PRACTICE ASSESSMENT: RN Mental Health Online Practice 2019 B

1. A nurse is talking with a group of parents who have recently experienced the death of a child which of the following actions should the nurse take?
    - Encourage the parents to avoid discussing the death of their other children to protect their feelings
    - Recommend each parent grieve in a private to avoid hindering each other's healing
    - Suggest forming a weekly support group for parents who have experienced the death of a child.
    - Advise the parents to begin counseling if they are still grieving in a few months

2. A nurse in a community Health Center is working with a group of clients who have post-traumatic stress disorder. Which of the following interventions should the nurse include to reduce anxiety among the group members?
    - Response prevention
    - Guided imagery
    - Aversion therapy
    - Light therapy

3. A nurse is planning care for a client who is to undergo electroconvulsive therapy (ECT). Which of the following actions should the nurse include in the plan?
    - Administer phenytoin 30 min prior to procedure
    - Instruct the client to expect a headache following the procedure
    - Place the client in a four-point restraint prior to the procedure
    - Monitor the client's cardiac rhythm during the procedure

4. A nurse is planning prevention strategies for partner violence in the community. Which of the following strategies should the nurse include as a method of secondary prevention?
    - Provide teaching about the use of positive coping mechanisms
    - Establish screening programs to identify at risk clients
    - Refer survivors to intimate partner abuse to a legal advocacy program
    - Organize rehabilitation therapy for clients who have experienced intimate partner abuse

5. A nurse in a mental health facility is caring for a client who has schizophrenia. Which of the following findings places the client at a greater risk for self-directed injury or injuring others?
    - Inability to communicate with others
    - Feelings of absence of self-worth
    - Lack of motivation to perform daily tasks
    - Command hallucinations

6. A nurse is caring for a child who is taking methylphenidate. The nurse should monitor the child for which of the following findings as an adverse effect of methylphenidate?
    - Weight gain
    - Tinnitus
    - Tachycardia
    - Increased salivation

7. A nurse observes a client on a mental health unit pushing on the locked unit door. Which of the following statements should the nurse make?
    - "It appears as though you would like to open the door."
    - "You will feel more comfortable after you've been here for a while."
    - "It is ok to not want to be here."
    - "You really shouldn't be pushing on the door."

8. A nurse is assisting a client who has a terminal illness adjust to progressive loss of independence. Which of the following statements by the client indicates acceptance of her illness?
    - "I am going to order a wheelchair for when I'm unable to walk."
    - "I am going to stop paying my bills since I won't be around much longer."
    - "I wish you would go take care of somebody who actually needs you."
    - "I am sure I'm going to be able to continue to care for myself without help."

9. A nurse is preparing to participate in an interdisciplinary conference or client who has bipolar disorder. Which of the following behaviors is the priority for the nurse to report to the treatment team?
    - Calling family members
    - Spending time alone
    - Giving away possessions
    - Excessive crying

10. A nurse is teaching the partner of a client who has bipolar disorder how to identify manifestations of acute mania. Which of the following findings should the clients partner report to the provider?
    - Obsessive attention to detail
    - Inability to sleep
    - Reports of fatigue
    - Isolation from others

11. A nurse on an acute mental health facility is receiving change of shift report for four clients which of the following clients should the nurse assess first?

- A client who does not recognize familiar people
- A client who cannot verbalize their needs
- A client who is awake and disoriented at night
- A client who is experiencing delusions of persecution

12. A nurse is counseling and adolescent who has anorexia nervosa and reports excessive laxative use and a fear of gaining weight. The client states “I'm so fat I can't even stand to look at myself.” Which of the following therapeutic responses demonstrate the nurses use of summarizing?
    - “You've discussed several concerns about your weight let's go back and talk about your belief that you are fat.”
    - “You are saying that you think you are fat and are using laxatives because you are afraid of gaining weight.”
    - “You don't want to look at yourself because you think you are fat.”
    - “You and I can work together to overcome your fears of gaining weight.”

13. A nurse in a mental health clinic is caring for a client who has post-traumatic stress disorder (PTSD) after returning from military deployment which of the following is the priority action for the nurse to take?
    - Assist the client to identify personal areas of strength
    - Encourage the client to talk about experiences during the deployment
    - Stay with the client when flashbacks occur
    - Teach the client stress management techniques

14. A nurse is discussing a 12-step-program with a client who has alcohol use disorder and is in an acute care facility undergoing detoxification. Which of the following information should the nurse include in the teaching?
    - The program will help the client accept responsibility for the disorder
    - the client should obtain a sponsor before discharge for an increased chance of recovery
    - the client will need to identify individuals who have contributed to the disorder
    - The program will need a prescription for the clients provider prior to attendance

15. A client who has a recent diagnosis of bipolar disorder is placed in a room with a client who has severe depression the client who has depression reports to the nurse “My roommate never sleeps and keeps me up, too.” Which of the following actions should the nurse take?
    - Move the client who has bipolar disorder to a private room
    - administer sleep medication to the client who has bipolar disorder
    - move the client who has severe depression to a private room
    - administer sleep medication to the client who has severe depression

16. A nurse is performing an admission assessment on a client and notices that the client appears withdrawn and fearful to establish a trusting nurse client relationship. Which of the following actions should the nurse take first?
    - Inform the client that this admission is confidential
    - Introduce the client to other clients in the dayroom
    - Assist the client in facilitating behavioral change
    - Determine coping strategies that the client has used in the past

17. A nurse is teaching coping strategies to a client who is experiencing depression related to partner violence. Which of the following statements by the client indicates an understanding of the teaching?
    - I will spend extra time at work to keep from feeling depressed
    - I will talk about my feelings with a close friend
    - I will be able to learn how to prevent my partner's attacks
    - I will use meditation instead of taking my anti depressants

18. A nurse is assessing a school age child who experienced the traumatic loss of a parent 8 months ago. Which of the following findings should the nurse identify as an indication of the child is it is experiencing post-traumatic stress disorder (PTSD)?
    - Clinging behaviors directed toward a teacher
    - Increased time spending sleeping
    - Intense focus on schoolwork
    - Lack of interest in an upcoming holiday

19. A nurse on a mental health unit is caring for a group of clients. Which of the following actions by the nurse is an example of the ethical principle of justice?
    - Allowing a client to choose which unit activities to attend
    - Attempting alternative therapies instead of restraints for a client who is combative
    - Providing a client with accurate information about their prognosis
    - Spending adequate time with a client who is verbally abusive

20. A nurse is performing a cognitive assessment to distinguish delirium from dementia in a client whose family reports episodes of confusion. Which of the following assessment findings support the nurse’s suspicion of delirium?
    - Slow onset
    - Aphasia
    - Confabulation
    - Easily distracted

21. A nurse is assessing a client who has bulimia nervosa. The nurse should expect which of the following findings?
    - Amenorrhea
    - Lanugo
    - Cold extremities
    - Tooth erosion

22. A nurse is teaching the guardians of a client about their adolescent child's diagnosis of bulimia nervosa. Which of the following statements made by the guardian indicates an understanding of their child's illness?
    - “The disease will increase our child's risk of high blood pressure.”
    - “It is important for our child to have regular dental checkups.”
    - “We need to weigh our child daily for several weeks then once per week.”
    - “Bleeding during our child's periods will increase because of this disease.”

23. A nurse any providers office is interviewing older adult which of the following action should the nurse plan to take? (Click on exhibit button for additional information about the client there are 3 tabs that contain separate categories of data).
    - Use a screening tool to evaluate the client for depression
    - ask the provider to decrease the dosage of the client’s blood pressure medication
    - instruct the client to decrease intake of vitamin B12
    - suggest the client go for brisk walk 20 minutes just before bedtime

24. A nurse is caring for an older adult client who is experiencing delirium. Which the following intervention should the nurse include in the client's plan of care?
    - Offer the client various choices for milk selection
    - Assign different nursing personnel for each shift
    - Permit the client to perform daily rituals to decrease anxiety
    - Maintain an environment that has low lighting

25. A nurse is facilitating a community meeting for acute care clients. One client is constantly talking and using the majority of the group’s time. Which of the following interventions should the nurse implement?
    - Tell the client to talk less or risk being removed from the meeting
    - Ask the group members to discuss their feelings about the client’s monopolizing behavior
    - End the group meeting and take the client aside to discuss the disruptive behavior
    - Focus on the group members and ignore the client who is doing all the talking