NR 326 MENTAL HESI 7 real exam 2023-2024 latest update graded A

Practice exam

1. A 30-year-old sales manager tells the nurse, "I am thinking about a job change. I don't feel like I am living up to my potential." Which of Maslow's developmental stages is the sales manager attempting to achieve?

A. Self-Actualization. Correct

B. Loving and Belonging.

C. Basic Needs.

D. Safety and Security.

Self-actualization is the highest level of Maslow's development stages, which is an attempt to fulfill one's full potential (C). (B) is identifying support systems. (C) is the first level of Maslow's developmental stages and is the foundation upon which higher needs rest. Individuals who feel safe and secure (D) in their environment perceive themselves as having physical safety and lack fear of harm.

2. The nurse observes a client who is admitted to the mental health unit and identifies that the client is talking continuously, using words that rhyme but that have no context or relationship with one topic to the next in the conversation. This client's behavior and thought processes are consistent with which syndrome?

A. Dementia.

B. Depression.

C. Schizophrenia. Correct

D. Chronic brain syndrome.

The client is demonstrating symptoms of schizophrenia (C), such as disorganized speech that may include word salad (communication that includes both real and imaginary words in no logical order), incoherent speech, and clanging (rhyming). Dementia (A) is a

global impairment of intellectual (cognitive) functions that may be progressive, such as Alzheimer's or organic brain syndrome (D). Depression (C) is typified by psychomotor retardation, and the client appears to be slowed down in movement, in speech, and would appear listless and disheveled.

3. A homeless person who is in the manic phase of bipolar disorder is admitted to the mental health unit. Which laboratory finding obtained on admission is most important for the nurse to report to the healthcare provider?

A. Decreased thyroid stimulating hormone level. Correct

B. Elevated liver function profile.

C. Increased white blood cell count.

D. Decreased hematocrit and hemoglobin levels.

Hyperthyroidism causes an increased level of serum thyroid hormones (T3 and T4), which inhibit the release of TSH (A), so the client's manic behavior may be related to an endocrine disorder. (B, C, and D) are abnormal findings that are commonly found in the homeless population because of poor sanitation, poor nutrition, and the prevalence of substance abuse.

4. An adult male client who was admitted to the mental health unit yesterday tells the nurse that microchips were planted in his head for military surveillance of his every move. Which response is best for the nurse to provide?

A. You are in the hospital, and I am the nurse caring for you.

B. It must be difficult for you to control your anxious feelings.

C. Go to occupational therapy and start a project. Correct

D. You are not in a war area now; this is the United States.

Delusions often generate fear and isolation, so the nurse should help the client participate in activities that avoid focusing on the false belief and encourage interaction with others (C). Delusions are often well-fixed, and though (A) reinforces reality, it is

argumentative and dismisses the client's fears. It is often difficult for the client to recognize the relationship between delusions and anxiety (B), and the nurse should reassure the client that he is in a safe place. Dismissing delusional thinking (D) is unrealistic because neurochemical imbalances that cause positive symptoms of schizophrenia require antipsychotic drug therapy.

5. The nurse is assessing a client's intelligence. Which factor should the nurse remember during this part of the mental status exam?

A. Acute psychiatric illnesses impair intelligence.

B. Intelligence is influenced by social and cultural beliefs. Correct

C. Poor concentration skills suggests limited intelligence.

D. The inability to think abstractly indicates limited intelligence.

Social and cultural beliefs (B) have significant impact on intelligence. Chronic psychiatric illness may impair intelligence (A), especially if it remains untreated. Limited concentration does not suggest limited intelligence (C). Difficulties with abstractions are suggestive of psychotic thinking (D), not limited intelligence.

6. At a support meeting of parents of a teenager with polysubstance dependency, a parent states, "Each time my son tries to quit taking drugs, he gets so depressed that I'm afraid he will commit suicide." The nurse's response should be based on which information?

A. Addiction is a chronic, incurable disease.

B. Tolerance to the effects of drugs causes feelings of depression.

C. Feelings of depression frequently lead to drug abuse and addiction.

D. Careful monitoring should be provided during withdrawal from the drugs. Correct

The priority is to teach the parents that their son will need monitoring and support during withdrawal (D) to ensure that he does not attempt suicide. Although (A and C) are true, they are not as relevant to the parent's expressed concern. There is no information to support (B).

7. The wife of a male client recently diagnosed with schizophrenia asks the nurse, "What exactly is schizophrenia? Is my husband all right?" Which response is best for the nurse to provide to this family member?

A. It sounds like you're worried about your husband. Let's sit down and talk.

B. It is a chemical imbalance in the brain that causes disorganized thinking. Correct

C. Your husband will be just fine if he takes his medications regularly.

D. I think you should talk to your husband's psychologist about this question.

The nurse should answer the client's question with factual information and explain that schizophrenia is a chemical imbalance in the brain (B). (A) is a therapeutic response but does not answer the question, and may be an appropriate response after the nurse answers the question asked. Although (C) is likely true to some degree, it is also true that some clients continue to have disorganized thinking even with antipsychotic medications. Referring the spouse to the psychologist (D) is avoiding the issue; the nurse can and should answer the question.

8. A young adult male client, diagnosed with paranoid schizophrenia, believes that world is trying poison him. What intervention should the nurse include in this client's plan of care?

A. Remind the client that his suspicions are not true.

B. Ask one nurse to spend time with the client daily. Correct

C. Encourage the client to participate in group activities.

D. Assign the client to a room closest to the activity room.

A client with paranoid schizophrenia has difficulty with trust and developing a trusting relationship with one nurse (B) is likely to be therapeutic for this client. (A) is argumentative. Stress increases anxiety, and anxiety increases paranoid ideation; (C) would be too stressful and anxiety-promoting for a client who is experiencing pathological suspicions. (D) also might increase anxiety and stress.

9. The community health nurse talks to a male client who has bipolar disorder. The client explains that he sleeps 4 to 5 hours a night and is working with his partner to start two new businesses and build an empire. The client stopped taking his medications several days ago. What nursing problem has the highest priority?

A. Excessive work activity.

B. Decreased need for sleep.

C. Medication management. Correct

D. Inflated self-esteem.

The most important nursing problem is medication management (C) because compliance with the medication regimen will help prevent hospitalization. The client is also exhibiting signs of (A, B, and C); however, these problems do not have the priority of medication management.

10. A female client with obsessive-compulsive disorder (OCD) is describing her obsessions and compulsions and asks the nurse why these make her feel safer. What information should the nurse include in this client's teaching plan? (Select all that apply.)

A. Compulsions relieve anxiety. Correct

B. Anxiety is the key reason for OCD. Correct

C. Obsessions cause compulsions.

D. Obsessive thoughts are linked to levels of neurochemicals. Correct

E. Antidepressant medications increase serotonin levels. Correct

Correct choices are (A, B, D, and E). To promote client understanding and compliance, the teaching plan should include explanations about the origin and treatment options of OCD symptomology. Compulsions are behaviors that help relieve anxiety (A), which is a vague feeling related to unknown fears, that motivate behavior (B) to help the client cope and feel secure. All obsessions (C) do not result in compulsive behavior. OCD is supported by the neurophysiology theory, which attributes a diminished level of

neurochemicals (D), particularly serotonin, and responds to selective serotonin reuptake inhibitors (SSRI).

11. The nurse observes a female client with schizophrenia watching the news on TV. She begins to laugh softly and says, "Yes, my love, I'll do it." When the nurse questions the client about her comment she states, "The news commentator is my lover and he speaks to me each evening. Only I can understand what he says." What is the best response for the nurse to make?

A. What do you believe the news commentator said to you? Correct

B. Let's watch news on a different television channel.

C. Does the news commentator have plans to harm you or others?

D. The news commentator is not talking to you.

It is imperative that the nurse determine what the client believes she heard (A). The idea of reference may be to hurt herself or someone else, and the main function of a psychiatric nurse is to maintain safety. (B) is acceptable, but it is best to determine the client's beliefs. (C) is validating the idea of reference, while (D) is challenging the client.

12. A 40-year-old male client diagnosed with schizophrenia and alcohol dependence has not had any visitors or phone calls since admission. He reports he has no family that cares about him and was living on the streets prior to this admission. According to Erikson's theory of psychosocial development, which stage is the client in at this time?

A. Isolation.

B. Stagnation. Correct

C. Despair.

D. Role confusion.

The client is in Erikson's "Generativity vs. Stagnation" stage (age 24 to 45), and meeting the task includes maintaining intimate relationships and moving toward developing a family (B). (A) occurs in young adulthood (age 18 to 25), (C) occurs in maturity (age 45

to death), and (D) occurs in adolescence (age 12 to 20). These are all stages that occur if individuals are not successfully coping with their psychosocial developmental stage.

13. The parents of a 14-year-old boy bring their son to the hospital. He is lethargic, but responsive. The mother states, "I think he took some of my pain pills." During initial assessment of the teenager, what information is most important for the nurse to obtain from the parents?

A. If he has seemed depressed recently.

B. If a drug overdose has ever occurred before.

C. If he might have taken any other drugs. Correct

D. If he has a desire to quit taking drugs.

Knowledge of all substances taken (C) will guide further treatment, such as administration of antagonists, so obtaining this information has the highest priority. (A and B) are also valuable in planning treatment. (D) is not appropriate during the acute management of a drug overdose.

14. A male client with mental illness and substance dependency tells the mental health nurse that he has started using illegal drugs again and wants to seek treatment. Since he has a dual diagnosis, which person is best for the nurse to refer this client to first?

A. The emergency room nurse.

B. His case manager.

C. The clinic healthcare provider.

D. His support group sponsor.

The case manager (B) is responsible for coordinating community services, and since this client has a dual diagnosis, this is the best person to describe available treatment options. (A) is unnecessary, unless the client experiences behaviors that threaten his safety or the safety of others. (C and D) might also be useful, but it is most important at this time that a treatment program be coordinated to meet this client's needs.

15. A male client is admitted to a mental health unit on Friday afternoon and is very upset on Sunday because he has not had the opportunity to talk with the healthcare provider. Which response is best for the nurse to provide this client?

A. Let me call and leave a message for your healthcare provider.

B. The healthcare provider should be here on Monday morning.

C. How can I help answer your questions?

D. What concerns do you have at this time?

It is best for the nurse to call the healthcare provider (A) because clients have the right to information about their treatment. Suggesting that the healthcare provider will be available the following day (B) does not provide immediate reassurance to the client. The nurse can also implement offer to assist the client (C and D), but the highest priority intervention is contacting the healthcare provider.

16. A female client refuses to take an oral hypoglycemic agent because she believes that the drug is being administered as part of an elaborate plan by the Mafia to harm her. Which nursing intervention is most important to include in this client's plan of care?

A. Reassure the client that no one will harm her while she is in the hospital.

B. Ask the healthcare provider to give the client the medication.

C. Explain that the diabetic medication is important to take.

D. Reassess client's mental status for thought processes and content.

The most important intervention is to reassess the client's mental status (D) and to take further action based on the findings of this assessment. Attempting to reassure the client (A) is in effect arguing with the client's delusions and could escalate an already anxious situation. Collaborating about diabetic care (B and C) is not likely to help change the client's false beliefs.

17. A male client is admitted to the psychiatric unit with a medical diagnosis of paranoid schizophrenia. During the admission procedure, the client

looks up and states, "No, it's not MY fault. You can't blame me. I didn't kill him, you did." What action is best for the nurse to take?

A. Reassure the client by telling him that his fear of the admission procedure is to be expected.

B. Tell the client that no one is accusing him of murder and remind him that the hospital is a safe place.

C. Assess the content of the hallucinations by asking the client what he is hearing.

D. Ignore the behavior and make no response at all to his delusional statements.

Further assessment is indicated (C). The nurse should obtain information about what the client believes the voices are telling him--they may be telling him to kill the nurse! (A) is telling the client how he feels (fearful). The nurse should leave communications open and seek more information. (B) is arguing with the client's delusion, and the nurse should never argue with a client's hallucinations or delusions, also (B) is possibly offering false reassurance. (D) is avoiding the situation and the client's needs.

18. An 86-year-old female client with Alzheimer's disease is wandering the busy halls of the extended care facility and asks the nurse, "Where should I stand for the parade?" Which response is best for the nurse to provide?

A. Anywhere you want to stand as long as you do not get hurt by those in the parade.

B. You are confused because of all the activity in the hall. There is no parade.

C. Let us go back to the activity room and see what is going on in there.

D. Remember I told you that this is a nursing home and I am your nurse.

It is common for those with Alzheimer's disease to use the wrong words. Redirecting the client (using an accepting non-judgmental dialogue) to a safer place and familiar activities (C) is most helpful because clients experience short-term memory loss. (A) dismisses the client's attempt to find order and does not help her relate to her surroundings. (B) dismisses the client and may increase her anxiety level because it

merely labels the client's behavior and offers no solution. It is very frustrating for those with Alzheimer's disease to "remember," and scolding them (D) may hurt their feelings.

19. Physical examination of a 6-year-old reveals several bite marks in various locations on his body. X-ray examination reveals healed fractures of the ribs. The mother tells the nurse that her child is always having accidents. Which initial response by the nurse would be most appropriate?

A. I need to inform the healthcare provider about your child's tendency to be accident prone.

B. Tell me more specifically about your child's accidents.

C. I must report these injuries to the authorities because they do not seem accidental.

D. Boys this age always seem to require more supervision and can be quite accident prone.

(B) seeks more information using an open ended, non-threatening statement. (A) could be appropriate, but it is not the best answer because the nurse is being somewhat sarcastic and is also avoiding the situation by referring it to the healthcare provider for resolution. Although it is true that suspected cases of child abuse must be reported, (C) is virtually an attack and is jumping to conclusions before conclusive data has been obtained. (D) is a cliché and dismisses the seriousness of the situation.

20. A child is brought to the emergency room with a broken arm. Because of other injuries, the nurse suspects the child may be a victim of abuse. When the nurse tries to give the child an injection, the child's mother becomes very loud and shouts, "I won't leave my son! Don't you touch him! You'll hurt my child!" What is the best interpretation of the mother's statements? The mother is

A. regressing to an earlier behavior pattern.

B. sublimating her anger.

C. projecting her feelings onto the nurse.

D. suppressing her fear.