ELSEVIER Clinical Skills

Anxiety Management (Ambulatory) – CE

CHECKLIST

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

Step	S	U	NP	Comments
Performed hand hygiene.				
Introduced self to the patient.				
Verified the correct patient using two identifiers.				
Explained the procedure to the patient and ensured that he or she agreed to treatment.				
Ensured that evaluation findings were communicated to the clinical team leader per the organization's practice.				
Evaluated the patient for increased risk for suicide.				
Evaluated the patient's level of anxiety by asking if he or she was experiencing any uncomfortable symptoms.				
Evaluated the patient for physical signs and symptoms of anxiety.				
Evaluated the patient for somatic symptoms of anxiety.				
Evaluated the patient for nonverbal expressions of anxiety.				
Used an organization-approved anxiety evaluation scale to evaluate the presence and severity of the patient's anxiety.				
Obtained the patient's social history, including smoking and tobacco use, illicit substance use, and frequency and amount of alcohol consumed.				
Evaluated the effect of the patient's medical illnesses on anxiety signs and symptoms.				
Evaluated the patient's level of comfort with health care team members entering his or her personal space.				
Evaluated the patient's comfort level with having several health care team members in the room at one time.				
Evaluated the patient's need for assistance in performing self-care activities at home.				
Evaluated the need for a psychiatric practitioner consult, and sought a consult as appropriate.				
Evaluated the patient for problems with medications, including suicidal thoughts, adverse reactions, and inadequate symptom management.				
Performed a physical and neurologic evaluation.				

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Collaborated with the patient and practitioner to develop a care plan.				
Promoted the establishment of a trusting relationship with the patient.				
Recognized when anxiety may be playing a role in the patient's symptomatology and behavior.				
Reviewed the patient's triggers to feelings of anxiety.				
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.				
Incorporated recommendations from a behavioral health practitioner, if available, for specific interventions.				
Explained to the patient the strategies for treatment. Confirmed his or her understanding via verbal, written, or other means.				
Provided the patient with an opportunity to ask questions, to express concerns, and to give input on the treatment plan.				
Provided the patient with clear, concise instructions on anxiety management.				
Reevaluated the patient for decreased anxiety.				
Determined whether the patient recognized his or her symptoms of anxiety.				
Determined whether the patient verbalized his or her symptoms of anxiety.				
Determined whether the patient listened to and retained instructions and information.				
Evaluated the patient's need for assistance with relaxation techniques and self-care activities.				
Evaluated the patient's ability to identify triggers for anxiety and coping skills, medications, and forms of social support that decreased anxiety.				
Evaluated the patient's response to changes in the environment.				
Assessed, treated, and reassessed pain.				
Performed hand hygiene.				

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Documented the procedure in the patient's record.				

Learner: _____ Signature: _____

Evaluator: _____ Signature: _____

Date: _____