ELSEVIER Clinical Skills

Anxiety - CE

CHECKLIST

S = Satisfactory **U** = Unsatisfactory **NP** = Not Performed

Step	S	U	NP	Comments
Performed hand hygiene before patient contact.				
Introduced self to the patient.				
Verified the correct patient using two identifiers.				
Used an organization-approved standardized tool for suicide assessment.				
Assessed the patient's level of anxiety by asking if he or she has experienced any uncomfortable symptoms.				
Assessed the patient for physical symptoms of anxiety, such as tachycardia, diaphoresis, elevated blood pressure, increased respirations, and pain.				
Assessed the patient for somatic symptoms of anxiety, such as stomach distress, headaches, or muscle tension.				
Assessed the patient for nonverbal expressions of anxiety, such as grimacing, tense facial muscles, fidgeting, restlessness, or guardedness.				
Used an organization-approved assessment scale to assess anxiety.				
Assessed the patient's use of alcohol, nicotine, or illicit substances.				
Assessed the effect of the patient's medical illnesses on anxiety symptoms.				
Assessed the patient's level of comfort with health care team member entering his or her personal space.				
Assessed the patient's comfort level with having several health care team member in the room at one time.				
Assessed the patient's need for assistance in performing self-care activities.				
Assessed the need for a psychiatric practitioner consult and sought a consult as appropriate.				
Assessed the patient for problems with medications, including suicidal thoughts side effects, and inadequate symptom management.				
Explained the strategies to the patient and ensured that he or she agreed to treatment.				
Performed a physical and neurologic assessment.				

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Communicated with the patient to create a care plan.				
1. Recognized when anxiety might be playing a role in the patient's symptomatology and behavior.				
2. Reviewed the patient's triggers to feelings of anxiety.				
3. Encouraged the patient to identify coping skills, medications, and social supports that had helped in the past. Considered inquiring about interventions that had not worked or had worsened the anxiety symptoms.				
4. Provided a safe environment based on unit practice and patient preference. Asked the patient what health care team members could do to increase the feeling of security and ease.				
5. Incorporated recommendations from a behavioral health practitioner for specific interventions, if available.				
6. Explained to the patient and family the strategies for treatment and confirmed their understanding via verbal, written, or other means. Provided them with an opportunity to ask questions, express concerns, and give input on the treatment plan.				
Confirmed consent for implementing the care plan.				
Provided the patient with clear, concise instructions on anxiety management.				
Promoted self-care activities.				
Assessed, treated, and reassessed pain.				
Performed hand hygiene.				
Documented the strategies in the patient's record.				

Learner: _____ Signature: _____

Evaluator: _____ Signature: _____

Date: _____