PATIENT SAFETY SCREENER (PSS-3) IMPLEMENTATION SCENARIOS

How suicide screening is done is almost as important as whether it is done. This document provides some additional guidance on how to do screening well.

INTRODUCTION

Screening with the Patient Safety Screener (PSS-3) might seem like a simple practice, but it can involve unexpected complexity when implemented in the real acute care setting. It can be a challenge to fit suicide screening into the acute care culture, and patients' situations are not always straightforward. This document provides some additional resources for trainers to support the successful implementation of universal suicide screening at their site. Trainers can use the patient scenarios presented here to spur discussion, review common pitfalls, and share a role-play video to augment the basic training on the Patient Safety Screener (PSS-3).

PATIENT SCENARIOS

1. **Sally**

Sally (43 YO, separated 2 months prior from lesbian partner) drove herself to the ED. She stated she was out hiking and stepped in a small hole, injuring her left ankle. Ankle severely swollen and discolored; slightly elevated BP, otherwise vitals within normal limits. Nurse conducted PSS-3 with the following results:

- ✓ Yes to item 1 (depression) Sally stated she feels sad about relationship ending
- χ No to Item 2 (ideation) no thoughts/plans to kill herself
- χ Yes to Item 3, (previous attempt) OD'd with Tylenol at age 17 when she felt "depressed," **but** no recent attempt on 3a

How would you interpret Sally's PSS results?

Discussion points: Sally stated feeling depressed about her relationship breakup (Item 1). She reported no current ideation (Item 2). Although she had a previous suicide attempt, no recent attempt was reported (Item 3). With no current ideation and recent attempt, she would be considered low to moderate risk. After treating ankle issue, the physician could evaluate the severity of her depression and recommend outpatient follow-up.

2. **Bill**

Bill (42) was brought to ED in police custody to be checked out after driving his car at low speed into a shallow ditch. Vital signs within normal limits. No visible injuries but appears intoxicated, unable to maintain balance,

slurred speech, glassy eyes, and strong ETOH breath odor. During Patient Safety Screener, his eyes are closed and responses are unintelligible.

Discussion points: Bill was intoxicated at time of screening. Multiple risk factors: Middle aged-male, intoxicated, in police custody.

Multiple choice quiz: What would be the next step for completing the Patient Safety Screener for Bill?

- ❑ **Patient does not need to be screened; document PSS-3 items as "no"**
- ❑ **Patient should be re-screened when clinically sober**
- ❑ **Patient's responses while intoxicated can be considered reliable**

Responses given by patients while intoxicated may be unreliable. Patient should be re-screened when sober to examine suicide risk and determine whether collision was intentional.

3. **Sue**

Sue (15) brought to ED by mother to evaluate her infected thigh wound. She is alert, oriented, takes no meds. Vital signs within normal limits. Sue states she was preparing a sandwich and "the knife slipped." She has a similar, healed wound on other thigh; shrugs shoulders and does not respond to inquiry about injury. Mother is worried because Sue has missed a lot of school lately after parents' recent marital breakup. A few days ago, Sue said she "just can't take it anymore."

How would this information relate to Sue's responses to the Patient Safety Screener?

Discussion points: Patient denies previous suicidal behavior, patient denies current injury represents a suicide attempt, but the patient's mother provides key information. Although this may be a "negative screen" for suicide risk, additional collateral information is suggestive of suicide risk and indicates the need to follow standard risk management protocols, such as conducting a psychiatric evaluation.

COMMON PITFALLS IN SUICIDE SCREENING

There are several issues that clinicians encounter when screening in a busy acute care setting. Each of these can adversely affect the fidelity of screening. Common mistakes made when screening include:

- ☓ **Re-wording or combining PSS-3 questions**
- ☓ **Using negative phrasing (such as "You haven't ever attempted to kill yourself, have you?")**
- ☓ **Racing through PSS-3 questions on autopilot**
- ☓ **Skipping or branching PSS-3 questions (for example, skipping the item on suicidal ideation because the patient has answered "no" to the depression item)**

SUICIDE SCREENING ROLE PLAYS

You can watch a nurse administering the PSS-3 here and here.

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