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Coping resources strained by illness or social stress Panic attack assessment

Mental Health Nursing | Focused diagnosis-based template

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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.

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.

Medical / surgical management

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

Illustrative drug and treatment study

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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.

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Focused nursing-problem template

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 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: At the next patient-specific reassessment: 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. 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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Apply this template

Complete with verified data: assessment cues; supported actual problem or risk; measurable outcome and review time; selected authorized interventions and rationale; observed response and next action.

Subjective / objective cues: _____

Patient-specific target and review time: _____

Evaluation evidence and next action: _____

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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: Coping resources strained by illness or social stress.
- 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: What assessment evidence supports this problem, and what measurable result would demonstrate improvement?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

Nursing Mental Health and Community Concepts, 2e - Open RN / WisTech Open, 2025
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Nursing Pharmacology, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2023
https://wtcs.pressbooks.pub/pharmacology2e/

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https://www.indiannursingcouncil.org/gazette-notification

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