

TITLE: Suicide care from the nursing perspective: a meta-synthesis of qualitative studies

ABSTRACT

Aims: To explore nurses' experiences of suicide care and to identify and synthesize the most suitable interventions for the care of people with suicidal behaviour from a nursing perspective.

Design: Qualitative meta-synthesis.

Data sources: Comprehensive search of five electronic databases for qualitative studies published between January 2015 - June 2019.

Review Methods: The PRISMA statement was used for reporting the different phases of the literature search and the Critical Appraisal Skills Programme (CASP) qualitative research checklist was used as an appraisal framework. Data synthesis was conducted using Sandelowski and Barroso's method.

Results: Seventeen articles met the inclusion criteria. The data analysis revealed 13 subcategories from which four main categories emerged: 'Understanding suicidal behavior as a consequence of suffering', 'Nurses' personal distress in suicide care', 'The presence of the nurse as the axis of suicide care' and, 'Improving nurses' relational competences for a better therapeutic environment'.

Conclusion: Further training of nurses on the therapeutic relationship, particularly in non-mental health care work settings, and monitoring of the emotional impact on nurses in relation to suicide is required to promote more effective prevention and care.

Impact: This review provides new insights on how suicide is interpreted, the associated emotions, the way suicide is approached and proposals for improving clinical practice from the point of view of nurses. The results of this review demonstrate that the nurse-patient relationship, ongoing assessment, and the promotion of a sense of security and hope are critical in nursing care for suicidal patients. Consequently, to promote an effective nursing care of suicide, nurses should be provided with further training on the therapeutic relationship. Thus, health institutions do not only provide the time and space to conduct an adequate therapeutic relationship, but also, through their managers, they should supervise and address the emotional impact that is generated in nurses caring for suicidal patients.

Key words: Attempted Suicide; Nursing Care; Nurse-Patient Relationships; Qualitative Research; Suicide.

Main paper

INTRODUCTION

Worldwide, over 800,000 people die from suicide every year, and approximately 20 times as many attempts to commit suicide (Hegerl, 2016; World Health Organization, 2019). In most countries, the risk of suicide is higher for adult men, and the risk of attempted suicide is higher for young women (Hegerl, 2016). Concerning the deaths, almost one third of suicides take place among young people, ranked as the second leading cause of death in young people aged 15-29 and the second leading cause of death in women aged 15-19 (World Health Organization, 2019).

The most commonly used methods of suicide are pesticide poisoning, hanging and the use of firearms, followed by alternative methods, such as jumping from heights or drug poisoning (Ajdacic-Gross et al., 2008). However, there are notable differences between countries and sex (Ajdacic-Gross et al., 2008; Hegerl, 2016; World Health Organization, 2019). Poisoning is the method most used by women in 71% of cases, while in men it represents 50% of cases, with lethality being determinant according to the geographical area (Ajdacic-Gross et al., 2008). In Europe, more than 95% of cases survive intoxication, while in low- and middle-income countries, where there is access to pesticides and other toxic substances banned in European countries, women have a more lethal outcome than men, which is also the case in China (Hegerl, 2016).

Concerning the reasons for suicide, there is an open debate among professionals in the areas of health and social sciences as well as lay people (Hegerl, 2016; Zadavec and Grad, 2013). However, evidence shows that a high percentage of suicide cases are people with mental disorders and/or in contact with health services. Studies involving psychological autopsies conclude that about 90% of the victims in high-income countries had a mental disorder (Hegerl, 2016). According to other studies, about 20-40% of all suicide cases are people who are receiving follow-up for affective disorders and ongoing treatment in mental health services (Hegerl, 2016; Rytterström et al., 2019). Therefore, suicide prevention practices should be implemented in clinical settings.

Background

Suicidal behavior is defined as the act of intentionally ending one's life. These behaviours include suicide ideation, suicide plan, and suicide attempt (Nock et al., 2008; Silverman et al., 2007). Suicide prevention involves continuous monitoring and assessment of patients who exhibit suicidal behaviour and are therefore at risk of suicide. Since most risk assessment tools show a low predictive value for suicide (Runeson et al., 2017), a series of measures are necessary for prevention. These include establishing good communication and developing a support process for high-risk patients, analysing the situation from a contextual approach, using extreme safety to limit the presence of objects, substances in the environment or spaces that patients may

use to commit suicide, and encouraging coordination and supervision of professionals to improve teamwork (Hagen et al., 2017).

Nurses are key players in suicide prevention by providing one-on-one care to patients with opportunities for preventing and identifying signs of suicide risk. Nurses play a fundamental role in suicide prevention within health teams, by providing most of the direct patient care and because of their greater opportunities for preventing and identifying the warning signs of suicide in people who exhibit suicidal behaviour (Bolster et al., 2015; Lees et al., 2014). In this sense, nursing care in suicidal behaviour is carried out through activities aimed at assessing suicidal behaviour and promoting a safe environment to prevent suicide and the recovery of patients (Bolster et al., 2015; Nock et al., 2008). Nonetheless, difficulties have been detected in assessing the risk of suicide by nurses who lack specific training and coping strategies for this type of situation. (Bolster et al., 2015). In addition, suicide has been identified as causing negative attitudes and emotions in nurses that affect the delivery of care and, consequently, patient safety (Bolster et al., 2015).

In recent years there has been increased interest in the role of nurses in suicide care, with an exponential increase in the publication of evidence on this phenomenon, with a notable increase in studies that take a qualitative approach on experiences and perceptions of suicide care from a nursing perspective in different geographical contexts and areas of intervention (Bolster et al., 2015; Pestaner et al., 2019; Talseth and Gilje, 2011). However, there are no known qualitative syntheses that have integrated the main findings on suicide care from the nurse's perspective. Although there is a greater production of quantitative studies, the qualitative results allow for a more holistic and nuanced perspective for optimal suicide intervention and add depth to nurses' experiences that are key to understanding barriers to care and the impact on the care of people with suicidal behaviour. Consequently, it seems clear that there is a need to collect, examine and critically evaluate the available evidence in order to integrate the findings and provide new knowledge that may be key to improving nursing care. In this regard, the main question that guided the review was: what are the experiences and interventions that nurses carry out in the care of people with suicidal behaviour? More specifically, three questions were formulated to answer the review's guiding question. First, it was considered important to collect the meaning nurses attribute to suicide and suicide attempts in order to understand and contextualize the care that takes place in clinical practice. To this end, the following question was asked: how do nurses interpret the reasons for suicide? Secondly, since there is evidence pointing to the influence of the emotional impact of suicide on the clinical practice of nurses, the following question was considered relevant: What is the emotional impact of suicide on professionals?. Finally, with the intention of compiling and integrating the most appropriate and valuable interventions for suicide care from a nurse's perspective, the following question was addressed: what are the most suitable interventions for the care of people with suicidal behaviour according to nurses? Responding to these questions will provide an understanding of the

difficulties and barriers nurses face in suicide prevention and care. In response to these issues, the results will help identify the best interventions from the nursing perspective.

THE REVIEW

Aim

To explore nurses' experiences in suicide care and to identify and synthesize the most suitable interventions for the care of people with suicidal behaviour from a nursing perspective.

Design

This review was designed as a meta-synthesis. As such, it aimed to integrate several different, albeit interrelated qualitative studies, in order to generate new knowledge to enable a more in-depth understanding and improve the development of theory and the transfer of knowledge in the face of a given phenomenon (Paterson et al., 2001; Sandelowski et al., 1997; Walsh and Downe, 2005). This type of design consists of a rigorous process to extract the main findings of qualitative studies and synthesize them from a holistic interpretation for a new conceptualization that allows us to understand the complexity of the phenomenon being studied and how to approach it in the future (Paterson et al., 2001; Sandelowski and Barroso, 2007).

Search methods

A comprehensive and systematic search was conducted using Paterson et al. (2001) and Sandelowski and Barroso's (2003) methods. The search was conducted between April and June 2019. The following databases were searched: PubMed, SciELO, Cuiden, Lilacs, and Google Scholar. Two researchers, who were nurses specialized in mental health, developed the search strategy using the following MeSH terms: "suicide," "attempted suicide," "nurses," "nursing," "qualitative research," and the free terms "qualitative study," "qualitative methods," "grounded theory," "phenomenology," and "ethnography" for the Anglo-Saxon bases, and their Spanish and Portuguese equivalents for the databases that allow descriptors in these languages (SciELO, cuiden, Lilacs). Boolean operators ("AND" and "OR") were used for combining terms. Studies written in English, French, Portuguese and Spanish and published between 2015 and 2019 were searched in order to access the most recent literature and which had not been published within a systematic review of qualitative studies. For the sake of thoroughness, citations were retrieved (using the snowball technique) to identify possible articles that met the search criteria.

Search outcomes

Two of the researchers developed a screening protocol for selecting the references to be reviewed (Figure 1). First, the titles and abstracts were screened to identify and exclude duplicate studies found in the different literature bases. Next, the selection criteria were applied. The inclusion criteria included qualitative articles which examined nurses' experiences regarding how they interpret suicidal behaviour and emotional impact during care, as well as studies that looked

at suicide care interventions from the nurse's perspective. To do so, we understand the concept of "nurse perspective" as the professionals' point of view towards suicide, and "care" as the different means employed to prevent, intervene and act upon suicidal behaviour. The exclusion criteria consisted of publications related to assisted suicide or euthanasia, non-suicidal self-harm, suicide among nursing staff, student-based studies, and studies with samples involving different types of health professionals that did not highlight nursing interventions, as well as studies with mixed methods. A third researcher, a nurse specialised in mental health with research experience on suicide, met with the team to discuss the inclusion and exclusion criteria throughout the search process to select the qualitative studies required to fulfil the research aim.

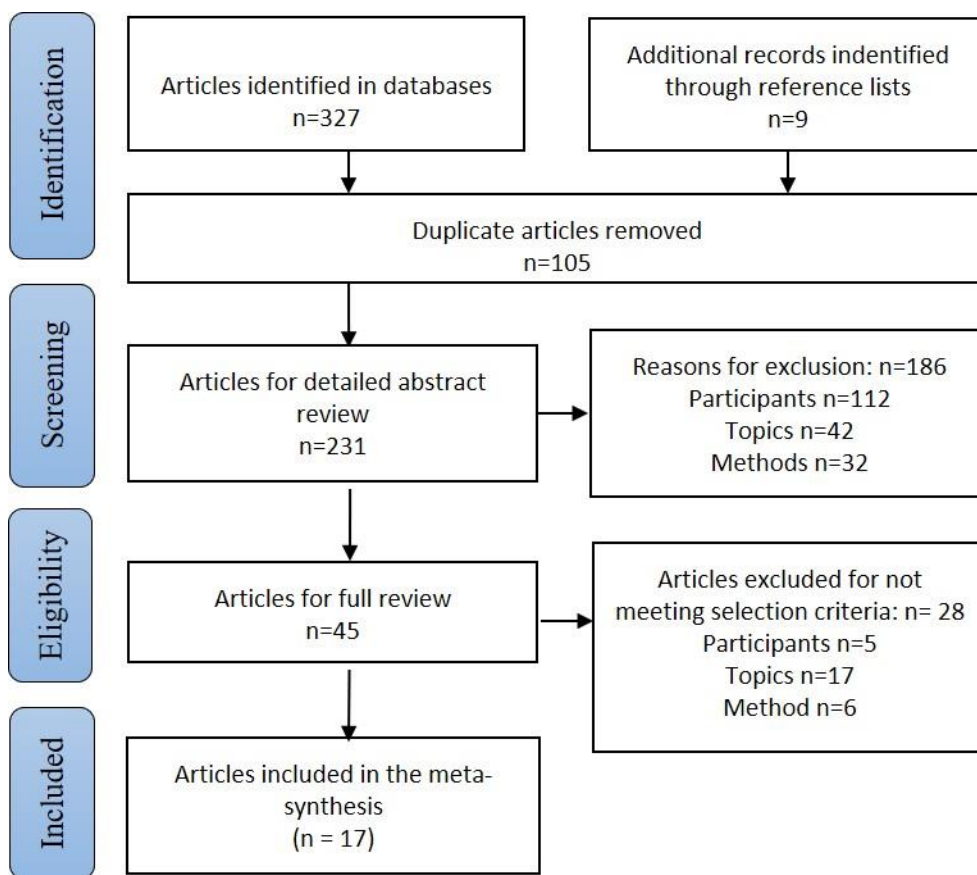


Figure 1. Flowchart of the literature search

Quality appraisal

Articles that met the selection criteria were evaluated using the Critical Appraisal Skills Program tool (CASP: 2018). The CASP is a 10-question tool with "Yes", "No" or "Can't Tell" responses, comprising two initial selection questions on the aims and congruence of the qualitative methodology, and eight questions addressing design, sampling, data collection, reflexivity among researcher-participants, ethical considerations, data rigor, clarity of findings

and applicability of results. All the studies that underwent evaluation based on the CASP scored above 8 points, therefore, all papers were included in the review. (Supplementary Table S1). The aim of this tool was to measure quality in relation to confirmability, credibility, reliability and external transferability (Lincoln and Guba, 1985), and to assess the contribution of the selected literature in the pooling of results, with a lesser contribution from studies with poorer quality. This did not result in excluding papers from the review, given that the CASP tool focuses on research procedures and not on the inclusion criteria and the relevance of the literature for responding to the research topic (Dixon-Woods et al., 2007; Sandelowski et al., 1997). Thus, we consider that items 9 and 10 of the CASP checklist refer to the overall result and applicability of the results, and therefore these depend more on the opinions of the reviewer, compared to items concerning quality. Furthermore, this meta-synthesis detected that in ten studies there was an absence of author reflexivity in relation to the object of study, possibly due to restrictions related to the journals.

Data abstraction and synthesis

Two of the researchers extracted the formal characteristics of the studies, subsequently the entire team independently analysed the main results and findings to classify the information. For the synthesis of findings, the meta-synthesis procedures proposed by Paterson et al. (2001) and Sandelowski & Barroso (2003) were applied to respond inductively to the study questions and to integrate the new knowledge. First, coding was performed to uncover concepts on an interim basis. During this process, memos were noted, together with theoretical ideas about the codes and the relationships established between them. Throughout the process, a series of concepts emerged. Via comparison and discussion within the team, sub-themes were then generated, as classification elements which were then grouped into categories. A data matrix was created for each category, to analyse the properties and relationships between the same, transforming these categories until more precise codes were obtained to classify and reorder the information. Finally, a synthesis of findings was generated to explain the central categories and subcategories, to provide a theoretical explanation of the study topic. Rigor was obtained by triangulation of the research team, who independently analysed the studies, reviewed the synthesized results, and discussed their different positions during regular meetings to ensure reliability of the findings (Lincoln and Guba, 1985).

RESULTS

Characteristics of studies

Seventeen articles were included in the review. The following data were extracted from each study: authors, year and country, objectives, data collection method and techniques, population, and main findings (Table 1).

Eight studies were conducted in Europe, four of these in Nordic countries. Four studies were carried out in Asian countries, three in Brazil, one in the USA and one in South Africa. In

relation to the work setting, five studies were performed in psychiatric hospitals or mental health units, four in general hospitals, three in emergency departments, three in outpatient mental health services and two collected data from nurses in different work settings. The study sample included 297 nurses and 12 nursing assistants.

Concerning the objectives, all articles examined suicide from the nursing perspective. However, there were differences in the areas of interest, with the application of different methodological perspectives and qualitative techniques. Of the 17 studies, six used grounded theory, four were phenomenological, five were exploratory qualitative studies and two were descriptive qualitative studies. In terms of data collection, 12 used semi-structured interviews, three used in-depth interviews and two used focus groups.

Qualitative synthesis

The data analysis revealed 13 subcategories from which four main categories emerged: a) Understanding suicidal behaviour as a consequence of suffering; b) Nurses' personal distress in suicide care; c) The presence of the nurse as the axis of suicide care) and d) Improving nurses' relational competences for a better therapeutic environment (Supplementary Table S2).

Understanding suicidal behaviour as a consequence of suffering

This category refers to how nurses perceived from their cognitive perspective the reasons for suicidal behaviours and specific behaviours prior to these behaviours. These aspects are important in that they can help to plan care and improve screening of people at risk of suicide.

In most studies, the nurses understood suicide as a relief of physical, psychological and social suffering that was difficult to overcome (Hu et al., 2015; Hulstj  et al., 2019; Jansson and Graneheim, 2018; Jones et al., 2015; Rytterstr m et al., 2019; T rkle  et al., 2018). In studies conducted at various mental health services in Sweden (Hulstj  et al., 2019; Rytterstr m et al., 2019), nurses stated that patients choose to commit suicide because of pain related to a serious physical illness or traumatic life situations (divorce, childhood trauma, and pain in old age) which meant that to continue to live made no sense to these patients. Nurses have linked suicide to lost opportunities, talent and loneliness as a result of a mental health disorder (Hulstj  et al., 2019; T rkle  et al., 2018).

In addition, in environments with high cultural and religious commitment, nurses interpreted the person's failure to meet family expectations as a reason for suicide. In this regard, Jones et al. (2015), in a study conducted at a general hospital in southern India, noted that nurses linked suicide to mismatches in family expectations of the suicidal patient: school failure, low job success, loss of status, unsuccessful romantic relationships, loss of faith, and family rejection. In China, Hu et al. (2015), reported that nurses perceived patients to be suicidal because they felt guilty of being sick, regretted being a family burden, and were unable to care for their families

due to economic hardship, an aspect that is accentuated in women, who are assigned the caregiver role.

The nurses detected a number of behaviours prior to the suicide attempt. Nurses reported that patients are more isolated and disconnected, do not express their needs and exhibit a mismatch between verbal and non-verbal communication (Jansson and Graneheim, 2018; Rytterström et al., 2019; Vandewalle et al., 2019; Wolf et al., 2018). Rytterström et al. (2019) and Hultsjö et al. (2019) identified that nurses observed that patients felt as if they were in a state of darkness and showed a silent attitude before suicide. Rytterström et al. (2019) added that patients sometimes appeared to be improving in contrast to pessimistic displays, failing to talk about future projects and showing concern about death. In the moments before suicide, patients showed non-verbal signs of saying goodbye and thankfulness. Hultsjö et al. (2019) noted that many suicides occurred following episodes of psychotic symptoms, and were related to poor adherence to treatment, missed appointments and drug use.

Nurses' personal distress in suicide care

This category refers to barriers perceived by nurses to address suicidal behaviours. These barriers caused a negative emotional response in the nurses. The nurses attributed them to their own limitations, such as prejudice towards these types of acts and the emotional impact of caring for people with suicidal intent. In addition, these difficulties were related to organizational issues from the different health devices. This category is a central issue in most of the studies included in the review, and it is considered of great importance to know these emotional barriers in care in order to guarantee tools to nurses and to enable services to prevent suicide.

In some studies with nurses from non-mental health settings, prejudiced attitudes towards suicide were detected. In Fontão et al. (2018) and Vedana et al. (2017), studies conducted in emergency departments in Brazil, and in Jones et al. (2015), a study in a general hospital in India, nurses expressed a lack of understanding of the subjective aspects of suicidal behaviour and made value judgments with condemnatory feelings and discriminatory attitudes towards patients. In general, these attitudes were related to the lack of integration of psychological aspects in work settings where physical health problems are paramount.

In relation to the feelings behind suicide cases, nurses in several studies shared a range of emotions, thoughts and memories. In general, these were negative feelings such as sadness, anger, guilt, exhaustion, stress, anxiety, loss of control, doubt, disappointment, failure, and responsibility that were relieved by sharing them with family and professional staff (Hagen et al., 2017; Jansson and Graneheim, 2018; Matandela, 2016; Morrissey and Higgins, 2019; Türkleş et al., 2018; Vedana et al., 2017; Wang et al., 2016). Rytterström et al. (2019) and Morrissey and Higgins (2019), conducted studies in which professionals had established a strong link with suicidal patients, expressing physically feeling their patients' pain. In studies conducted in hospital settings (Matandela, 2016; Türkleş et al., 2018; Wang et al., 2016), nurses expressed

fear that the organization would retaliate and take legal action to blame them for their inability to prevent the suicide attempt. In addition, they were afraid to talk to the family, trying not to remember the events and avoiding the scene where the suicide took place.

The nurses expressed a number of difficulties and limitations for caring for suicidal patients. Thus, some of the consistent complaints included lack of time, anxiety, and a poor and insecure work environment (Fontão et al., 2018; Jansson and Graneheim, 2018; Matandela, 2016; Morrissey and Higgins, 2019; Türkleş et al., 2018; Vandewalle et al., 2019b; Wolf et al., 2018). This led to misuse of protocols, limitations for providing comprehensive care and lack of control. In other cases, nurses spoke of a lack of skills, abilities and resourcefulness (Fontão et al., 2018; Morrissey and Higgins, 2019; Wang et al., 2016; Wolf et al., 2018) which, in some cases, led to a desire to be trained and to seek support and supervision from the responsible health organization (Fontão et al., 2018; Morrissey and Higgins, 2019) or, in drastic cases, causing some nurses to be unwilling to work with this type of patient (Türkleş et al., 2018).

The presence of the nurse as the axis of suicide care

This category includes the strategies that nurses considered positive and more suitable for the care of people with suicidal behaviour. All the interventions referred to both physical and psychological accompaniment, referring to the capacity to empathise, listen, observe, be present and available, according to the patients' needs. In this sense, the category includes four aspects: 1) the link with the patient, which refers to the dimension of the therapeutic relationship that nurses establish with patients in order to create a safe and empathic climate and which facilitates the detection of the risk of suicide; 2) the assessment of the risk of suicide, in which experience-based care is indicated together with protocols for the detection of patients with suicidal intent; 3) continuous monitoring, which refers to the continuous follow-up of patients who have shown suicidal behaviour and the commitments established for the prevention of suicide; and 4) actions taken in response to suicide, regarding the actions taken in cases of attempted suicide.

The studies revealed that nurses identified skills and strategies that they considered valuable in suicide care. In matters of suicide prevention, from the nurses' perspective it was critical to establish a rapport via active listening and empathy, creating a safe environment and meeting patient needs (Hagen et al., 2017; Hu et al., 2015; Jansson and Graneheim, 2018; Morrissey and Higgins, 2019; Oliveira et al., 2017; Türkleş et al., 2018; Vandewalle et al., 2019a; Vandewalle et al., 2019b). In various work settings, nurses reported openly discussing suicide with patients to demonstrate that it was not a taboo subject (Jansson and Graneheim, 2018; Oliveira et al., 2017; Vandewalle et al., 2019a; Vandewalle et al., 2019b).

Regarding the assessment of suicide, there were notable differences according to the experience of nurses and the work environment. Some studies (Hagen et al., 2017; Jansson and Graneheim, 2018; Vandewalle et al., 2019a) indicated that senior nurses assessed suicide based on their experience and intuition and indirectly by analysing mood, verbal and non-verbal

communication and patient feelings. In contrast, less experienced nurses reported using more instrumental methods, such as protocols, to monitor and evaluate patients (Vandewalle et al., 2019a). Although studies in various work settings, regardless of nurses' experience, considered organised and protocol-based suicide assessment important (Hu et al., 2015; Vandewalle et al., 2019a; Vandewalle et al., 2019b; Wolf et al., 2018). Marutani et al. (2016), in a study among public health nurses in the Tokyo Metropolitan area, evaluated suicides after they were committed, collecting information from the community to understand the reasons for suicide. Vedana et al. (2017) performed a study set in an emergency department in Brazil, identifying that the nurses lack protocols or ways of monitoring suicide.

A number of studies have emphasised the continuous follow-up of suicidal patients and the importance of sharing information with the professional team (Hagen et al., 2017; Hu et al., 2015; Oliveira et al., 2017; Vandewalle et al., 2019a; Wolf et al., 2018). In some cases, nurses reached agreements with patients through the therapeutic contract as a way of systematizing care and reducing uncertainty and anxiety (Jansson and Graneheim, 2018; Morrissey and Higgins, 2019; Oliveira et al., 2017). In two studies conducted at hospital mental health units, some nurses reported delving into patients' life histories, assessing suffering and trauma throughout the life cycle (Oliveira et al., 2017; Vandewalle et al., 2019b). In Marutani et al. (2016), public health nurses promoted follow-up and commitment among the community through a web-based network of care and mutual aid with the aim of legitimizing suicide prevention.

Studies conducted among various work settings reported that nurses took action to promote safety and give hope to patients when faced with suicide attempts (Hagen et al., 2017; Hu et al., 2015; Oliveira et al., 2017; Vandewalle et al., 2019a; Vandewalle et al., 2019b; Wolf et al., 2018). They stressed that the intervention should be rapid and precise, while collaborating with other professionals to carry out first aid following the protocols and actions established for the different suicide methods (Türkleş et al., 2018; Vedana et al., 2017).

Improving nurses' relational competences for better therapeutic environment

In all the studies included in the review, nurses made proposals to improve clinical practice in the face of suicide. Thus, nurses considered relational competence as a key to improving care in suicide prevention. The improvements can be grouped into four aspects: 1) the nurse-patient relationship, which refers to the proposals that nurses highlighted as necessary to create a favourable climate in the therapeutic relationship with patients; 2) the assessment and follow-up of suicide, referring to recommendations for the monitoring of patients who have presented suicidal behaviour; 3) the emotional supervision of nurses, in terms of formal support proposals to enable nurses to deal with the emotional impact generated by the care of people with suicidal behaviour; and 4) continuous learning, referring to training proposals to improve the care of suicide.

In several studies, to improve the care of people with suicidal behaviour, nurses highlighted the therapeutic relationship as a key tool in addressing patients with suicidal behaviour (Fontão et al., 2018; Jones et al. 2015; Morrissey and Higgins, 2019; Rytterström et al., 2019; Vandewalle et al., 2019a; Vedana et al., 2017). Nurses proposed observation of verbal and non-verbal behaviour and active listening as basic strategies (Fontão et al., 2018; Vedana et al., 2017; Wolf et al., 2018). Similarly, nurses from a variety of work settings valued that the patient bond enabled them to progress from a surveillance role to one that was more focused on the therapeutic relationship (Hultsjö et al., 2019; Morrissey and Higgins, 2019; Oliveira et al., 2017; Rytterström et al., 2019). Other studies conducted in general hospitals or low-security work environments reported that nurses proposed strengthening surveillance and safety strategies, such as increasing security staff and removing objects and substances that could be used to commit suicide (Hu et al., 2015; Matandela, 2016; Türkleş et al., 2018; Vedana et al., 2017).

Nurses from various work settings recommended increased follow-up and continuous assessment of patients. Thus, emergency department nurses suggested that referral to outpatient mental health care services should be intensified after discharge (Fontão et al., 2018; Wolf et al., 2018). Similarly, nurses in rural areas in Sweden proposed the use of mobile units for increased access and follow-up of patients using the telephone or telehealth system (Jansson and Graneheim, 2018). Nurses also assigned importance to the creation of a network of community care, raising the issue of suicide in the political policy portfolio (Marutani et al., 2016). Furthermore, nurses proposed a model of psychosocial care taking into account religious and cultural aspects and focusing on the patient and family (Jones et al., 2015).

Several studies proposed emotional supervision of nurses to prevent negative feelings about suicide from influencing clinical practice (Hagen et al., 2017; Jansson and Graneheim, 2018; Jones et al., 2015; Matandela, 2016; Morrissey and Higgins, 2019; Türkleş et al., 2018; Vandewalle et al., 2019a; Vandewalle et al., 2019b; Wang et al., 2016). Several studies conducted in general and mental health hospitals (Hagen et al., 2017; Hu et al., 2015; Jones et al., 2015; Türkleş et al., 2018; Vandewalle et al., 2019a; Wang et al., 2016) proposed the formal supervision of nurses who had experienced suicide through psychological care and support groups.

In relation to continuing education, hospital and emergency room nurses suggested increasing general training in mental health to expand knowledge on comprehensive suicide care (Fontão et al., 2018; Hagen et al., 2017; Matandela, 2016; Wang et al., 2016).

DISCUSSION

This meta-synthesis of qualitative studies published between 2015 and 2019, expands on the current understanding of suicide care from the nursing perspective. The review indicates that nurses possess knowledge on suicide that integrates psychosocial and biomedical approaches.

Nurses understand suicide as a way to overcome personal, physical, psychological and social suffering that may be related to health problems, physical or psychological, or to a trauma or difficult life situations. In this manner, nurses develop an understanding of suicide as a multifactorial and multidimensional phenomenon along the same lines proposed by Zadavec and Grad (2013).

The synthesis shows that suicide has a major professional impact. Nurses experience negative feelings towards attempted and accomplished suicides that are expressed with strong emotional distress, stress and helplessness that is relieved by sharing this with family members and peers. This finding is important because the emotional distress of nurses negatively affects the quality of the nurse-patient relationship (Moreno-Poyato & Rodríguez-Nogueira, 2020). In addition, several of the studies reviewed report that overcoming trauma following suicide episodes requires formal supervision to prevent the experiences from negatively impacting on clinical practice, as recommended by studies on the impact of suicide on physicians (Draper et al., 2014; Rotar Pavlič et al., 2018).

A relevant finding in the case of a suspected suicide or attempted suicide, nurses stress the importance of establishing a plan to keep the patient safe, including protocolled observation and restriction of the means that may be used to harm themselves, as recommended by other studies (Bernert et al., 2014; Hegerl, 2016). However, according to nurses, suicide prevention should not be limited to hospital settings but requires continuous monitoring and evaluation in community services, as stated in other studies (Ghanbari et al., 2015; Suelves and Robert, 2012).

This synthesis reveals that nurses value the nurse-patient relationship as an essential care tool for openly discussing suicide and delving into the needs and suffering of people with suicidal ideation. Thus, the findings indicate that the therapeutic relationship is highlighted as an ideal tool for enhancing this relationship. A narrative review on the therapeutic relationship conducted by Moreno-Poyato et al. (2016) concluded that this approach favours the establishment of a climate of trust and respect, enabling the management of various interventions, thus promoting a horizontal and humanistic model of care with a positive impact on clinical practice in mental health settings.

Nonetheless, the findings show que nurses acknowledge a number of limitations and difficulties in suicide care related to heavy workloads and lack of time, high levels of anxiety, and work insecurity issues, which hinder patient bonding. These findings confirm the importance of a more favourable practice environment in order to establish a better therapeutic relationship with patients who exhibit suicidal behaviour (Roviralta-Vilella, Moreno-Poyato, Rodríguez-Nogueira, Duran-Jordà, & Roldán-Merino, 2019). These findings should alert health service managers to the need to promote safe environments and adequate staffing for more effective suicide care. However, the studies reviewed highlight that the greatest constraint on suicide care appears to be the lack of specific training, particularly for nurses in general hospitals and emergency departments. Nurses therefore demand increased training in mental health,

specifically in suicide care, especially in the case of nurses with little experience or those working in non-specialist work settings. Along these lines, several previous studies have favourably evaluated suicide prevention training for nurses with positive results on attitudes towards suicide attempts (Blair et al., 2018; Bolster et al., 2015; Botega et al., 2007).

Limitations

This review has included studies on the care of adults in a number of countries and work settings. No articles on the nursing perspective have been found with populations that have a higher incidence of suicide than the general population, for example, people deprived of their liberty (Fazel et al., 2017), LGBT groups (Haas et al., 2010) or young people (World Health Organization, 2019). Most likely, no studies have been carried out with these groups as they are populations that are hidden or difficult to access, raising ethical or methodological issues that are difficult to address. However, we recommend that studies must be carried out from a nursing perspective in order to analyse the specific requirements for care in these populations. Nonetheless, we believe that the studies included in this review provide relevant evidence to address the research questions and generate a collective understanding of the topic. In relation to the research design, studies with a focus on grounded theory, phenomenology, and descriptive and exploratory qualitative studies were included in this review. No studies with an ethnographic perspective were found.

CONCLUSION

This review provides new insights on how suicide is interpreted, the associated emotions, the way suicide is approached and proposals for improving clinical practice from the point of view of nurses. The findings indicate that for nursing care of suicidal patients, the nurse-patient therapeutic relationship is essential, together with continuous assessment and the ability to convey a sense of security and hope. Consequently, to promote a more effective nursing care of suicide, nurses should be provided with further training on the therapeutic relationship, particularly in services that lack mental health specialization. Thus, we recommend health institutions to not only provide the time and space to conduct an adequate therapeutic relationship, but also, through their managers, they should supervise and address the emotional impact that is generated in nurses caring for suicidal patients. Concerning future lines of research, studies with an ethnographic design should be carried out to provide in-depth knowledge of the interactions between nurses and patients with suicidal behaviour. Such studies would be highly valuable for clinical practice. In addition, studies on the need for care from the perspective of suicidal ideation may also offer further much-needed insight.

Conflict of Interest statement

No conflict of interest has been declared by the authors.

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Table 1. Summary of selected articles included in the review

Authors, year, country	Objective	Data collection method and techniques	Population	Main results
Vandewalle et al., 2019, Belgium	Discover and understand the central elements of how nurses in psychiatric hospitals contact patients who experience suicidal ideation.	Grounded theory Semi-structured interviews	19 nurses from 4 psychiatric hospitals.	Nurses create a climate of trust and conditions for therapeutic communication focused on assessing suicide risk. Veterans place more emphasis on assessment during the therapeutic relationship process, while those with less experience prioritise control of suicide risk with continued assessment through protocols.
Vandewalle et al., 2019, Belgium	Discover and understand the actions and goals of nurses in psychiatric hospitals in interactions with patients who experience suicidal thoughts.	Grounded theory Semi-structured interviews	26 nurses from 12 wards of 4 psychiatric hospitals.	The actions and goals of nurses in interaction with patients who experience suicidal thoughts focus on promoting and preserving safety and promoting hope to continue living. Nurses manage the risk of suicide, guide patients away from suicidal ideation, and seek balance to avoid overprotection of patients and accountability and/or blame for suicide episodes.
Rytterström et al., 2019, Sweden	Explore nurses' experiences with non-verbal communication of suicide intent and planning patients' daily lives before committing suicide.	Hermeneutic phenomenological Semi-structured interviews	7 nurses: 3 outpatient psychiatric care and 4 for inpatient psychiatric care.	Nurses detect a series of changes in patients before they commit suicide: they show a supposed improvement, hide their real feelings and stop treatment. They also describe that patients become aware of painful conditions in their lives feeling a loss of hope and confidence for the future. In the last moments, they report that patients show a greater concern about death and finding ways to express farewell. Furthermore, they make preparations and express gratitude, which are interpreted as a way of saying goodbye.
Morrissey & Higgins, 2019, Ireland	Develop a grounded theory to explain mental health nurses'	Grounded theory	33 mental health nurses from an urban area	The main concerns of nurses relate to feelings of professional and personal vulnerability and the need to protect themselves and patients. The process for relieving such anxiety is comprised of four stages: a) experiencing anxiety at the exposure of suicidal patients' speeches; b) reducing anxiety to maintain a low-suicide

	responses to patients with suicidal behaviour.	In-depth interviews		risk environment; c) protecting themselves against anxiety in the face of the fear of a patient's death by suicide; and d) learning to manage anxiety through psychotherapeutic training to deal with these situations.
Hultsjö, Wärdig & Rytterström, 2019, Sweden	To explore mental health professionals' experiences regarding circumstances that cause patients to commit suicide during the continuum of care.	Phenomenological Semi-structured interviews	8 nurses and 4 nursing assistants; 4 forensic psychiatrists, 4 outpatient psychiatrists and 4 inpatient psychiatrists.	Nurses interpret the decision to take one's own life as a logical solution and as a response to the loss of dignity with a difficult solution. The professionals apprehend the patients struggle to decide between life and death, the darkness of their life and their desperate situation. This shared experience makes professionals want to relieve the patient's suffering, but it also gives them an idea of why patients decide to commit suicide.

Wolf et al., 2018, USA	Explore the process by which emergency nurses identify the risk of suicidal ideation and how to act.	Exploratory qualitative Focus groups	41 nurses from 4 regions of the USA (northeast, south, midwest, west) who work in emergencies in urban, suburban and rural areas.	Emergency nurses value that for an early detection of suicide it is necessary to use screening tools and evaluate the appearances and behaviour of patients. They acknowledge that evaluation may not be effective when there are chaotic conditions in the emergency environment. Given the suspicion of suicide, searching for a private space was effective to preserve the patient's safety and establish an open conversation.
Türkles, Yilmaz & Soyly, 2018, Turkey	Know the feelings, thoughts, and experiences of mental health clinic nurses with people with suicidal behaviour and suicide attempts.	Exploratory qualitative In-depth interviews	33 nurses from a mental health hospital.	Nurses caring for suicide patients experience sadness, worry, anxiety, stress, restlessness and fear; they are blamed by the hospital administration when a patient commits suicide; they blame themselves and the doctors; and develop proposals to prevent suicide among hospitalized and discharged patients. In addition, they report that patients commit suicide at night or in the early hours of the morning by strangulation, hanging, or by injury with sharp objects.
Jansson & Granheim, 2018, Sweden	Describe the experiences of nurses to assess the suicide risk of patients from outpatient mental health centres in rural areas.	Descriptive qualitative Semi-structured interviews	12 nurses from outpatient psychiatric care centres from three municipalities located in rural areas	Nurses feel distress related to a lack of control. They express uncertainty and loneliness, and difficulties in managing ethical dilemmas and organizational challenges. Professionals assess the risk of suicide on their own, a situation that involves a high level of responsibility that can increase emotional vulnerability and moral stress. A favourable work climate and an organization that supports nurses is necessary to prevent distress.
Fontão et al., 2018, Brazil	Analyse the perception and nursing care of people attended in an emergency department for a suicide attempt.	Exploratory qualitative Semi-structured interviews	8 nurses and 8 nursing assistants in the emergency department of a general hospital.	Nursing professionals report having basic technical knowledge to deal with suicide attempts, showing a deficit in psychosocial care skills. They feel they are limited by the overload of work, lack of support from the institution and lack of preparation. However, they seek solutions to overcome difficulties in the emergency services. They report that organizational changes to improve the suicide approach are timid and

				lacking, therefore they recommend actions to improve assistance especially in psychosocial care.
Vedana et al., 2017, Brazil	Understand emergency nursing experiences in assisting people with suicidal behaviour.	Grounded theory with a perspective of symbolic interactionism Semi-structured interviews	19 nurses from an emergency department of a pre-hospital hospital.	Nurses report that assisting people with suicidal behaviour is critical, challenging, emotionally draining, and requires high levels of knowledge, skills, and emotional control. They express not feeling prepared and supported, and point out various limitations and difficulties in care. Consequently, a moralistic and conflictive attitude prevails due to a lack of understanding towards the patients, playing a limited role with scarce knowledge in psychosocial care.

Oliveira et al., 2017, Brazil	Identify nursing actions towards patients at risk of suicide who are hospitalized in a mental health unit.	Descriptive qualitative Semi-structured interviews	20 nurses from a hospital psychiatric unit.	Nurses report that care for patients at risk of suicide focuses on building links, based on the therapeutic contract and organizing team care routines. In this way, it is possible to better understand the life experience of patients, to establish a favourable nurse-patient relationship and to assess the risk of suicide. Based on these data, an institutional protocol for suicide risk assessment has been designed and is being used favourably by the nursing team of the psychiatric unit studied.
Matandela, 2017, South Africa	Explore the experiences of nurses caring for patients who have successfully committed suicide at a general hospital.	Exploratory qualitative In-depth interviews	6 nurses from a general hospital.	When a suicide occurs it is considered by the hospital authorities and studied as a negative event. In these cases, nurses experience feelings of shock, guilt and fear of reprisal. In addition, they consider that they receive little attention from the organization. This study suggests that more support is needed for nurses to help them deal with their emotions after a suicide case.
Hagen, Knizek, Hjelmeland, 2017, Norway	Explore the experiences of mental health nurses with hospitalized patients with suicidal behaviour / self-harm and to know about the emotional challenges in caring for these type of patients.	Exploratory qualitative Semi-structured interviews	8 nurses from 5 psychiatric units in 2 hospitals.	Nurses with mental health experience have an important role in the prevention of suicide and self-harm among patients. By providing care and getting to know patients, they have the opportunity to recognize and respond to their expressions of mental distress (verbal and non-verbal) that are possible warning signs of suicide or self-harm. However, caring for potentially suicidal patients carries a high level of emotional involvement that can be exhausting. The study points out the importance of providing mental health nurses with sufficient resources and support for more effective care.
Wang et al., 2016, China	Explore the impact of inpatient suicides, patterns of regulation and the support needs of general hospital nurses.	Phenomenological Semi-structured interviews	15 nurses from a general hospital.	Nurses who have witnessed inpatient suicide cases have high levels of emotional distress and a negative impact on clinical practice. Therefore, in order to attend to the well-being of nursing staff it is necessary to implement interventions to improve coping mechanisms against the negative consequences of suicide in order to acquire prevention skills.

Marutani, Yamamoto-Mitani, Kodama, 2016, Japon	Develop a conceptual framework that clarifies the activities of Japanese public health nurses in suicide prevention	Grounded theory Semi-structured interviews	15 public health nurses from the Tokyo metropolitan area.	Suicide prevention by public health nurses is about networking and training the community to deal with the problem. This consists of three phases: Phase I, which consists of understanding suicide cases in the community; Phase II, dedicated to contact, network and the spread of suicide prevention among the community; and Phase III, focused on maintaining motivation and commitment to suicide prevention.
Jones et al., 2015, India	Explore from a professional and cultural perspective the experiences and attitudes of nursing staff towards patients who had attempted suicide.	Phenomenological Semi-structured interviews	15 nurses from a general hospital.	The care and treatment of the suicidal patient is influenced by religious beliefs. Hospital nurses prioritize physical care over psychological support. The results allow for a series of recommendations and educational initiatives to overcome negative attitudes, improve evaluation and treatment of patients and their families under culturally sensitive clinical supervision.
Hu et al., 2015, China	Explore the risk factors and precautions that provide a theoretical basis for reducing the rate of suicide in hospitals.	Grounded theory Focus groups	12 nurses who had experienced suicide cases in a general hospital.	Nurses identify guilt, hopelessness and low self-esteem as individual risk factors, and negative events during the life cycle and lack of economic and social support as social factors. Regarding hospital suicide prevention, they highlight how effective the creation of a safe environment for psychological monitoring and evaluation, the therapeutic relationship and the share information between patients, family and nurses.