ELSEVIER Clinical Skills

Anxiety: Generalized Anxiety Disorder Assessment (Behavioral Health) – CE

CHECKLIST

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

Step	S	U	NP	Comments
Performed hand hygiene.				
Introduced self to the patient, family, and designated support person.				
Verified the correct patient using two identifiers.				
Assessed the patient's mental status and ability to understand information and participate in decisions. Included the patient as much as possible in all decisions.				
Assessed the patient for suicidal or homicidal ideation or thoughts of self-harm.				
Evaluated the patient's, family's, and designated support person's understanding of the patient's illness.				
Assessed and discussed the patient's goal for treatment.				
Collaborated with the patient, family, and designated support person to develop a plan of care.				
Identified the patient's psychiatric advance directives, if available.				
Determined the patient's desire for the family or designated support person to be kept informed and involved in treatment.				
Determined the family's or designated support person's ability to support the patient during treatment.				
Assessed the patient's symptoms of GAD and its impact on his or her ability to function.				
Assessed the patient for medical conditions that might mimic the symptoms of GAD.				
Assessed the patient for nonverbal expressions of GAD.				
Used an organization-approved assessment scale to assess anxiety.				
Assessed the patient's use of alcohol, nicotine, or illicit substances.				
Assessed the patient's need for assistance in performing self-care activities.				
Assessed the patient for suicidal or homicidal ideation or thoughts of self-harm, and if present, implemented appropriate precautions based on the patient's status.				

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Explained the strategies to the patient, family, and designated support person and ensured that they agreed to treatment. Ensured that the patient understood the information presented.				
Maintained a calm, collaborative communication approach, avoiding the use of coercion.				
Created an environment of trust that allowed the development of a therapeutic relationship.				
Oriented the patient to the unit. Included discussion of unit routines, guidelines, patients' rights and expectations, and schedules. Informed the patient that he or she would be checked on frequently throughout the stay.				
Created an environment that advocated for the patient's needs using an interdisciplinary team. Engaged the team in collaborative assessment and treatment planning with the patient.				
Engaged the patient in treatment, including participation in therapeutic groups and individual sessions.				
Administered psychiatric medications as ordered and monitored the patient's response to the medications.				
Monitored the patient's responses and social interactions in the milieu; reinforced appropriate social skills.				
Implemented appropriate precautions based on the patient's status.				
Responded to crisis in a calm, therapeutic, and nonthreatening manner. Used the least restrictive interventions to prevent harm to patients or staff.				
Reviewed physical and somatic signs and symptoms in addition to emotional and cognitive signs and symptoms the patient might be experiencing.				
When discussing the patient's concerns, avoided focusing on specific issues or items that he or she was worried about; focused on the experience of worrying excessively.				

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Assessed the methods the patient uses to cope with symptoms of anxiety.				
Engaged the patient in developing the plan of care and provided support and encouragement as needed.				
Considered using a standardized assessment scale to determine baseline signs and symptoms.				
Evaluated the patient for co-occurring psychiatric and medical conditions that might negatively impact the patient's status.				
Collaborated with the patient, family, designated support person, and team in planning for patient discharge and follow-up care.				
Assessed the patient for decreased symptoms of GAD.				
Assessed the patient's ability to recognize his or her signs and symptoms of GAD.				
Assessed the patient's ability to comprehend and retain instructions and information.				
Reassessed the patient's pain status and provided appropriate pain management.				
Provided the appropriate education related to medications, crisis management, and follow-up care to the patient, family, and designated support person at the time of discharge.				
Explained to the patient, family, and designated support person that ongoing treatment was vital to continuing recovery.				
Performed hand hygiene.				
Documented the strategies in the patient's record.				

Learner: _____ Signature: _____

Evaluator: _____ Signature: _____

Date: _____