PATIENT SAFETY SCREENER (PSS-3) AND TIP SHEET

Providers in acute care settings can administer the PSS-3 during triage or primary nursing assessment to identify patients at risk of suicide.

INTRODUCTION

Most of those who die by suicide have interacted with health care services in the year before their death (often for non-psychiatric problems).[1] Up to one in 10 emergency department patients presenting with medical issues have hidden suicide risk, such as recent suicidal ideation or suicide attempts.[2,3] Universal screening allows us to detect this risk[4] and intervene early, before a person goes on to attempt suicide. The Patient Safety Screener (PSS-3) is a brief screening tool to detect suicide risk in all patients presenting to acute care settings.

THE PATIENT SAFETY SCREENER (PSS-3)

The PSS-3 consists of just three items (with one follow-up question depending on the patient's response to the third item) and is designed to be simple to use in a busy health care environment. The screener has been validated in emergency department patients ages 18 and older,[5] and implemented in EDs and inpatient medical settings with patients ages 12 years and older.

The PSS-3 consists of three items, assessing depression, active suicidal ideation, and lifetime suicide attempt. Each of these items taps a different aspect of suicide risk:

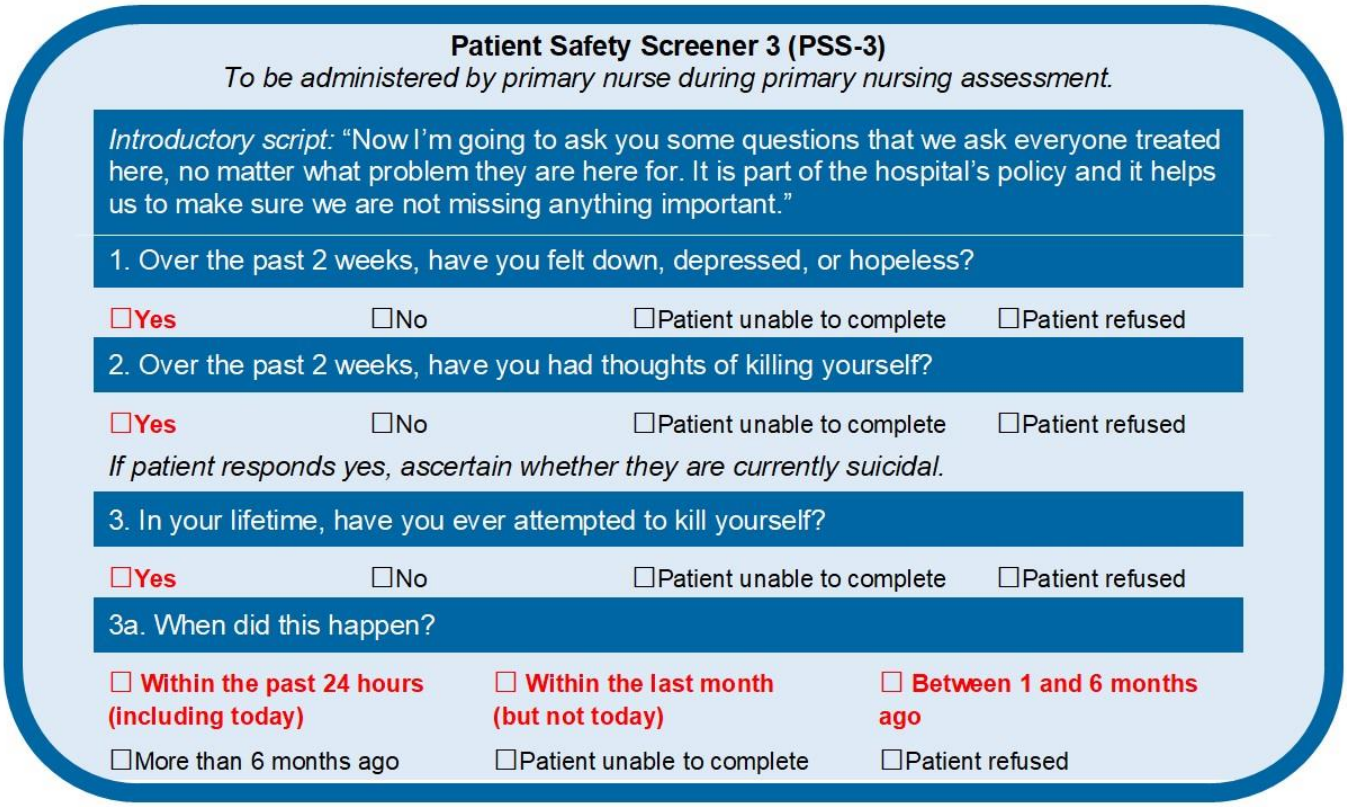
- **Depression** is a common precipitant of suicidal ideation and behavior and is the most common diagnosis among those who die by suicide.
- Thinking about killing oneself, or "**active suicidal ideation**," is a precondition for suicidal behavior.
- A **lifetime suicide attempt** is one of the most consistent risk factors for completed suicide.

It is important to introduce the screening in a way that helps the patient understand its purpose and normalize questions that might otherwise seem intrusive. A nurse might introduce it in the following way:

> *"Now I'm going to ask you some questions that we ask everyone treated here, no matter what problem they are here for. It is part of the hospital's policy, and it helps us to make sure we are not missing anything important."*

The PSS-3 screener is presented in full on the next page.

Ask all questions exactly as worded: do not skip, combine, or re-word the items



Patient Safety Screener 3 (PSS-3)

To be administered by primary nurse during primary nursing assessment.

Introductory script: "Now I'm going to ask you some questions that we ask everyone treated here, no matter what problem they are here for. It is part of the hospital's policy and it helps us to make sure we are not missing anything important."

1. Over the past 2 weeks, have you felt down, depressed, or hopeless?

☐Yes ☐No ☐Patient unable to complete ☐Patient refused

2. Over the past 2 weeks, have you had thoughts of killing yourself?

☐Yes ☐No ☐Patient unable to complete ☐Patient refused

If patient responds yes, ascertain whether they are currently suicidal.

3. In your lifetime, have you ever attempted to kill yourself?

☐Yes ☐No ☐Patient unable to complete ☐Patient refused

3a. When did this happen?

☐ **Within the past 24 hours (including today)** ☐ **Within the last month (but not today)** ☐ **Between 1 and 6 months ago**

☐More than 6 months ago ☐Patient unable to complete ☐Patient refused

SCORING AND INTERPRETATION

All responses should be documented in the patient's chart. It is never appropriate to document a "No" response unless you have asked the patient the exact screening questions as worded above.

1. If a patient says "yes" to "Over the past 2 weeks, have you felt down, depressed, or hopeless?," they are exhibiting **Depressed Mood.**
2. If a patient says "yes" to "Over the past 2 weeks, have you had thoughts of killing yourself?," they are exhibiting **Active Suicidal Ideation (SI).**
3. If a patient says "yes" to "In your lifetime, have you ever attempted to kill yourself?," they are exhibiting **Lifetime Suicide Attempt (SA).** If it happened within the last 6 months, it is considered a recent attempt.

In the clinical setting, interpret as follows:

- ✓ **Yes to 1. Depressed Mood** in past 2 weeks → **Positive screen for depression**
- ✓ **Yes to 2. Active Suicidal Ideation (SI)** in past 2 weeks → **Positive screen for suicide risk**
- ✓ **Yes to 3. Suicide Attempt (SA)** in past 6 months → **Positive screen for suicide risk**

If a patient is presenting because of current suicidal ideation or a current suicide attempt, this is automatically a positive screen and can be considered high risk. **A positive screen only for depression will entail less intensive intervention than a positive screen for suicide risk.**

Other sources of information about the patient's risk level could include the Patient Safety Secondary Screener; collateral information from family, police, or EMS; and any other clinical judgment suggesting that the patient is at risk for depression or suicide.

RESPONDING TO A POSITIVE SCREEN

The first step in responding to a positive screen is to thank the patient for disclosing this information, and tell them that you will let their treatment team know.

The next step is deciding whether to apply immediate safety precautions if the patient screened positive on either of the suicide-related items. Examples of safety precautions include one-on-one observation and accommodating the patient in a safe room. This decision and other clinical processes of care can be informed in part by assessing the severity of the patient's current ideation. When a patient endorses suicidal ideation in the past two weeks, they should be asked about the severity of that ideation (for example, whether it includes method, intent, and plan) and whether they have current suicidal ideation, for example "Are you having thoughts of killing yourself right now?" or "Are you having thoughts of suicide right now?"

Apply protocols for further suicide evaluation and management as appropriate to the clinical practice guidelines in place at your hospital. A sample suicide care management plan is presented in an accompanying handout.

TIPS FOR DELIVERING HIGH-QUALITY SCREENING

Acute care settings can be busy with many competing demands. However, it is important to take the time to deliver high-quality suicide screening. As well as delivering the screening items exactly as worded, delivering high-quality screening requires an empathic stance. A patient struggling with hidden suicidality is more likely to disclose if they feel safe and respected. Actions can speak louder than words, so think about your tone and rate of speech, making eye contact and sitting with the patient if possible. Remember:

- ✓ **Treat the patient with empathy and pay attention to your body language**
- ✓ **Ask all questions <u>exactly</u> as worded**
- ✓ **Do not combine or re-word questions**
- ✓ **Avoid negative phrasing, such as "You haven't ever attempted to kill yourself, have you?"**
- ✓ **Document the response to each screening question (Do not infer a "No" based on presenting complaint or other clinical impression.)**
- ✓ **Apply protocols for further suicide evaluation and management as appropriate**

References

1. Ahmedani BK, Simon GE, Stewart C, Beck A, Waitzfelder BE, Rossom R, Lynch F, Owen-Smith A, Hunkeler EM, Whiteside U, Operskalski BH. Health care contacts in the year before suicide death. Journal of General Internal Medicine. 2014 Jun 1;29(6):870-7.
2. Claassen CA, Larkin GL. Occult suicidality in an emergency department population. The British Journal of Psychiatry. 2005 Apr 1;186(4):352-3.
3. Ilgen MA, Walton MA, Cunningham RM, Barry KL, Chermack ST, De Chavez P, Blow FC. Recent suicidal ideation among patients in an inner city emergency department. Suicide and Life-Threatening Behavior. 2009 Oct 1;39(5):508-17.
4. Boudreaux ED, Camargo CA, Arias SA, Sullivan AF, Allen MH, Goldstein AB, Manton AP, Espinola JA, Miller IW. Improving suicide risk screening and detection in the emergency department. American Journal of Preventive Medicine. 2016 Apr 1;50(4):445-53.
5. Boudreaux ED, Jaques ML, Brady KM, Matson A, Allen MH. The patient safety screener: validation of a brief suicide risk screener for emergency department settings. Archives of suicide research. 2015 Apr 3;19(2):151-60.

Visit the Suicide Prevention Resource Center's website at http://www.sprc.org/micro-learnings/patientsafetyscreener to view additional resources.