

Anxiety - Severe – Level II

ANXIETY - SEVERE
Level II
(No Level I)

Skill Level: RN

Definition: A state of apprehension, uncertainty, and fear resulting from the anticipation of a realistic or fantasized threatening event or situation, often impairing physical and psychological functioning.

<p>Subjective:</p> <ul style="list-style-type: none">• "I'm stressed out."• "I've never been in prison before, I'm scared."• "I got a letter. Things at home are worrying me..."• Shortness of breath, nausea, chest pain, palpitations, and dizziness may be present.• Change in sleeping, eating, grooming patterns is common.	<p>Assessment:</p> <ul style="list-style-type: none">• Inability to complete activities of daily living: Situational anxiety.• Coping, ineffective
<p>Objective:</p> <ul style="list-style-type: none">• Blood Pressure and pulse may be elevated.• May demonstrate decreased attention span, poor hygiene, trembling, tearfulness, pressured speech, hyperventilation, and diaphoresis.• Pupils may be dilated.• Patient may or may not be at risk of self harm.• Patient unable to self regulate anxiety using coping techniques.	<p>Plan:</p> <ul style="list-style-type: none">• <u>Anxious patients may be at risk for suicide. Evaluate all anxious patients for suicide risk and follow Suicide Prevention Policy P-G-05.</u>• Call Mental Health Provider if patient is at risk for suicide. Use the Suicide Prevention and Intervention Emergency Nursing Protocol if it applies.• Consider underlying medical causes first. Evaluate cardiac risk and other factors.• Offer time to talk through problems - discuss self-help techniques.• Check for allergies to medications.• Check current medications.• <u>Call provider before issuing any medications to pregnant patients, complete pregnancy test as needed.</u>• <u>If anxiety is interfering with completion of daily activities,</u> may give Vistaril 50 mg PO bid x 24 hours

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	<p>(two doses total) - FIB.</p> <ul style="list-style-type: none">• Refer for mental health treatment provider appointment if med is given.
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Nursing Education:

1. **Please evaluate for possible:**
 - a. Cardiac or respiratory conditions.
 - b. Thyroid problems.
 - c. Depression.
 - d. Vertigo.
 - e. GI disturbances.
 - f. Recent stressors, including threats of physical or sexual exploitation.

Patient Education:

2. **Encourage these self care measures:**
 - a. Encourage patient to rest in quiet surroundings.
 - b. Journal feelings.
 - c. Educate regarding deep breathing exercises.
 - d. Access support network in time of need.
 - e. See anxiety handout.
3. **Increased Suicide Risk**
 - a. Recent arrival into the corrections system; violent crime, long sentence, history of violence to self or others, previous suicide attempts (not ideations) and positive mental health history and diagnosis of any kind.
 - b. Patients in isolated or secluded housing (such as segregation) are often at higher risk for suicide.
 - c. Recent additional sentencing with significant mental health history severely increases the risk of self-harm.
 - d. Recent relationship change.
 - e. Impending release from corrections system.
 - f. Suicide Risk Assessments should include the use of the Suicide Risk Screening Form and Mental Status Screening Tool as well as chart documentation. If an inmate is at risk for suicide, then refer to Behavioral Health Services (BHS) mental health treatment provider and contact the on-call prescriber.

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APPROVED:

Medical Services Manager

Date

Chief Medical Officer

Date

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2/24/2015

Medical Director

Date

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