**Texas Lutheran Nursing Program**

**NURS 342 Behavioral Health Nursing Care Plan**

Student Name: Breana Herrera Client Initials: M.S.

Client Admission Date: October 11, 2015 Age: 12 Gender: Male

Admitting Medical Health Diagnosis & DSM V Axis: Increasing homicidal & Suicidal ideations

Medical Diagnosis (if any list): MDD, ODD, GAD, Axis I unspecified ADHD

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| **Nursing Diagnosis (Minimum of 2 Mental Health Diagnosis) must include related to and evidenced by on each diagnosis used** | **Desired Outcomes**  **1 short term and 1 long term goal for each NANDA.** | **Nursing Interventions (I) for Independent or (C) for Collaborative** | **Rationale and Pathophysiology** | **Evaluation of Interventions**  **Indicate (M) Met or (NM) Not met** |
| -Risk for homicidal tendencies related to MDD as evidenced by verbal threats to kill step-mother and step-brother.  -Risk for ineffective coping related to ADHD as evidenced by destructive and assaultive behaviors.  Subjective data: Patient denies threats to harm himself. Pt verbalizes that his stepmother is the cause of all of his problems. Pt states he is attempting to maintain good/adequate behavior to move up in treatment levels.  Objective data: Patient actively participates in therapeutic communication exercises. Patient has identified scar on left forearm. Patient becomes distracted easily and loses focus on relative topic. Pt engages in conversation with peers. Pt mood and affect appears stable and seems to be responding well to current treatment. | Patient will actively participate in group therapy at 1530 and will verbalize one positive behavior of himself and one positive behavior of a peer.  Patient will no longer be a danger to himself or others, learn how to communicate, problem solve effectively, and to learn effective coping skills to use in place of negative behavior. | 1. Establish therapeutic relationship with patient.(C) 2. Monitor, document, and report client’s potential for homicide.(C) 3. Refer to group therapy sessions 5 times a week. (I) 4. Use positive reinforcement when behavior permits.(C) 5. Administer prescribed medications.(C) 6. Validate patient’s feelings regarding concerns about current crisis and family functioning.(I) | 1. Aids in identifying and preventing suicide. 2. Aids in assessing impulsivity, poor social adjustment, and mood disorders. 3. Aids in evaluating patient’s progress and effectiveness of treatment. 4. Encourages patient to continue practicing good behavior. 5. Ensures patient receives proper treatment to minimize risk for regression. 6. Ensures that nurse has heard and understands what has been said. Promotes nurse-client relationship. | Short-term goal:  Patient met short-term goal by demonstrating active and positive participation in the day’s group therapy session. Patient was able to identify numerous positive behaviors from himself and others.  Long-term goal:  Goal not met:  Unable to properly evaluate due to end of clinical rotation. |