HESI MENTAL HEALTH RN V1-V3 2019 TEST BANKS (ALL TOGETHER)

A client with depression remains in bed most of the day, and declines activities. Which nursing problem has the greatest priority for this client?

A. Loss of interest in diversional activity.
B. Social isolation.
C. Refusal to address nutritional needs.
D. Low self-esteem.

The RN is preparing medications for a client with bipolar disorder and notices that the client discontinued antipsychotic medication for several days. Which medication should also be discontinued?

a. Lithium. (Lithotabs)
b. Benzotropine (Cogentin).
c. Alprazolam (Xanax).
d. Magnesium (Milk of Magnesia).

A female client requests that her husband be allowed to stay in the room during the admission assessment. When interviewing the client, the RN notes a discrepancy between the client's verbal and nonverbal communication. What action does the RN take?

A. Pay close attention and document the nonverbal messages.
B. Ask the client's husband to interpret the discrepancy.
C. Ignore the nonverbal behavior and focus on the client's verbal messages.
D. Integrate the verbal and nonverbal messages and interpret them as one.

A male client approaches the RN with an angry expression on his face and raises his voice, saying "My roommate is the most selfish, self-centered, angry person I have ever met. If he loses his temper one more time with me, I am going to punch him out!" The RN recognizes that the client is using which defense mechanism?

A. Denial.
B. Projection.
C. Rationalization.
D. Splitting.

A male client with bipolar disorder who began taking lithium carbonate five days ago is complaining of excessive thirst, and the RN finds him attempting to drink water from the bathroom sink faucet. Which intervention should the RN implement?

A. Report the client's serum lithium level to the HCP.
B. Encourage the client to suck on hard candy to relieve the symptoms.
C. No action is needed since polydipsia is a common side effect.
D. Tell the client that drinking from the faucet is not allowed.

The RN is teaching a client about the initiation of the prescribed abstinence therapy using disulfiram (Antabuse). What information should the client acknowledge understanding?

A. Completely abstain from heroin or cocaine use.
B. Remain alcohol free for 12 hours prior to the first dose.
C. Attend monthly meetings of alcoholics anonymous.
D. Admit to others that he is a substance user.

A male client with schizophrenia is admitted to the mental health unit after abruptly stopping his prescription for ziprasidone (Geodon) one month ago. Which question is most important for the RN to ask the client?

A. Have you lost interest in the things that you used to enjoy?
B. Is your ability to think or concentrate decreased?
C. How many continuous hours do you sleep at night?
D. Do you hear sounds or voices that others do not hear?

During an annual physical by the occupational RN working in a corporate clinic, a male employee tells the RN that is high-stress job is causing trouble in his personal life. He further explains that he often gets so angry while driving to and from work that he has considered "getting even" with other drivers. How should the RN respond?

A. "Anger is contagious and could result in major confrontation."
B. "Try not to let your anger cause you to act impulsively."
C. "Expressing your anger to a stranger could result in an unsafe situation."
D. "It sounds as if there are many situations that make you feel angry."

A client who has agoraphobia (a fear of crowds) is beginning desensitization with the therapist, and the RN is reinforcing the process. Which intervention has the highest priority for this client's plan of care?

A. Encourage substitution of positive thoughts and negative ones.
B. Establish trust by providing a calm, safe environment.
C. Progressively expose the client to larger crowds.
D. Encourage deep breathing when anxiety escalates in a crowd.

Which nursing actions are likely to help promote the self-esteem of a male client with modern depression?

A. Ask the client what his long term goals are.

B. Discuss the challenges of his medical condition.
C. Include the client in determining treatment protocol.
D. Encourage the client to engage in recreational therapy.
E. Provide opportunities for the client to discuss his concerns.

A male client is admitted to the psychiatric unit for recurrent negative symptoms of chronic schizophrenia and medication adjustment of Risperidone (Risperdal). When the client walks to the nurse's station in a laterally contracted position, he states that something has made his body contort into a monster. What action should the RN take?

A. Medicate the client with the prescribed antipsychotic thioridazine (Mellaril).
B. Offer the client a prescribed physical therapy hot pack for muscle spasms.
C. Direct client to occupational therapy to distract him from somatic complaints.
D. Administer the prescribed anticholinergic benztropine (Cogentin) for dystonia.

A mental health worker is caring for a client with escalating aggressive behavior. Which action by the MHW warrant immediate intervention by the RN?

A. Is attempting to physically restrain the patient.
B. Tells the client to go to the quiet area of the unit.
C. Is using a loid voice to talk to the client.
D. Remains at a distance of 4 feet from the client.

A client on the mental health unit is becoming more agitated, shouting at the staff, and pacing in the hallway. When the PRN medication is offered, the client refuses the medication and defiantly sits on the floor in the middle of the unit hallway. What nursing intervention should the RN implement first?

A. Transport of the client to the seclusion room.
B. Quietly approach the client with additional staff members.
C. Take other clients in the area to the client lounge.
D. Administer medication to chemically restrain the patient.

A client is admitted to the mental health unit and reports taking extra antianxiety medication because, "I'm so stressed out. I just want to go to sleep." The RN should plan one-on-one observation of the client based on which statement?

A. "What should I do? Nothing seems to help."
B. "I have been so tired lately and needed to sleep."

C. “I really think that I don’t need to be here.”
D. “I don’t want to walk. Nothing matters anymore.”

A male hospital employee is pushed out the way by a female employee because of an oncoming gurney. The pushed employee becomes very angry and swings at the female employee. Both employees are referred for counseling with the staff psychiatric RN. Which factor in the pushed employee’s history is most related to the reaction that occurred?

A. Is worried about losing his job to a woman.
B. Tortured animals as a child.
C. Was physically abused by his mother.
D. Hates to be touched by anyone.

The RN documents the mental status of a female client who has been hospitalized for several days by court order. The client states, “I don’t need to be here” and tells the RN that she believes the television talks to her. The RN should document these assessment findings in which section of the mental status exam/

A. Level of concentration.
B. Insight and judgement.
C. Remote memory.
D. Mood and affect.

A client is admitted to the mental health unit reports shortness of breath and dizziness. The client tells the RN, “I feel like I’m going to die”. Which nursing problem should the RN include in this client’s plan of care?

A. Mood disturbance.
B. Moderate anxiety.
C. Altered thoughts.
D. Social isolation.

A female client who is wearing dirty clothes and has foul body odor, comes to the clinic reporting feeling scared because she is being stalked. What action is most important for the RN to take?

A. Offer the client a safe place to relax before interviewing her.
B. Ask the client to describe why she is being stalked.
C. Recommend that the client talk with a social worker.
D. Assure the client that the HCP will see her today.

The RN leading a group session of adolescent clients gives the members a handout about anger management. One of the male clients is fidgety, interrupts peers when they try and talk, and talks about his pets at home. What nursing action is best for the RN to take?

A. Explore the client’s feelings about his pets and home life.
B. Encourage his peers to help involve him in the activity.
C. Give the client permission to leave and return in 10 minutes.
D. Redirect him by encouraging him to read from the handout.

A male adolescent was admitted to the unit two days ago for depression. When the mental health RN tries to interview the client to establish rapport, he becomes very irritated and sarcastic. Which action is best for the RN to take?

A. Report the behavior to the next shift.
B. Offer to play a game of cards with the client.
C. Document the behavior in the chart.
D. Plan to talk with the client the next day.

A male adult is admitted because of an acetaminophen (Tylenol) overdose. After transfer to the mental health unit, the client is told he has liver damage. Which information is most important for the nurse to include in the client's discharge plan?

A. Do not take any over the counter meds.
B. Eat a high carb, low fat, low protein diet.
C. Call the crisis hotline if feeling lonely.
D. Avoid exposure to large crowds.

After receiving treatment for anorexia, a student asks the school RN for permission to work in the school cafeteria as part of the school’s work study program. What action should the RN take?

A. Refer the student to a psychiatrist for further discussion.
B. Recommend assignment to the receptionist’s office.
C. Suggest that student work in the athletic department.
D. Determine the parent’s opinion of the work assignment.

The Rn accepts a transfer to the metal health unit and understands that the client is distractible and is exhibiting a decreased ability to concentrate. The RN only has 15 minutes to talk to the client. To develop treatment plan for this client, which assessment is most important for the RN to obtain?

A. Motivation of treatment.
B. History of substance use.
C. Medication compliance.
D. Mental status examination.

A male client who recently lost a loved one arrives at the mental health center and tells the RN he is no longer interested is his usual activities and has not slept for several days. Which priority nursing problem should the RN include in the client's plan of care?

A. Risk for suicide.
B. Sleep deprivation.
C. Situational low self-esteem.
D. Social isolation.

A male client with long history of alcohol dependency arrives in the emergency department describing the feelings of bugs crawling on his body. His blood pressure is 170/102, his pulse rate is 110 bpm, and is blood alcohol level is 0mg/dL. Which prescription should the RN administer?

A. Haloperidol (Haldol).
B. Thiamine (Vitamin B1).
C. Diphenhydramine (Benadryl).
D. Lorazepam (Ativan).

A client who refuses antipsychotic medications disrupts group activities, talks with nonsensical words and wanders into client's rooms. The RN decides that the client needs constant observation based on which of these assessment findings?

A. Wanders into the clients rooms.
B. Refuses antipsychotic medications.
C. Talks with nonsensical words.
D. Disrupts group activities.

A client with schizophrenia explains that she has 20 children and then very seriously points to the RN and explains that she is one of them. What is the most therapeutic response for the RN to provide/

A. "Let's go ask another RN is this is true."
B. "My name tag shows that I am a RN here."
C. "I can't possibly be one if your children."
D. "I know that you don't have 20 children."

A high school girl reveals to the high school RN that she has been engaging in self-induced vomiting as weight-control measure. Which initial assessment should the RN focus on with this adolescent?

A. National percentile of weight and height.

B. Frequency of bingeing and purging behaviors.

C. Perceptions of family and social relationships.

D. School grades and extracurricular activities.

Narcan was administered to an adult client following a suicide attempt with an overdose of hydrocodone bitartrate (Vicodin). Within 15 minutes, the client is alert and oriented. In planning nursing care, which intervention has the highest priority at this time?

A. Encourage the client to increase fluid intake.
B. Obtain the client's serum Vicodin level.

C. Observe the client for further narcotic effects.

D. Determine the client's reason for attempting suicide.

Following surgery, a male client with antisocial personality disorder frequently requests that a specific RN be assigned to is care and is belligerent when another RN is assigned. What action should the charge RN implement?

A. Reassure the client that his request will be met whenever possible.

B. Advise the client that assignments are not based on the client's request.

C. Ask the client to explain why he constantly requests the RN.

D. Encourage the client to verbalize his feelings about the RN.

When preparing to administer a prescribed medication to a homeless male at a community clinic, the client tells the RN that he usually takes a different dosage. What action should the RN take?

A. Tell him to take the medication then verify the dosage at the next healthcare team meeting.

B. Withhold the medication until the dosage can be confirmed.

C. Inform him that he may refuse the medication and document whether or not he takes it.

D. Explain to the client that the dosage has been changed.

The nurse orients a female client with depression to the new room on the mental health unit. The client states “It seems strange that I don’t have a T.V in my room.” Which statement would be best for the RN to provide?

A. “You can watch T.V as much as you want outside of your room.”

B. “Sometimes clients feel like the T.V is sending them messages.”

C. “It’s important to be out of you room and talking to others.”

D. “Watching T.V is a passive activity and we want you to be active.”

A client admitted with a closed head injury after a fall has a blood alcohol level of 0.28 (28%) and is difficult to arouse. Which intervention during the first 6 hours following admission should the RN identify as the priority?

A. Give lorazepam (Ativan) PRN for signs of withdrawal.

B. Administer disulfiram (Antabuse) immediately.

C. Place in a side lying position with head of bed elevated.

D. Provide thiamine and folate supplements as prescribed.

The RN is completing the admission assessment of an underweight adolescent who is admitted to a psychiatric unit with a diagnosis of depression. Which finding requires notification to the HCP?

A. Potassium level of 2.9 mEq/dl.

B. Blood pressure of 110/70 mmHg.

C. WBC of 10,000mm^3.

D. Body mass index of 21.

The Rn is planning client teaching for a 35-year-old client with alcoholic cirrhosis. Which self-care measure should the RN emphasize for the client’s recovery?

A. Support group meetings.

B. Vitamin B and multivitamin supplements.

C. Diet with adequate calories and protein.

D. Alcohol abstinence.

A teenager has lost 20 pounds in the last three months is admitted to the hospital with hypotension and tachycardia. The client reports irregular menses and hair loss. Which intervention is most important for the RN to include in the clients plan of care?

A. Implement behavioral modification therapy.

B. Initiate caloric and nutritional therapy.

C. Evaluate the client for low self-esteem.

D. Record daily weights and graft trend.

While interviewing a client, the nurse takes notes to assist with accurate documentation later. Which statement is most accurate regarding note-taking during an interview?

A. The client's comfort level is increased when the RN breaks eye contact to take notes.

B. The interview process is enhanced with note taking and allows the client to speak at a normal pace.

C. Taking notes during an interview is a legal obligation of examining RN.

D. The RN's ability to directly observe the client's non-verbal communication is limited with note taking.

A client is receiving substitution therapy during withdrawal from benzodiazepines. Which expected outcome statement has the highest priority when planning nursing care?

a. Client will not demonstrate cross addiction.

b. Co-dependent behaviors will be decreased.

c. CNS stimulation will be reduced.

d. Client's level of consciousness will increase.

A client who is being treated with lithium carbonate for manic depression begins to develop diarrhea, vomiting, and drowsiness. What action should the nurse take?

a. Notify the physician immediately and force fluids.

b. Prior to giving the next dose, notify the physician of the symptoms.

c. Record the symptoms and continue medication as prescribed.

d. Hold the medication and refuse to administer additional amounts of the drug.

While caring for an older client, the RN observes multiple bruises in

Over the client's legs, arms, back, and gluteal areas. When the client

Contact, the RN suspects elder abuse. What action should the RN take?

A. Report family conversations and anger towards the client when visiting.
B. Ask the client specific questions about someone causing the bruising.
C. Question the family members and caregiver how the bruising occurred.
D. Measure and document size, shape and color of the bruised areas.

The RN is performing intake interviews at a psychiatric clinic. A female client with a known history of drug abuse reports that she had a heart attack four years ago. Use of which substance places the client at highest risk for myocardial infarction?

A. Benzodiazepine
B. Alcohol
C. Methamphetamine
D. Marijuana

After receiving treatment for anorexia, a student asks the school RN for permission to work in the school cafeteria as part of the school's work study program. What action should the RN take?

A. Suggest that the student work in the athletic department.
B. Determine the parent's opinion of the work assignments.
C. Refer the student to a psychiatrist for further discussion.
D. Recommend assignment to the receptionist's office.

A client who is homeless is diagnosed with schizophrenia and admitted on an involuntary basis to a mental health hospital 4 days ago. The client stopped

taking prescribed antipsychotic drugs approximately one month ago. Since hospitalization the client continues to have poor judgment and refuses all medications. What action should the RN take?

A. Encourage the client to stay in the hospital so the client does not have to be homeless.
B. Provide the client with medication if the client presents an imminent risk to self and others.
C. Administer a long acting antipsychotic medication so that the client can be discharged to a shelter.
D. Describe to the client treatment options provided at the community mental health clinics.

A male client comes to the emergency center because he has an erection that will not resolve. The client reports that he is taking trazodone (Desyrel) for insomnia. Which information is most important for the nurse ask the client?

A. When was the last time you drank alcoholic beverage?
B. ou taken any medications for erectile dysfunction? Have y
C. Are you having any other sexual dysfunctions or problems?
D. Do you have a history of angina or high blood pressure?

On admission to the mental health unit, a client diagnosed with schizophrenia tells the RN that he is the son of god. Based on this statement, which intervention should the RN include in this client's plan of care?

A. Lead the client by his arm to the seclusion room.
B. Ensure the client's environment is safe.
C. Schedule activity therapy twice a week.
D. Confront his delusion as not consistent with reality.

The RN on the day shift receive report about a client with depression who was in bed most of the weekend. The RN walks into the client's room in the morning and finds the client in bed. What intervention is best for the RN to implement?

A. Monitor the client's appetite and pattern of sleep.
B. Assess the client's feelings about the hospital stay.
C. Assist the client to get out of bed and involved in an activity.
D. Explain that staff will check on the client every 30 minutes.

Which client information indicates the need for the RN to use CAGE questionnaire during the admission interview?

A. Client's medication history includes the frequent use of antidepressants.
B. Describe self as a social drinker who drinks alcoholic beverages daily.
C. Reports difficulties with short term memory since traumatic brain injury.
D. Medical history includes that the client was recently sexually assaulted.

A female client admitted to the mental health unit starts to shout and scream at the RN. What is the best approach for the RN to take?

A. Stay quietly with the patient
B. Tell her that she is out of control.
C. Distract her by offering her finger foods.
D. Ignore the client's acting out behavior.

A woman is brought to the psychiatric clinic by her husband. He reports that his wife is reluctant to leave home because of what she describes as a fear of open places and crowds. Which nursing problem applies to this client's behavior?

A. Ineffective protection to guard self from internal or external threats.
B. Risk for injury related to inability to communicate.
C. Risk prone health behavior related to self-esteem assault.
D. Anxiety related to real or perceived threat to physical integrity.

A client is receiving benztropine mesylate (Cogentin) for drug-induced extrapyramidal syndrome (EPS). Which finding indicates that the RN should further evaluate the client?

A. Decreased bowel movements.
B. Presence of a dry mouth.
C. Decreasing hand tremors.
D. Increased mouth movements.

A male client in the mental health unit is guarded and vaguely answers the nurse's questions. He isolates in his room and sometimes opens the door to peek into the hall. Which problem can the RN anticipate?

A. Visual hallucinations.
B. Auditory hallucinations.
C. Excessive motor activity.
D. Delusions of persecution.

A female client with obsessive compulsive personality disorder is admitted to the hospital for a cardiac catheterization. The afternoon before the procedure, the client begins to keep detailed notes of the nursing care she is receiving, and reports her findings to the RN at bedtime. What action should the nurse implement?

A. Explain to the client that her behavior invades the rights of the nursing staff.
B. Ask the client to explain why she is keeping a detailed record of her nursing care.
C. Teach the client strategies to control her obsessive compulsive behavior.
D. Encourage the client to express her feelings regarding the upcoming procedure.

During admission to the psychiatric unit, a female client is extremely anxious and states that she is worried about the sun coming up the next day. What intervention is most important for the RN to implement during the admission process?

A. Assist the client in developing alternative coping skills.
B. Remain calm and use a matter of fact approach.
C. Ask the client why she is so anxious
D. Administer a PRN sedative to help relieve her anxiety.

A female client is brought to the emergency department after police officers found her disoriented, disorganized, and confused. The RN also determines that the client is homeless and is exhibiting suspiciousness. The client's plan of care should include what priority problem?

A. Acute confusion.
B. Ineffective community coping
C. Disturbed sensory perception.
D. Self-care deficit.

The occupational health nurse is working with a female employee who was just notified that her child was involved in a MVA and taken to the hospital. The employee states, "I can't believe this. What should I do?" Which response is best for the RN to provide in this crisis?

A. Tell me what you think should happen.
B. How serious was the collision?
C. What do you think you should do?

D. Call for transportation to the hospital.

A client tells the RN that he has an IQ of 400+ and is a genius and an inventor. He also reports that he is married to a female movie star and thinks that his brother wants a sexual relationship with her. What is the priority nursing problem for admission to the psychiatric unit?

A. Ineffective sexual patterns.
B. Impaired environmental interpretation.
C. Disturbed sensory perception.
D. Compromised family coping.

The RN is providing care for a client diagnosed with borderline personality disorder who has self-inflicted lacerations on the abdomen. Which approach should the RN use when changing this client's dressing?

A. Provide detailed thorough explanations when cleansing wound.
B. Perform the dressing change in a non-judgmental manner.
C. Ask in a non-threatening manner why the client cut own abdomen.
D. Request another staff member assist with the dressing change.

While sitting in the day room of the mental health unit, a male adolescent avoids eye contact, looks at the floor, and talks softly when interacting verbally with the RN. The two trade places, and the RN demonstrates the client's behaviors. What is the main goal of this therapeutic technique?

A. Initiate a non-threatening conversation with the client.
B. Dialog about the ineffectiveness of his interactions.
C. Allow the client to identify the way he interacts.
D. Discuss the client's feelings when he responds.

An antidepressant medication is prescribed for a client who reports sleeping only 4 hours in the past 2 days and weight loss of 9 lbs within the last month. Which client goal is most important to achieve within the first three days of treatment?

A. Meet scheduled appointment with dietitian.
B. Sleep at least 6 hours a night.
C. Understands the purpose of the medication regimen.
D. Describes the reasons for hospitalization.

When preparing to administer to domestic violence screening tool to a female client, which statement should the RN provide?

A. If your partner is abusing you, I need to ask these questions.
B. State law mandates that I ask if you are a victim of domestic violence.

C. The HCP provider needs to know if you are experiencing any domestic abuse.
D. All clients are screened for domestic abuse because it is common in our society.

A young adult female visits the mental health clinic complaining of diarrhea, headache, and muscle aches. She is afebrile, denies chills, and all laboratory findings are within normal limits. During the physical assessment, the client tells the RN that her sister thinks she is neurotic and calls her a hypochondriac. Which response is best for the RN to provide?

A. Unless your sister has a medical education, ignore her comments.
B. I can hear that your sister comments are over-whelming you.
C. Do you think it's possible that you might be a hypochondriac?
D. Besides your sister's comments, what in your life is troubling you?

The RN is leading a group on the inpatient psychiatric unit. Which approach should the RN use during the working phase of group development?

A. Establishing a rapport with group members.
B. Clarifying the nurse's role and clients' responsibilities.
C. Discussing ways to use new coping skills learned.
D. Helping clients identify areas of problem in their lives.

A male client with schizophrenia is demonstrating echolalia, which is becoming annoying to other clients on the unit. What intervention is best for the RN to implement?

A. Isolate the client from the other clients.
B. Administer PRN sedative.
C. Avoid recognizing the behavior.
D. Escort the client to his room.

A client is admitted for bipolar disorder and alcohol withdrawal, depressive phase. Based on which assessment finding will the RN withhold the clonidine (Catapres) prescription?

A. Blood pressure readings of 90/62 mmHg to 92/58 mmHg.
B. Pulse rate of 68-78 BPM.
C. Temperature of 99.5-99.7 F.