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Panic attack assessment Comfort & daily function

Mental Health Nursing | Comfort & daily function

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

23-year-old man with sudden intense fear. Care stage: During supported recovery and essential daily activity.

Medical history: A sudden episode of intense fear and physical symptoms prompted assessment. Medical causes are being evaluated before attributing all symptoms to panic. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The person wishes to participate in decisions and prefers permission before others are involved. Assess support, work/study function, substance use and practical access without stigma.

Scenario: The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

Clinical assessment

Subjective: Palpitations, breathlessness and fear of dying.

Objective findings and required checks: Distress and rapid breathing; serious physical causes must not be assumed absent.

Physical examination and investigations: Assess observations, onset, cardiac/respiratory red flags and clinically indicated investigations.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Panic attack assessment: Acute autonomic arousal can amplify bodily sensations and fear in a feedback cycle.

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Medical / surgical management

Stay with the person, communicate calmly and support comfortable paced breathing while assessing physical causes.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed acute treatment	Use only after clinical assessment	Monitor sedation and response
longer-term therapy	Manage recurrent panic through the agreed plan	Review benefits and adverse effects.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Palpitations, breathlessness and fear of dying. Distress and rapid breathing; serious physical causes must not be assumed absent. The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

Nursing diagnosis

Prioritize emotional distress affecting participation in care; breathing difficulty affecting oxygenation; coping resources strained by illness or social stress; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

During the next agreed care or activity session: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Stay with the person, communicate calmly and support comfortable paced breathing while assessing physical causes. Identify the safest achievable activity or comfort goal without overlooking the underlying illness. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Identify the safest achievable activity or comfort goal without overlooking the underlying illness.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask what worries the patient most and how they prefer to receive information. Assess: Observe distress, attention and ability to engage without making assumptions.	Emotional distress affecting participation in care. Possible factors: uncertainty, symptoms or unfamiliar treatment. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Identifies one immediate concern and participates in an agreed next step. Longer-term: Before the clinically approved transition or agreed follow-up: Describes helpful support and coping strategies before transition of care.	1. Listen without judgment and acknowledge specific concerns. Rationale: Feeling heard supports trust and therapeutic engagement. 2. Explain one step at a time and use teach-back with permission. Rationale: Manageable information reduces uncertainty and checks understanding. 3. Offer culturally appropriate support and refer when distress persists or safety concerns arise. Rationale: Additional support may be needed beyond bedside reassurance. 4. Stay with the person, communicate calmly and support comfortable paced breathing while assessing physical causes. Rationale: Acute autonomic arousal can amplify bodily sensations and fear in a feedback cycle. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about breathlessness, chest tightness and activity tolerance. Assess: Record respiratory rate, effort, SpO2 and mental state against the prescribed target.	Breathing difficulty affecting oxygenation. Possible factors: altered ventilation or gas exchange. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Breathing effort improves and oxygenation remains within the individualized target. Longer-term: Before the clinically approved transition or agreed follow-up: Explains the respiratory action plan and demonstrates the prescribed device technique.	1. Reassess work of breathing and response to each intervention. Rationale: Trend changes identify deterioration earlier than a single reading. 2. Position to ease breathing, cluster care and allow rest. Rationale: This can reduce respiratory demand and distress. 3. Give oxygen and respiratory medicines only according to the clinical prescription or emergency protocol. Rationale: Individualized treatment supports oxygenation without unsafe blanket targets.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about stressors, strengths, support people and previous coping. Assess: Assess function, engagement and immediate safety needs.	Coping resources strained by illness or social stress. Possible factors: demands exceeding currently available support. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Chooses one feasible coping action and identifies a support person or service. Longer-term: Before the clinically approved transition or agreed follow-up: Has a realistic follow-up and support plan agreed with the care team.	1. Assess strengths and barriers collaboratively. Rationale: An individualized plan builds on resources the person can actually use. 2. Practice a simple coping strategy and divide tasks into achievable steps. Rationale: Small successes support confidence and participation. 3. Coordinate social, psychological or community support as indicated. Rationale: Practical barriers can limit recovery even when clinical treatment is available.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to	Learning needs about the condition and care plan. Possible	Short-term: During the next agreed care or activity session:	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves	Record the baseline and reassessed

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
understand. Assess: Use teach-back or demonstration to identify specific gaps.	factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	Explains the most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	understanding. 2. Teach a few condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Explain the assessed cause, coping practice and follow-up; avoid paper-bag breathing. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Explain the assessed cause, coping practice and follow-up; avoid paper-bag breathing.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Persistent chest pain, hypoxia, collapse or atypical features requires urgent medical assessment.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Acute autonomic arousal can amplify bodily sensations and fear in a feedback cycle.

- Priority concerns: Emotional distress affecting participation in care; Breathing difficulty affecting oxygenation; Coping resources strained by illness or social stress; Learning needs about the condition and care plan.

- Persistent chest pain, hypoxia, collapse or atypical features requires urgent medical assessment.

- Explain the assessed cause, coping practice and follow-up; avoid paper-bag breathing.

Exam / viva: How can care preserve independence while staying within the patient's assessed limits?

References

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