### 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  
   □ No  
   □ Unable to complete  
   Notes:__________________________________

2. **Recent or current suicide plan***  
   *Suggested wording: Have you been thinking about how you might kill yourself?*  
   □ Yes  
   □ No  
   □ 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  
   □ No  
   □ Unable to complete  
   Notes:__________________________________

4. **Lifetime psychiatric hospitalization**  
   *Suggested wording: Have you ever been hospitalized for a mental health or substance use problem?*  
   □ Yes  
   □ No  
   □ 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  
   □ No  
   □ Unable to complete  
   Notes:__________________________________

6. **Current irritability, agitation, or aggression**  
   *Source: Clinical observation, collateral report*  
   □ Yes  
   □ No  
   □ 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:

<table>
<thead>
<tr>
<th>Negligible</th>
<th>Mild risk</th>
<th>Moderate risk</th>
<th>High risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Score</td>
<td>Not applicable (negative on primary screener)</td>
<td>0 – 2</td>
<td>3 – 4</td>
</tr>
<tr>
<td>B. Critical items</td>
<td>□ No current attempt</td>
<td>□ No current attempt</td>
<td>□ No current attempt</td>
</tr>
<tr>
<td></td>
<td>□ No suicide plan or intent</td>
<td>□ No suicide plan or intent</td>
<td>□ Suicide plan or intent (not both)</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Mitigation and recommended care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mild</strong></td>
</tr>
<tr>
<td>● Constant observation not required</td>
</tr>
<tr>
<td>● Behavioral health evaluation voluntary</td>
</tr>
<tr>
<td>● Suicide Prevention and Mental Health discharge resources</td>
</tr>
<tr>
<td>● Safety plan recommended at discharge</td>
</tr>
</tbody>
</table>

**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.