Commission recommends using clinical judgment tools for the final determination of safety for a patient at suspected risk of suicide, as research findings suggest that a screening tool can identify persons at risk for suicide more reliably than a clinician's personal judgment. Our participants report that when they assessed suicide risk at triage, it was usually by asking a single question such as "Do you have thoughts or plans to harm yourself?" and they expressed concern about the effectiveness of doing so. Participants described their efforts to improve suicide screening across the duration of the patient's ED stay through an iterative process of assessment that included further probing and eliciting, evaluating, and reacting to the patient's response.

**Keywords:** Triage; Suicide; Risk assessment; Qualitative methods; Emergency nursing

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## Introduction

Screening for suicidality is a critical nursing function at the initial ED encounter. Suicide is the tenth leading cause of death in the United States,[1] and a substantial percentage of people who die by suicide present for health care in the year before their deaths.[2] The emergency department provides health care professionals with an opportunity to identify patients at risk for suicide and intervene appropriately; a 2003 literature review[3] concludes that schools, primary care, and ED settings are appropriate places to screen for suicidality in youths. The Joint Commission[4] (TJC) recommends screening every patient for suicidal ideation and risk in the emergency department, as suicidal ideation is estimated to be present in as many as 11% of all ED patients, although only 3% are identified by current screening efforts.[5]

Suicide-risk screening tools with moderate recommendation by the Emergency Nurses Association[6] as being useful for practice in the emergency department include the Ask

Suicide-Screening Questions (ASQ), the Manchester Self-Harm Rule, and the Risk of Suicide Questionnaire. Research findings suggest that triage assessment reliability is dependent on the experience, information, and intuition of the nurse in making the decision[7]; environmental factors in the emergency care setting also influence acuity assignation.[8–10] The iterative process by which nurses collect data, make judgments, and then seek out further information to confirm those judgments is a critical component of clinical decision making.[11] Interruptions and lack of privacy and time in the triage area can impede communication, preventing confirmation of judgment and frustrating the determination of suicidality.[8]

Studies of ED behavioral health (BH) practices report that 60% of emergency nurse respondents received no specific post-licensure education on the assessment or management of BH patients[12] and report a lack of skills to assess severity of suicide risk, to provide brief counseling, or negotiate a safety plan with patients who meet the criteria for high risk of suicidality.[13] The purpose of this study was to explore the process by which emergency nurses assess patients for suicidal ideation during the initial patient encounter and how they respond once risk is ascertained.

## Methods

This was a qualitative exploratory study using focus groups to collect data from a sample of emergency nurses.

### THEORETICAL FRAMEWORK

This exploration was located within Orlando's Deliberative Nursing Process Theory,[14] in which nursing process is described using 3 concepts: patient behavior, nursing reaction (which can be a thought or perception, followed by an action), and nurse activity—which can be automatic or the result of a deliberative process—that allows the nurse to identify patients' needs and offers information or resources that may be of help. Importantly, the definition of effective nursing practice, as described by Orlando,[14,15] requires that patient needs are assessed accurately and met.

### SAMPLE

This purposive convenience sample comprised a total of 41 English-speaking emergency nurses above the age of 18 who provide direct care to patients in emergency departments that were geographically distributed within 4 regions of the country (Northeastern, Southern, Midwestern, Western); 2 participants worked in emergency departments in Australasia (Tables 1 and 2). Participants were recruited via E-mail from a list of nurses registered to attend the Emergency Nurses Association's Annual Conference held September 13–16, 2017, in St. Louis, Missouri.

### DATA COLLECTION

As part of the recruitment process, participants completed an online survey (Qualtrics, Provo, Utah) that collected demographic and practice-setting data. Focus groups were facilitated by the principal investigator (PI) (LW) and co-PIs (PRC, KEZ, MDM); researchers also took field notes and digitally audio-recorded the proceedings. The focus-group discussions were transcribed verbatim, and, along with field notes, provided the data set for thematic analysis.

The research questions that guided the semistructured focus-group discussion were derived from the elements of Orlando's model, as follows:

- Q1: What patient behaviors raise concern about suicide?
- Q2: How do you understand and interpret those behaviors to determine suicide risk?
- Q3: What actions do you take in response to your understanding of patient risk?
- Q4: How do you determine the effectiveness of your response?
- Q5: What are the facilitators and barriers to effective triage of a patient with overt or occult suicidality?

### DATA ANALYSIS

Demographic data were exported to an IBM SPSS Statistics 22 database, and descriptive statistics were performed. Focus-group transcriptions and field notes were analyzed by the members of the research team individually, using open coding, simultaneous coding, and subcoding techniques as described by Saldana[16] and then re-examined multiple times as a team to determine the final categories and themes by consensus. Member checking took place at 2 points during the process: the first at the end of each session, when the PI (LW) reviewed and summarized the discussion for initial confirmation of content and theme, and again via E-mail after the final themes had been determined by the research team. Twenty- one of the 41 participants responded to our E-mail request for confirmation; all confirmed the correctness of our findings. This 2-step process determined saturation during data collection and enhanced the credibility and dependability of the study's findings.

## Findings

Our findings are presented here, using the concepts identified in Orlando's deliberative nursing process theory[14] (patient

TABLE 1
**Participants' demographics (N = 41)**

| Characteristic | | Participants (%) | | | |
|---|---|---|---|---|---|
| **Gender** | Female | 92.7 | | | |
| | Male | 7.3 | | | |
| **Age** | 25–34 | 7.3 | | | |
| | 35–44 | 22.0 | | | |
| | 45–54 | 24.4 | | | |
| | 55–64 | 36.6 | | | |
| | >64 | 9.8 | | | |
| **Highest Educational Degree in Nursing** | Nursing Diploma | 4.9 | | | |
| | Associate | 12.2 | | | |
| | Bachelor | 30.6 | | | |
| | Master's | 39.0 | | | |
| | Doctorate | 7.3 | | | |
| **Primary ED Role** | Charge Nurse | 9.8 | | | |
| | Clinical/Nurse Educator | 22.0 | | | |
| | Clinical Nurse Specialist | 9.8 | | | |
| | Director | 7.3 | | | |
| | Manager | 9.8 | | | |
| | Nurse Practitioner | 9.8 | | | |
| | Staff Nurse | 26.8 | | | |
| | Other | 4.9 | | | |
| **ENA Member** | Yes | 100.0 | | | |
| | No | 0.0 | | | |
| Years of Experience | | Mean | SD | Min | Max |
| | As a nurse in all areas, including the ED (n = 41) | 25.2 | 13.3 | 0.0 | 45.5 |
| | As an emergency nurse only (n = 41) | 21.1 | 13.1 | 5.1 | 60.0 |
| | In current ED (n = 41) | 12.8 | 13.6 | 0.0 | 60.0 |
| | In all areas of emergency care, excluding nursing (eg, tech) (n = 28) | 8.8 | 14.7 | 0.0 | 60.0 |

behavior, nursing reaction, and nursing activity), as well as examining what Orlando described as conditions for determining effective nursing practice.

## PATIENT BEHAVIORS

In their work on assessment of suicide risk, Berman and Silverman[2] describe multiple considerations in the process of formulation of risk, including presenting patient behavior. Our participants report not only nonverbal behaviors, presentation, and mismatch between the patient's injury or complaint and their stories, but also a feeling that there are unstated and unmet patient needs. These reports gave rise to the themes of *hesitation at disclosure, presentation mismatch*, and *gathering courage*. Although all participants reported that their institutions had some form of direct suicide-assessment questioning at triage (eg, "Do you feel like you want to hurt yourself or someone else?"), they described how they paid less attention to the actual answer and more to the patient's reaction to the question. Specifically, nurses reported behaviors such as a lack of eye contact or hesitation in answering screening questions as significant cues that required further investigation of patient risk for suicide.

> *I always just kind of watched their flat affect and lack of eye contact because soldiers are very confident for the most part, and when I have that lack of eye con.tact, that's a red flag. (Nurse Female [NF]26)*

TABLE 2
**Facility characteristics (N = 41)**

| Characteristic | | Participants (%) |
|---|---|---|
| **ED Patient Population** | General Emergency Department | 92.7 |
| | Adult-Only Emergency Department | 2.4 |
| | Pediatric-Only Emergency Department | 4.9 |
| **Facility Type** | Non-Government, Not-for-Profit | 70.7 |
| | Investor-Owned, For-Profit | 12.2 |
| | State or Local Government | 14.6 |
| | Federal, Military, or VA | 2.4 |
| **Geographic Location** | Urban | 31.7 |
| | Suburban | 36.6 |
| | Rural | 31.7 |
| **Annual ED Patient Visits** | 1–5,000 | 7.3 |
| | 5,001–10,000 | 2.4 |
| | 10,001–20,000 | 2.4 |
| | 20,001–30,000 | 19.5 |
| | 30,001–40,000 | 7.3 |
| | 40,001–50,000 | 4.9 |
| | 50,001–75,000 | 29.3 |
| | 75,001–100,000 | 17.1 |
| | >100,000 | 7.3 |
| | Missing | 2.4 |
| **Geographic Distribution** | Outside the United States | 4.9 |
| | Northeast (MA, ME, NH, NJ, NY, PA, VT) | 22.0 |
| | Midwest (IL, IN, KS, MN, MO, NE, WI) | 26.8 |
| | South (AL, DC, FL, GA, KY, LA, MD, NC, TN, TX, VA) | 19.5 |
| | West (AK, AZ, CA, MT, NM, WA) | 26.8 |

*There's an occasion where there's a hesitancy to answer, and that is always a clue to me to stop and say, "You're hesitating, what's going on?" I think that hesitancy for me [is a cue], although we do ask everybody who comes in. (NF36)*

### *Presentation Mismatch*

Other red flags were reported as disengagement, agitation, and mismatch between the presenting complaint and the patient's description of mechanism of injury or situation. These factors in constellation prompted concern about occult suicidality, which we understood as suicidal ideation that is not stated by the patient and not the presenting complaint, but becomes a primary focus of the nurse's attention.

*…they're complaining about a scratch that looks self-inflicted but they're telling you a different story, but you look on their other arm and you see scarring from previous scratching. (NF10)*

*If the injury doesn't match what they're telling you, so I mean we see this with, you know, kids that come in and say, "I cut myself with a bottle," and then, "I've fallen down the stairs"… is this something that they are trying to tell us … that this is actually a suicide attempt as opposed to, "Did you really fall down the stairs with a bottle in your hand?" (NF15)*

### *Gathering Courage*

Another significant assessment was recognition of patterns of presentation. Participants reported that when a patient presented several times in a short period with vague complaints, they became concerned.

*I have noticed that oftentimes with our SI [suicidal ideation] patients, you'll see a previous history of them checking into emergency departments every day, or once a week… you'll see a whole bunch of minor complaints*

*ahead of time where they're trying to get up the courage to say what they're really here for. (NF2)*

## NURSING REACTIONS AND ACTIONS

Our participants report the process of understanding and interpreting these patient behaviors as dependent on a nurse's level of nursing experience; patient behaviors can be mediated or interpreted considering overall patient presentation, which can include assessment data beyond the presenting complaint such as hygiene, appearance, and the patient's social support system or lack thereof. When suicidality is suspected, nurses' actions can include passing on concerns and information about their suspicions to colleagues, providing a safe space for patients to disclose more information, alerting a physician, or seeking out more information through other channels (eg, patient records, family). Themes in this category were *handing off*, *creating caring space for information to emerge*, and *probing further*.

*Handing off* described the process by which a nurse in the triage role had significant suspicion that warranted additional follow-up by another provider. Our respondents suggested that even if the patient specifically denied suicidality but had behaviors that prompted concern, they would alert the next provider assigned to the patient in hopes that provider would continue to assess for suicidality.

*Our triage is so fast paced that I do the same thing, if I'm picking up on something that doesn't seem right, I'll pass it onto that nurse who will be taking care of that patient to do some more exploration. (NF17)*
*…we put them in another room where we would say to the primary nurse, "Not really sure about this patient. They've got some indications; please can you get somebody to see them." But we also make an immediate referral at triage to the mental health professional. (NF12)*

*Handing off* is also viewed with some concern; our respondents reported that if the person to whom they are handing off did not have the competence or confidence to explore the patient's suicidality, the handoff did not produce good outcomes.

*Handing off sometimes depends on how my coworker or colleague engages in what I'm saying and believes that I'm, "Well, what makes you think that," and some folks are just, "Oh well, well he's got a drug problem. Whatever; it's his issue," … next thing you know they're not taking it seriously enough and the patient elopes. And we've had that happen more than once. (NF32)*

### *Creating Caring Space for Information to Emerge*

Our participants reported that given time and crowding constraints, they would try to create an opportunity for patients to give more information. There was a focus on conveying to patients that the nurse cared about them and wanted to help them; to foster that relationship, a safe, private space was created away from the initial triage area.

*… sometimes I have to make up a little story, if you will. "I'm going to put you over here for just a little bit until I get a room cleaned" or something …you know, we'll just do things to keep them busy and keep their mind occupied until we can keep….as long as we're keeping them safe and can hand them off to a safe spot. (NF17)*

*So …instead of "Are you suicidal?" they rephrase it to, "Do you feel hopeless?" so I will use that as an opening statement if I get any kind of clue to it. And then if they are hesitant, like the previous person said, I will usually use the bathroom as my privacy area, "Oh, let's get your urine sample," and when I walk to them or before I close the door, I will just usually ask directly, "Do you want to kill yourself?" that's what I do. (NF39)*

### *Probing Further*

Probing further exemplifies an iterative and confirmatory process of clinical reasoning, allowing the nurse to seek further detail from the patient to assess suicidality, with an emphasis on providing care to all patients in a personally and professionally caring way.

*…if we feel uncomfortable during that triage process, there's a red flag, whether it's eye contact or kind of a flat affect or just not really seeming like they're giving you the whole story, we have further questions we can ask, which are similar, that will build up that score, that kind of lead us down that path and justify our working that angle. (NF40)*

*…when you have a high degree of suspicion even when the patient says, "no," you'll look through their chart and you'll see schizophrenia, depression, previous suicide attempts, suicidal ideations. Or, you'll look at their prescriptions and you'll see a lot of psychiatry type medications that make you say, "No, we're going to push this further," and I flag them for a mental health professional to come and see them. (NF2)*

### *Effective Nursing Care*

*Effective nursing care* is defined by Orlando[14] as "recognizing and meeting the needs of the patient." The nurses in our study reported that effectiveness of care is generally difficult to capture because of lack of feedback after triage. In the

short term, our participants described effective nursing care as a set of actions and reactions that created a window of opportunity to reach the patient. The theme that emerged from these data was *ensuring safety for now,* which highlights the awareness among our participants that their actions and ability to help are limited by the constraints of the ED environment.

> *Really, we're trying to keep them from hurting themselves in the department, so – we did our job, we got them safely to the next part, the next follow-up whether it's inpatient care or outpatient. (NF27)…it's just getting them through the stage. And I know it discourages a lot of our staff when they keep coming back, but sometimes they just need a safe place to be. (NF40)*

### FACILITATORS AND BARRIERS

Inadequate time, experience, education, and training were identified as the most significant barriers to effective identification at triage. Participants also discussed bypassing or over-reliance on check boxes in electronic record screening tools and the emphasis on patient throughput procedures that may preclude the type of assessment that requires nursing presence. Another reported barrier was a lack of community resources, which was not only viewed as a challenge for managing patient care but also as a contributing factor to colleagues' unwillingness or inability to recognize and respond to the needs of patients at risk for suicide. Facilitators of effective triage were identified as the availability of BH nurses within the emergency department, nurses having adequate experience and training to detect a patient's subtle cues, and the ability to find a safe place for patients to be more fully assessed within the department.

> *I find one of the other challenges is new-to-triage nurses don't have the expertise to know what cues and what questions to ask or what about body language or how the patients are withdrawn or eye contact, you know, very quiet voice, soft spoken, evasive, those kinds of things. (NF32)*

> *Right, you have to check the box, but what they're doing is they're not asking it really; they're just going ahead and assuming, "You're here, I know you, you're here for abdominal pain," and so I'm not going to ask; I'm going to check "no," and move on to get through that because you get the hard stop. (NF27)*

> *I recently had a new nurse get a "yes" answer [to a question about suicidal ideation] for a patient who was presenting with, I don't know, a leg pain or something not very important, and they said, "Yeah, actually that's the real reason I'm here," and she just went, "I don't know what to do next." (NF33)*

## Discussion

A 2016 Sentinel Event Alert (on suicide screening) reports 1,089 suicides in the acute-care setting or within 72 hours of discharge from an emergency department.[4] The most common root cause documented for issues with National Patient Safety Goal associated with suicide screening was inadequate psychiatric assessment.[4] TJC recommends using clinical-judgment tools for the final determination of safety for a patient with suspected risk for suicide, as research findings suggest that a screening tool can identify persons at risk for suicide more reliably than a clinician's personal judgment.[4] Our participants report that when they assessed suicide risk at triage, it was usually by asking 1 question, such as "Do you have thoughts or plans to harm yourself?" and they expressed concern about the effectiveness of doing so. Perhaps more importantly, they described their efforts to improve suicide screening across the duration of the patient's ED stay using an iterative process of assessment that included further probing and eliciting, evaluating, and reacting to the patient's response.

Concern with the perceptions of the colleague to whom a patient is "handed off" revolved around use of clinical judgment, which our participants worried could be informed by bias. It is the initial clinical judgment of the triage nurse that may lead to the use of a decision-making tool further along in the patient care trajectory, and therefore education and experience that facilitates the discernment of subtle cues to suicidality is critical.

Consistent with the extant literature, our participants recognized that effective assessment necessarily includes observation of a person's behavior, reaction to questioning, emotional affect, and physical demeanor, all of which they reported as related to nurses' experience and ability to observe and assess verbal and nonverbal cues. Risk of suicide has been defined by previous researchers as fluid, highly state dependent, and variable over time,[17] leading to assessment challenges. Although there is no test or instrument that can identify suicidal patients definitively, Hirschfeld and Russell[18] outlined considerations in the assessment of patients for suicidality. Included in their algorithm are behaviors and risk factors, as well as an explicit statement of suicidal ideation or intent. Berman and Silverman[2] also describe constellations of factors that contribute to the process of suicide risk formulation.

Fowler[19] describes factors that are predictive of suicide risk but also may result in high false-positive rates for both suicidal ideation and mental-health diagnoses. In our study, emergency nurses expressed concern that a high number of false positives led to frustration from providers, interrupting the provision of BH care both during and beyond the ED visit. Several studies found that most patients who die by suicide deny such intentions at their last clinical encounter before the suicide[20,21]; this is consistent with our participants' position

that a more robust and thorough assessment is necessary to determine risk of suicide. They report nursing reactions to suspected suicidality as taking further steps to allow more information to be revealed to clarify the patient's true state.

Our participants frame their assessment of suicidality as a process. Although these emergency nurses could describe components of effective triage of suicide risk, they also acknowledged multiple barriers to accurate stratification of risk in the emergency-care setting, including a lack of nursing experience, capacity, or willingness to conduct more formal, tool-based suicide screenings, patient safety and privacy concerns, and poor handoffs and communication. Our participants described different protocols and access to resources that limit their ability to provide patients with consistent and appropriate care during the ED visit. Despite these differences, on at least some occasions, our participants could employ effective triage of suicide risk and improve care of ED patients with BH emergencies.

## Limitations

This was a qualitative exploratory study whose participants were a self-selecting group of emergency nurses attending a national conference. This purposive sample was small (although demographically representative and geographically diverse), thereby limiting the generalizability of the findings to the larger population of emergency nurses.

## Implications for Emergency Nurses

The findings of this study indicate that effective and accurate suicidality assessment occurs not by asking a single question but in conjunction with the assessment of patient behaviors and presentation (appearance, hygiene, etc). When emergency nurses suspected occult suicidality, additional actions (finding private space, keeping patients safe, and passing on information) took priority. Study participants further identified training needs to both decrease resistance and increase willingness to assess patients for suicidality consistently and accurately. Experienced emergency nurses also were recognized as having sharper acumen for assessing patient suicidality effectively than novice nurses who may be unfamiliar with caring for this patient population.

## Conclusions

The effectiveness of asking a single question to determine suicide risk in a public triage area is questionable. Our participants report engaging in an iterative assessment process that is not well served by the chaotic conditions of the emergency-care setting. They report being motivated to probe further, based on behaviors that raise suspicion of occult suicidality in patients. If suicidality is identified, they take specific actions to keep patients safe while in the emergency department. Future efforts to improve triage assessment of suicide risk should include screening tools that are revisited over the course of the ED visit and should have nonverbal items incorporated to weigh suicidality further.

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REFERENCES

1. Curten SA, Warner M, Hedegaard H. Increase in suicide in the United States 1999–2014, : Centers for Disease Control; 2016. https://www.cdc.gov/nchs/products/databriefs/db241.htm. Accessed November 16, 2017.
2. Berman AL, Silverman MM. Suicide risk assessment and risk formulation, part II: suicide risk formulation and the determination of levels of risk. *Suicide Life Threat Behav.* 2014;44(4):432-443.
3. Horowitz LM, Ballard ED. Suicide screening in schools, primary care and emergency departments. *Curr Opin Pediatr.* 2009;21(5):620.
4. Detecting and treating suicide ideation in all settingsThe Joint Commission .
5. Allen MH, Abar BW, McCormick M, et al. Screening for suicidal ideation and attempts among emergency department medical patients: instrument and results from the Psychiatric Emergency Research Collaboration. *Suicide Life Threat Behav.* 2013;43(3):313-323.
6. Clinical Practice Guideline: Suicide screening in the ED, : Emergency Nurses Association; 2017.
7. Chung JYM. An exploration of accident and emergency nurse experiences of triage decision making in Hong Kong. *Accid Emerg Nurs.* 2005;13(4):206-213. Q4
8. Gerdtz MF, Weiland TJ, Jelinek GA, Mackinlay C, Hill N. Perspectives of emergency department staff on the triage of mental health-related presentations: implications for education, policy and practice. *Emerg Med Australas.* 2012;245:492-500.
9. Wolf L. Acuity assignation: an ethnographic exploration of clinical decision making by emergency nurses at initial patient presentation. *Adv Emerg Nurs J.* 2010;32(3):234-246.
10. Wolf LA, Delao AM, Perhats C, Moon MD, Zavotsky KE. Triaging the emergency department, not the patient: US emergency nurses' experience of the triage process. *J Emerg Nurs.* 2017.
11. Wolf L. An integrated, ethically driven environmental model of clinical decision making in emergency settings. *Int J Nurs Knowl.* 2013;24(1):49-53.

12. Wolf LA, Perhats C, Delao AM. US emergency nurses' perceptions of challenges and facilitators in the management of behavioural health patients in the emergency department: a mixed-methods study. *Australas Emerg Nurs J.* 2015;18(3):138-148.
13. Betz ME, Sullivan AF, Manton AP, et al. Knowledge, attitudes, and practices of emergency department providers in the care of suicidal patients. *Depress Anxiety.* 2013;30(10):1005-1012.
14. Orlando IJ. The Discipline and Teaching of Nursing Process (An Evaluative Study), New York, NY: Putnam Publishing Group; 1972.
15. Fawcett J. Criteria for evaluation of theory. *Nurs Sci Q.* 2005;18 (2):131-135.
16. Saldana J. An introduction to codes and coding. *The Coding Manual for Qualitative Researchers* Thousand Oaks, CA: ; 2009:1-31.
17. Rudd MD, Berman AL, Joiner TEJr., et al. Warning signs for suicide: theory, research, and clinical applications. *Suicide Life Threat Behav.* 2006;36(3):255-262.
18. Hirschfeld R, Russell JM. Assessment and treatment of suicidal patients. *N Engl J Med.* 1997;337(13):910-915.
19. Fowler JC. Suicide Risk Assessment in Clinical Practice: Pragmatic Guidelines for Imperfect Assessments. *Psychother Theory Res Pract Train.* 2012;49(1):81-90.
20. Busch KA, Fawcett J, Jacobs DG. Clinical correlates of inpatient suicide. *J Clin Psychiatry.* 2003;64(1):14-19.
21. Denneson LM, Basham C, Dickinson KC, et al. Suicide risk assessment and content of VA health care contacts before suicide completion by veterans in Oregon. *Psychiatr Serv.* 2010;61(12):1192-1197.