

Nurses' Readiness to Manage Patients Following Suicide Attempts in Hospital Settings

A Systematic Review

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ARTICLE INFO

Article history

Received 5 February 2026

Revised 24 June 2026

Accepted 29 June 2026

ABSTRACT

Suicide remains a major public health concern worldwide, and nurses play a critical role in managing patients following suicide attempts. Nurses' readiness is essential to ensure patient safety and prevent recurrent suicidal behaviors. However, evidence suggests that preparedness among nurses varies widely. This systematic review aimed to identify, critically appraise, and synthesize available evidence regarding nurses' readiness in hospital settings to manage patients following suicide attempts. A systematic review was conducted following PRISMA guidelines. Electronic searches were performed in PubMed, Scopus, and ProQuest databases for articles published between 2021 and 2025. Studies examining nurses' readiness and related factors in hospital settings were included. Methodological quality was assessed using JBI critical appraisal tools. Data were synthesized narratively. A total of 103 records were identified, and nine studies met the inclusion criteria. Most studies employed quantitative cross-sectional designs, while one study used a quasi-experimental approach. The findings indicated that nurses' readiness varied considerably and was influenced by multiple factors. Higher readiness was associated with suicide prevention training, clinical experience, positive attitudes, and self-efficacy. Common barriers included high workload, lack of structured training programs, limited organizational support, and absence of clear clinical guidelines. However, the predominance of cross-sectional studies and heterogeneity of outcome measures limited quantitative comparison across studies. Nurses' readiness to manage patients following suicide attempts remains inconsistent across hospital settings.

These findings highlight the importance of implementing regular suicide prevention training programs, establishing clear clinical guidelines, and strengthening organizational support to improve nurses' readiness in hospital settings and enhance patient safety.

Keywords

Nurses' Readiness
Suicide Attempts
Hospital Settings
Suicide Prevention
Acute Care Nursing

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Introduction

Suicide is a global public health problem that causes more than 700,000 deaths each year, with the majority occurring in low- and middle-income countries [1]. The burden of suicide affects not only individuals but also families, health systems, and society at large, requiring a comprehensive prevention approach [2]. Although various prevention strategies have been developed, many efforts still focus on individual clinical management and have not fully integrated the readiness of health workers into the service system [3]. Hospitals are a crucial setting for suicide prevention because they are the main point of service for individuals who attempt suicide [4]. The post-suicide attempt period is a high-risk phase for recurrence of suicidal behavior if not handled optimally [5].

Patients hospitalized after a suicide attempt require continuous monitoring and integrated care during their treatment period [6]. Failure to provide continuous care can increase the risk of recurrence and psychosocial complications in patients [7]. Hospitals play a role not only in stabilizing physical conditions, but also in early detection of further suicide risk and planning follow-up care [8]. System limitations, including the lack of clear protocols and interprofessional coordination, remain challenges in the management of patients after suicide attempts [1]. Therefore, the quality of hospital services is highly dependent on the readiness of the health workers directly involved in patient care [9].

Nurses are the healthcare professionals who interact most frequently with patients during their inpatient stay after a suicide attempt [10]. The role of nurses includes suicide risk assessment, therapeutic communication, providing emotional support, and monitoring patient safety [11]. However, nurses often face emotional stress, ethical dilemmas, and fear of clinical errors when treating patients at risk of suicide [12]. These experiences can be exacerbated by the stigma surrounding suicide and a lack of organizational support in the workplace [13]. This situation indicates that nurses need adequate preparation to be able to provide safe and effective care [14].

The concept of nurses' readiness reflects nurses' preparedness in terms of knowledge, skills, attitudes, self-confidence, and emotional readiness in dealing with specific clinical situations [15]. Research shows that low nurse readiness can hurt the quality of clinical decision-making and communication with patients at risk of suicide [16]. Nurses' readiness is also influenced by systemic factors, such as training, hospital policies, and organizational culture [17]. However, most previous studies have focused more on nurses' knowledge or attitudes separately and have not specifically examined nurses' readiness in the post-suicide attempt hospital setting [18]. This gap highlights the need for research that specifically examines nurses' readiness in the hospital context as part of ongoing suicide prevention efforts [19]. Although previous studies have explored nurses' knowledge, attitudes, or suicide prevention practices, limited evidence has specifically synthesized nurses' readiness in hospital settings for managing patients following suicide attempts. Furthermore, no recent systematic review has comprehensively examined the multidimensional aspects of readiness, including knowledge, attitudes, self-efficacy, clinical experience, and organizational support. Therefore, this review provides updated evidence to address this gap and support future suicide prevention strategies in hospital settings.

This systematic review aims to identify, critically appraise, and synthesize evidence regarding nurses' readiness in hospital settings to manage patients following suicide attempts.

Methods

A. Study design

This study is a systematic review that aims to analyze and synthesize research results related to nurses' readiness in handling patients who have attempted suicide in hospitals.

B. Search strategy

The search strategy was developed using the PICOST (Population, Intervention, Comparison, Outcome, Study design, Time) framework to ensure that relevant studies were identified systematically and comprehensively. Literature searches were conducted in three electronic databases, namely PubMed, Scopus, and ProQuest. The PICOST components are defined as follows:

1. Population (P): Registered nurses or nursing staff working in hospitals or acute care settings.
2. Intervention/Exposure (I): Suicide prevention training, clinical experience, or involvement in the treatment of patients at risk or after attempting suicide.
3. Comparison (C): Nurses without formal suicide prevention training or with different levels of experience, if available.
4. Outcome (O): Nurses' readiness, which includes knowledge, attitudes, self-efficacy, confidence, skills, and perceived readiness in handling patients after suicide attempts.

5. Study design (S): Quantitative, qualitative, or mixed methods research, including cross-sectional, quasi-experimental, and observational designs.
6. Time (T): Articles published between 2021 and 2025.

Based on the PICOST framework, a search strategy was developed using Boolean operators AND and OR. The final search strategy applied to all databases was as follows: (nurs OR nurse) AND (suicide OR suicidal behavior OR suicide attempt) AND (readiness OR preparedness OR knowledge OR attitude OR training OR experience) AND (hospital OR acute care OR inpatient). The search terms were adapted to the indexing terms and search features of each database. The search was limited to peer-reviewed articles published in English between January 2021 and December 2025. This review was not registered in PROSPERO because the review protocol had not been prospectively developed prior to conducting the study. Nevertheless, the review process was conducted in accordance with the PRISMA 2020 guidelines to ensure methodological transparency and reporting quality.

C. Eligibility criteria

The inclusion criteria were nurses working in hospital settings, studies addressing nurses' readiness, knowledge, attitudes, training, or experiences in managing patients at risk of or following suicide attempts, articles published in English, available in full-text, and published between 2021 and 2025. The exclusion criteria were studies not relevant to nurses' readiness in hospital settings, articles not available in full-text, and articles that could not be accessed in full. Studies were selected based on predefined eligibility criteria to ensure that only studies relevant to the review objectives were included. Although some included studies involved multidisciplinary healthcare professionals, studies were included if they reported findings relevant to nurses or if nurses constituted a substantial proportion of the study population. Data related to nurses were extracted and interpreted specifically in the context of nurses' readiness in hospital settings.

D. Study selection

The initial search results from the three databases yielded 103 articles. Next, a gradual selection process was carried out, which included screening titles and abstracts to identify topic relevance. Articles that did not meet the inclusion criteria were eliminated. After the selection and eligibility assessment process, nine articles were obtained that met the criteria for further analysis. The article selection process is presented in the form of a flow diagram (PRISMA flow diagram).

E. Data extraction and analysis

Data from selected articles were systematically extracted using a data extraction sheet that included: Authors & Country, Study design, Sample sizes, Participant Characteristics, Outcome measures, and Key Findings. Data were analyzed descriptively and synthesized narratively to

identify factors that influence nurses' readiness to treat patients who have attempted suicide. All data extracted from the articles are presented in Table 2.

F. Quality appraisal

Article quality assessment was conducted using Joanna Briggs Institute (JBI) Critical Appraisal Tools tailored to the research design of each article. Each criterion was assessed with the options of yes, unclear, or no. Articles with a score of $\geq 50\%$ were deemed eligible and included in the systematic review analysis process. The quality assessment findings are presented in Appendix A.

Results

A. Study selection

A systematic search was conducted across three electronic databases, namely PubMed, Scopus, and ProQuest. A total of 103 records were initially identified, consisting of 8 records from PubMed, 66 from Scopus, and 29 from ProQuest. After removing 4 duplicate records, 99 articles remained for title and abstract screening.

During the screening process, 81 articles were excluded for not meeting the inclusion criteria. The primary reasons for exclusion included studies not focusing on nurses as the study population ($n = 29$), studies not conducted in hospital or acute care settings ($n = 21$), studies that did not address suicide attempts or suicide risk management ($n = 18$), and studies not related to nurses readiness, knowledge, training, or experience ($n = 13$).

Subsequently, 18 full-text articles were assessed for eligibility. Following full-text review and methodological quality appraisal using the Joanna Briggs Institute (JBI) Critical Appraisal Tools, 9 articles were excluded due to low methodological quality, or outcomes were not aligned with nurses' readiness in managing patients following suicide attempts. Finally, 9 studies met all inclusion criteria and were included in the final synthesis of this systematic review. The study selection process is presented in the PRISMA flow diagram (Figure 1).

B. Study characteristics

The nine included studies were conducted across diverse geographical regions and primarily employed quantitative cross-sectional designs, with one quasi-experimental study. Overall, the studies focused on nurses working in hospital and acute care settings, particularly in emergency departments, intensive care units, and general wards. Nurses' readiness was commonly assessed in relation to knowledge, attitudes, self-efficacy, training exposure, clinical experience, and organizational support. Across the included studies, nurses' readiness was operationalized through multiple dimensions, including knowledge, attitudes, self-efficacy, training exposure, clinical experience, and organizational support. A detailed overview of study characteristics and key findings is provided in Table 2.

C. Quality appraisal

Methodological quality assessment was conducted using the Joanna Briggs Institute (JBI) Critical Appraisal Tools, with the specific checklist selected according to each study's design. Overall, the quality of the included studies ranged from moderate to high. Six studies were rated as high quality, demonstrating clear study objectives, appropriate study designs, valid and reliable outcome measures, and adequate statistical analysis. Three studies were assessed as moderate quality, primarily due to limited reporting on confounding factors or sampling strategies. All included studies met the minimum quality threshold of $\geq 50\%$ based on JBI criteria. Therefore, the methodological quality of the included studies ranged from moderate to high. The detailed results of the quality appraisal are presented in Table 3 (Appendix A).

D. Summary of key findings

Overall, the findings across the included studies indicate that nurses' readiness to manage patients following suicide attempts remains variable and influenced by multiple interrelated factors. Higher levels of readiness were consistently associated with formal suicide prevention training, greater clinical experience, positive attitudes toward suicide prevention, and higher self-efficacy. Conversely, common barriers included high workload, lack of structured training programs, limited organizational support, and absence of clear clinical guidelines.

Several studies found that nurses who had received targeted training or depression management education demonstrated more favorable attitudes, greater confidence, and improved referral and risk assessment practices compared to those without such training. These findings underscore the importance of integrating structured training programs and organizational support to enhance nurses' readiness in hospital settings.

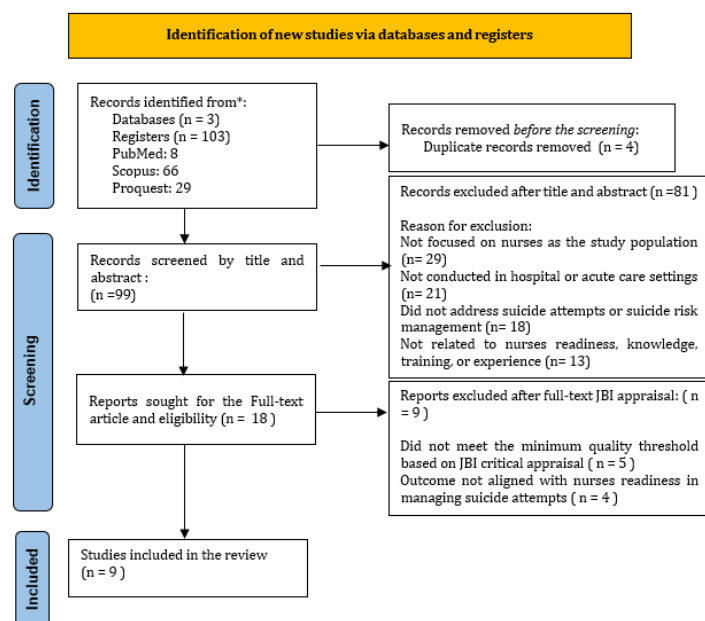


Fig. 1. PRISMA flow diagram

Table 2. Characteristics Study

No	Ref.	Country	Study design	Sample sizes	Participant	Characteristics	Outcome measures	Key Findings
1	[20]	USA	Cross-sectional survey	1,570	Clinicians in general healthcare settings	Multidisciplinary clinicians: varying roles and experience	Attitudes toward suicide prevention, self-efficacy, and reported practice use	Four clinician profiles were identified, and higher self-efficacy was associated with greater use of suicide prevention practices
2	[21]	Colombia	Cross-sectional study	354	Healthcare professionals (medicine, nursing, and assistants)	Interns and professionals with varied clinical experience	Attitudinal beliefs questionnaire (CCCS-18), ASETSA	Clinical experience influenced attitudes, gaps in comprehensive suicide prevention approaches
3	[22]	Saudi Arabia	Descriptive cross-sectional study	347	Nurses in a general hospital	The majority without formal suicide prevention training	Barriers and facilitators questionnaire (COM-B based)	Major barriers, workload, and lack of training were identified as the strongest facilitators
4	[23]	Iran	Descriptive analytical study	284	Emergency and ICU nurses	Nurses with experience caring for suicidal patients	ATTTS-31, caring dimensions inventory	Positive correlation between favorable attitudes and caring behaviors
5	[24]	China	Cross-sectional study	406	General hospital nurses	Predominantly female, varied work experience	KAP questionnaire, perceived social support scale	Training, social support, and work engagement significantly improved suicide prevention KAP
6	[25]	India	Cross-sectional comparative study	600	Doctors and nurses	Doctors are older and more experienced than nurses	LOSS-SF, ATTS	Doctors had higher literacy but more negative attitudes, and nurses showed more positive attitudes
7	[26]	Japan	Cross-sectional study	443	Paramedics, nurses, and social workers	Participant attending suicide prevention training sessions	Attitudes toward suicide scale (ATTTS)	Significant differences in attitudes across professions, training, and experience influenced more favorable suicide prevention attitudes
8	[12]	Israel	Quasi-experimental study	139	Community nurses	About half received depression management training	Attitude, self-competence, referent behavior	Trained nurses showed better attitudes, confidence, and referral practices
9	[7]	India	Hospital-based cross-sectional study	200	Nursing staff	Majority female, mean experience 12 years	KAP questionnaire	Adequate knowledge and attitudes, but a lack of formal suicide prevention training

Note: studies involving multidisciplinary healthcare professionals were included only when nurse-specific findings could be extracted or when nurses constituted a substantial proportion of the study population.

Table 3. Quality appraisal of included studies using the Joanna Briggs Institute (JBI) tools

Ref.	Study Design	JBI tools	Yes	No	Unclear	Overall quality
[20]	Cross-sectional survey	JBI Checklist for Analytical cross-sectional studies	7	1	0	High
[21]	Cross-sectional study	JBI Checklist for Analytical cross-sectional studies	6	2	0	Moderate
[22]	Descriptive cross-sectional study	JBI Checklist for Analytical cross-sectional studies	7	1	0	High
[23]	Descriptive analytical study	JBI Checklist for Analytical cross-sectional studies	7	1	0	High
[24]	Cross-sectional study	JBI Checklist for Analytical cross-sectional studies	7	1	0	High
[25]	Cross-sectional comparative study	JBI Checklist for Analytical cross-sectional studies	6	2	0	Moderate
[26]	Analytical cross-sectional study	JBI Checklist for Analytical cross-sectional studies	7	1	0	High
[12]	Quasi-experimental study	JBI Checklist for Quasi-experimental studies	8	1	0	High
[7]	Cross-sectional study	JBI Checklist for Analytical cross-sectional studies	6	2	0	Moderate

Discussion

A. Nurses' readiness in handling patients after suicide attempts

These findings are consistent with previous systematic reviews on suicide prevention education, which reported that training programs improve healthcare professionals' confidence, attitudes, and preparedness in managing suicidal patients [3]. Variability in nurses' readiness across hospital settings may reflect differences in educational background, clinical exposure, and organizational support [7, 20, 21]. Such differences indicate that readiness is a multidimensional concept encompassing knowledge, attitudes, self-confidence, and practical competence in suicide risk assessment and intervention [23, 24]. Since nurses are often the first healthcare professionals to interact with patients after a suicide attempt, inadequate preparedness may compromise early intervention, continuity of care, and relapse prevention [7,26]. However, unpreparedness in any one aspect of readiness can lead to delayed decision-making and inconsistent clinical practice [21]. These findings suggest that nurses' readiness is a multidimensional construct that cannot be understood from a single component alone [20]. Previous studies have similarly reported that inadequate preparedness among nurses may negatively affect suicide risk assessment and continuity of care. Similar challenges have been reported in emergency and mental health settings, where nurses often experience uncertainty and emotional burden when managing suicidal patients.

B. The effect of knowledge and training on nurses' readiness

Formal suicide prevention training appears to be a key mechanism through which nurses develop confidence, improve communication skills, and strengthen their ability to assess suicide risk [22, 24]. Nurses who have undergone structured training demonstrate better readiness, particularly in terms of positive attitudes toward suicide prevention and confidence in clinical practice [12,25]. Several studies also report that training is associated with improved nurses' ability to engage in therapeutic communication and assess suicide risk [23]. However, this review reveals that increased knowledge does not always automatically improve clinical readiness if it is not supported by adequate practical experience and organizational systems [7]. Therefore, training should be viewed as part of a sustainable strategy to strengthen nurses' readiness, not as a single intervention [22]. These findings support previous evidence showing that suicide prevention education enhances clinicians' confidence and promotes more positive attitudes toward suicidal individuals. Continuous training is therefore essential to sustain competency and readiness over time. However, some studies suggested that improved knowledge alone did not necessarily translate into higher clinical readiness. This discrepancy may be explained by differences in organizational support, workload, and opportunities for practical exposure across healthcare settings, indicating that training effectiveness depends on the availability of practical experience and organizational support.

C. The role of clinical experience and nurse confidence

In addition to training, clinical experience is an important factor that influences nurses' readiness in treating patients after suicide attempts [8, 20]. Greater clinical experience may enhance nurses' confidence in discussing suicidal ideation, performing risk assessments, and making appropriate clinical decisions [23, 26]. In contrast, nurses with limited experience often experience fear, uncertainty, and emotional discomfort when caring for patients at risk of suicide [21]. These emotional challenges may reduce nurses' active involvement in suicide prevention and continuity of care [7]. Therefore, clinical experience can be viewed as a contextual learning process that gradually strengthens nurses' competence, confidence, and overall readiness in managing suicidal patients [20].

D. The influence of organizational factors on nurses' readiness

This review confirms that nurses' readiness is not only influenced by individual factors, but also highly dependent on the readiness of the organization and the health care system [22]. Workload pressures, time constraints, and lack of resources are reported as major barriers that reduce nurses' ability to conduct comprehensive suicide risk assessments [7, 21]. In addition, the absence of clear clinical guidelines and structured referral pathways leads to uncertainty and variation in practice between hospitals [26]. Conversely, organizational support in the form of clear policies, supervision, and interprofessional collaboration has been shown to increase nurses' readiness in suicide prevention practices [24]. These findings reinforce that nurses' readiness is the result of an interaction between individual competence and organizational system support [20]. Therefore, individual competence alone may be insufficient without adequate organizational support. Hospitals should simultaneously strengthen both individual and system-level readiness to ensure effective suicide prevention practices.

E. Implications of findings for strengthening nurses' readiness

Based on the results of this systematic review, strengthening nurses' readiness requires a comprehensive and sustainable approach that covers individual and service system aspects [20, 22]. The integration of structured suicide prevention training, strengthening clinical experience, and providing guidelines and organizational support are key strategies for improving nurses' readiness in hospitals [7, 24]. By systematically improving nurses' readiness, hospitals can improve the quality of care and contribute significantly to efforts to prevent recurrent suicide [12]. These findings also emphasize the importance of integrating suicide prevention competencies into continuing nursing education and institutional policies to ensure sustainable improvements in clinical practice.

Limitations

This review has several limitations. First, only English-language studies published between 2021 and 2025 were included, which may have introduced publication and language bias. Second, most included studies used cross-sectional designs, limiting causal interpretation. Third, heterogeneity of outcome measures prevented quantitative synthesis through meta-analysis. Finally, several studies involved multidisciplinary healthcare professionals, which may limit the specificity of findings related exclusively to nurses. In addition, some included studies did not adequately control for potential confounding factors, such as years of professional experience, previous exposure to suicidal patients, and institutional characteristics, which may have influenced the reported levels of nurses' readiness.

Recommendations for Future Research

Future studies should employ longitudinal and interventional designs to evaluate the effectiveness of structured suicide prevention training programs among nurses. Research involving larger samples and diverse healthcare settings is also needed to better understand the influence of organizational factors on nurses' readiness. In addition, future studies should explore the long-term impact of suicide prevention education and investigate strategies to strengthen interprofessional collaboration in suicide care.

Conclusion

Nurses' readiness to manage patients following suicide attempts is influenced by individual and organizational factors, including training, clinical experience, self-confidence, and healthcare system support. These findings highlight the need for hospitals to implement regular and structured suicide prevention training, supported by clear clinical guidelines, clinical supervision, and interprofessional collaboration at both ward and hospital levels to ensure safe and effective suicide care.

Conflict of Interest

The authors declare that there is no conflict of interest regarding the publication of this article.

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