ED-SAFE PATIENT SECONDARY SCREENER (ESS-6)

Providers in acute care settings can administer this secondary screening tool to help decide whether an individual who has screened positive on the primary Patient Safety Screener (PSS-3) requires additional care processes, such as safety precautions and a psychiatric evaluation.

THE ED-SAFE SECONDARY SCREENER (ESS-6)

This tool should be administered by the provider after a patient endorses active ideation in the past two weeks (PSS Item 2= Yes) OR suicide attempt within the past 6 months (PSS Item 3 = within past 6 months).

Assess the following six indicators using all data available to you, including patient self-report, collateral information, medical record review, and current observations. Each "Yes" gets a score of 1.

1. Positive on both safety screener (PSS-3) items – active ideation with a past attempt
Source: Safety screening (PSS-3), documented on chart.

☐Yes[1] ☐No[0] ☐Unable to complete Notes:_____

2. Recent or current suicide plan*
Suggested wording: Have you been thinking about how you might kill yourself?

☐Yes[1] ☐No[0] ☐Unable to complete Notes:_____

3. Recent or current intent to act on ideation*
Suggested wording: Have you had some intention of acting on your thoughts?

☐Yes[1] ☐No[0] ☐Unable to complete Notes:_____

4. Lifetime psychiatric hospitalization
Suggested wording: Have you ever been hospitalized for a mental health or substance use problem?

☐Yes[1] ☐No[0] ☐Unable to complete Notes:_____

5. Pattern of excessive substance use
Suggested wording: Has drinking or drug abuse ever been a problem for you? Or positive on CAGE or other standardized substance use screener.

☐Yes[1] ☐No[0] ☐Unable to complete Notes:_____

6. Current irritability, agitation, or aggression
Source: Clinical observation, collateral report

☐Yes[1] ☐No[0] ☐Unable to complete Notes:_____

A. Assign a score of 1 for each "Yes" above and combine to obtain a total score. Score: _____/ 6

B. *Critical item review:

● Item 2: Suicide plan present? Y N ● Item 3: Intent present? Y N ● Current attempt? Y N

The purpose of this tool is initial stratification for clinical decision-making and risk mitigation, not highly accurate prediction of suicide. Stratification instructions are on Page 2.

STRATIFICATION AND CARE RECOMMENDATIONS

1. Check one box in each row below based on the score in A and the critical item status in B:

	Negligible	Mild risk	Moderate risk	High risk
A. Score	Not applicable (negative on primary screener)	☐ 0 – 2	☐ 3 – 4	☐ 5 – 6
B. Critical items	☐ No current attempt ☐ No suicide plan or intent	☐ No current attempt ☐ No suicide plan or intent	☐ No current attempt ☐ Suicide plan or intent (not both)	☐ Current attempt ☐ Suicide plan and intent

2. Conclude risk level based on **highest** level category endorsed on any row: ☐ **Mild** ☐ **Moderate** ☐ **High**

3. Enact mitigation and recommended care appropriate to risk level:

Mitigation and recommended care		
Mild	**Moderate**	**High**
● Constant observation not required	● Constant observation (1: several), make room safe recommended	● Constant observation (1:1) and make room safe or ligature resistant room recommended
● Behavioral health evaluation voluntary	● Behavioral health evaluation recommended	● Behavioral health evaluation recommended
● Suicide Prevention and Mental Health discharge resources	● Suicide Prevention and Mental Health discharge resources	● Suicide Prevention and Mental Health discharge resources
● Safety plan recommended at discharge	● Safety plan recommended at discharge	● Safety plan recommended at discharge

TIPS

- ✓ **Document carefully:** All responses should be documented in the patient's chart. It is not appropriate to document a "No" response unless you have used all sources available to you to assess the indicator.
- ✓ **Use your judgment:** This stratification should not replace clinical judgement, for example some factors like intoxication and aggression may be serious enough to designate the patient High Risk, even with a low score or absence of intent and plan.
- ✓ **Current suicide attempt:** Any patient presenting with a current suicide attempt should be considered a "yes" for intent and plan and always considered high risk