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Post-traumatic stress support Initial assessment

Mental Health Nursing | Initial assessment

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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

30-year-old woman with trauma-related distress. Care stage: At the first supervised assessment.

Medical history: The patient reports trauma-related intrusive memories and avoidance affecting sleep and function. Disclosure is paced according to consent and emotional safety. 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 wants to know which concern needs attention first.

Clinical assessment

Subjective: Intrusive memories, poor sleep and avoidance of reminders.

Objective findings and required checks: Hypervigilance and impaired daily function; assess safety and preferred support.

Physical examination and investigations: Assess symptoms, function, comorbidities and risk without pressuring disclosure of trauma details.

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

Clinical focus and pathophysiology

Post-traumatic stress support: Trauma-related changes in threat processing and memory can sustain re-experiencing and avoidance.

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Medical / surgical management

Use trauma-informed communication, offer choices and coordinate evidence-informed psychological care.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed medicine when indicated	Treat selected symptoms or comorbid conditions	Monitor the exact regimen and review response
psychological treatment	Support recovery through specialist therapy	Respect consent and pacing.

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

Nursing process - ADPIE

Assessment

Intrusive memories, poor sleep and avoidance of reminders. Hypervigilance and impaired daily function; assess safety and preferred support. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize emotional distress affecting participation in care; sleep disrupted by symptoms or the care environment; 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

After the first indicated intervention, at the documented review time: 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

Use trauma-informed communication, offer choices and coordinate evidence-informed psychological care. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. 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

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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: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

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: After the first indicated intervention, at the documented review time: 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. Use trauma-informed communication, offer choices and coordinate evidence-informed psychological care. Rationale: Trauma-related changes in threat processing and memory can sustain re-experiencing and avoidance. 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 usual sleep, current disruption and daytime fatigue. Assess: Record sleep pattern, symptom triggers and environmental disturbance.	Sleep disrupted by symptoms or the care environment. Possible factors: discomfort, anxiety or interrupted routines. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Reports improved rest during the next planned sleep period. Longer-term: Before the clinically approved transition or agreed follow-up: Identifies practical sleep-supporting routines for recovery.	1. Identify pain, breathlessness, anxiety and medicine-related causes of poor sleep. Rationale: Treating contributors is more useful than assuming a single cause. 2. Cluster non-urgent care and reduce light and noise when safe. Rationale: A predictable environment protects opportunities to sleep. 3. Use relaxation strategies and review prescribed sedating medicines carefully. Rationale: Rest should improve without avoidable oversedation or falls.	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: After the first indicated intervention, at the documented review time: 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: After the first indicated intervention, at the	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.	documented review time: 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. Teach grounding strategies agreed in care, support options and a predictable follow-up plan. 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

Teach grounding strategies agreed in care, support options and a predictable follow-up plan.

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

Immediate safety concerns, severe dissociation or inability to meet basic needs warrants urgent review.

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

- Trauma-related changes in threat processing and memory can sustain re-experiencing and avoidance.

- Priority concerns: Emotional distress affecting participation in care; Sleep disrupted by symptoms or the care environment; Coping resources strained by illness or social stress; Learning needs about the condition and care plan.

- Immediate safety concerns, severe dissociation or inability to meet basic needs warrants urgent review.

- Teach grounding strategies agreed in care, support options and a predictable follow-up plan.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

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