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."

Over the past 2 weeks,
1. …have you felt down, depressed, or hopeless? ☐ Yes ☐ No ☐Patient unable to complete ☐Patient refused
2. …have you had thoughts of killing yourself? ☐ Yes ☐ No ☐Patient unable to complete ☐Patient refused
In your lifetime,
3. … have you ever attempted to kill yourself? ☐ Yes ☐ No ☐Patient unable to complete ☐Patient refused 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

For scoring and interpretation, please see Page 2.

Scoring and interpretation

	Interpretation
Over the past 2 weeks,	
1. …have you felt down, depressed, or hopeless?	Depressed mood
2. …have you had thoughts of killing yourself?	Active suicidal ideation (SI)
In your lifetime,	
3. … have you ever attempted to kill yourself? When did this happen?	Lifetime attempt (SA) If within the last 6 months, considered recent attempt

For the validation study (Boudreaux et al., 2015a), a positive screen was defined as "yes" to **either**:

- SI in the past two weeks OR
- Lifetime history of SA

For clinical setting, a positive screen is defined as "yes" to **any** of:

- Depressed in past 2 weeks OR
- SI in past 2 weeks OR
- SA in past 6 months

Note: Other clinical considerations in identifying suicide risk include whether the patient is presenting with SI/SA as part of the presenting complaint, is at elevated risk according to the Patient Safety Secondary Screener, or other clinical judgment suggesting patient is at risk for depression or suicide.

Special precautions: The decision of whether to apply immediate safety precautions (such as one-on-one observation and accommodating in a safe room in the emergency) can be informed in part by assessing the severity of the patient's current ideation. Useful questions to assess the severity of ideation may include items from the Columbia Suicide Severity Rating Scale Triage version about presence of a suicide plan, or asking whether or the patient is suicidal right now or was suicidal at any point during the current day.

Apply protocols for further suicide evaluation and management as appropriate to the clinical practice guidelines in place at the individual site.

References

Boudreaux, E. D., Jaques, M. L., Brady, K. M., Matson, A., & Allen, M. H. (2015a). The Patient Safety Screener: validation of a brief suicide risk screener for emergency department settings. *Archives of Suicide Research*, *19*(2), 151-160.

Boudreaux, E. D., Camargo, C. A., Arias, S. A., Sullivan, A. F., Allen, M. H., Goldstein, A. B., ... & Miller, I. W. (2015b). Improving suicide risk screening and detection in the emergency department. *American Journal of Preventive Medicine*, *50*(4), 445-453.