Ati Mental Health C

1.A nurse is reviewing the medication administration record of a client who has major depressive disorder and a new prescription for selegiline. The nurse should recognize that which of the following client medications is contraindicated when taken with selegiline?

a) Warfarin
b) Fluoxetine
c) Calcium carbonate
d) Acetaminophen

2.A nurse is providing crisis intervention for a client who is involved in violent mass casualty situation in the community. Which of the following actions should the nursetake during the initial session with a client?

a) Identify the clients usual coping style
b) Help the client focus on a wide variety of topics regarding crisis
c) Tell the client that his life will soon return to normal
d) Encourage the client to display anger towards the cause of the crisis

3.A nurse is caring for a client who is schizophrenia experiencing auditory hallucinations. Which of the following actions should the nurse take first?

a) Encourage the client to listen to music
b) Monitor the client for indications of anxiety
c) Ask the client what she is missing
d) Focus the client on reality-based topics

4.A nurse is planning to lead a support group for clients who have alcohol use disorder. One of the group members is a client who speaks a different language than the nurse. The nurse should ask which of the following individuals to assist with communication?

a) A family member of the client
b) Another client who speaks the same language as the client
c) A translator of the same gender as the client
d) A unit secretary who speaks the same language as the client

5.A nurse in an emergency department is assessing a client who reports recently using cocaine. Which of the following clinical manifestations should the nurse expect?

a) Lethargy
b) Hypothermia
c) Hypertension
d) Bradycardia

6.A nurse is caring for a client who has severe depression and is scheduled to receive electro convulsive therapy. The nurse should recognize of the client will receive succinylcholine to prevent which of the following adverse effects?

a) Muscle distress
b) Aspiration
c) Elevated blood pressure
d) Decreased

7.A nurse and an outpatient clinic is assessing a client who has anorexia nervosa. Which of the following indicates a need for hospitalization?

a) Temp 35.6 C (96.1)
b) HR 56/min
c) Weight 10% below ideal weight
d) Potassium 3.8 mEq/L

8.A nurse is caring for a client who is under observation for suicidal ideation's and has verbalized a suicide plan. The client demands privacy and to be left alone. Which of the following statement should the nurse make?

a) "Since you were trying to follow the treatment plan, we can submit your requestto the provider"
b) "We are concerned about you I need to keep you safe"
c) "Until your medication has reached therapeutic levels, you will need constant observation"
d) "If you complete a contract that states you will not harm herself, you can be alone"

9.A nurse on a mental health unit is leading a therapy session for a group of clients. One client challenge is a nurse and she has no empathy for others in the group. Which of the following actions should the nurse take?

a) Request the client leave the therapy session immediately
b) Place the client in seclusion
c) Reassign the client to another group
d) Ask the client privately what is causing the anger

10.A nurse in a mental health clinic is assessing a client who has borderline personalitydisorder. Which of the following findings should the nurse expect?

a) Inability to maintain employment
b) Intense efforts to avoid abandonment
c) Avoidance of interpersonal relationships
d) Reluctance to discard worthless objects

11.A nurse in a long-term care facility is assessing an older adult for depression. Which of the following findings should the nurse expect?

a) Rapid mood swings
b) Sun downing
c) Insomnia
d) Rambling speech

12.A nurse is assessing a client has been taking thioridazine for 2 weeks. The client reports and inability to be still. Which of the following adverse effects should the nurse suspect?

a) Tardive dyskinesia
b) Pseudo parkinsonism
c) Akathisia
d) Acute dystonia

13.A nurse and a mental health facility is making plans for a client's discharge. Which of the following interdisciplinary team member should the nurse contact to assist the client with housing placement?

a) Clinical nurse specialist
b) Social worker
c) Occupational therapist
d) Recreational therapist

14.A nurse an interviewing and client who was recently sexually assaulted. The client cannot recall the attack. The nurse should identify that the client is using which of the following defense mechanisms?

a) Sublimation
b) Reaction formation
c) Suppression
d) Repression

15.A nurse is assessing a client who has antisocial personality disorder. Which of thefollowing client behaviors should the nurse expect?

a) Attention seeking
b) Anxious
c) Projects blame
d) Manipulative

16.A nurse is caring for a client who has physical restraints applied. The nurse determines that the restraints should be removed when which of the following occurs?

a) The client states that he will harm himself unless their strengths removed
b) The client refuses to take his medication unless he is released
c) The client demonstrates that he is oriented to place, person, and time
d) The client is able to follow commands

17.A nurse caring for a client who states, "Things will never work out." Which of the following responses to the nurse to make?

a) "Why do you feel like things will never work?"
b) "Have you been thinking about harming yourself?"
c) "You should try to focus on yourself for a change"
d) "Maybe an antidepressant will make you feel better"

18.A nurse and emergency department is caring for a client who reports recent sexual assault by her partner. Which of the following statements is the priority for the nurse tomake?

a) I want you to know that you are in a safe place here
b) I can contact to support person for
c) A trained sexual assault nurse will be assigned to your care
d) I can provide information about an advocacy group in the area

19.After assessing a client in a crisis situation, a nurse demonstrates the client is safe. Which of the following actions should the nurse take first?

a) Help the client identify social support
b) Involve the client in planning interventions
c) Assist the client to lower his anxiety level
d) Teach the client specific coping skills to handle stressful situations

20.A nurse is assessing a client who has bulimia nervosa. Which of the following findings should the nurse expect?

a) Acrocyanosis
b) Amenorrhea
c) Lanugo
d) Hyponatremia

21.A nurse is caring for a client who reports smoking marijuana several times per day. Theclient tells the nurse, "I don't know what the big deal is marijuana is a harmless herb". The nurse should identify that the client is displaying which of the following mechanisms?

a) Rationalization
b) Reaction formation
c) Compensation
d) Suppression

22.A nurse is creating a plan of care for a client who is major depressive disorder. Which of the following intervention should the nurse include in the plan?

a) Identify and schedule alternative group activities for the client
b) Encourage physical activity for the client during the day
c) Discourage the client from expressing feelings of anger
d) Keep a bright light on in the client's room at night

23.A nurse is teaching the family of a client who has Alzheimer's disease about the safetyinterventions for nighttime wondering, which of the following intervention should the nurse include?

a) Place rubber back to throw rugs on tile floors
b) Encourage the client to take naps during the day
c) Install locks for the bottom of exits
d) Place the client's mattress on the floor

24.A nurse and a mental health facility is reviewing the lab results of a client who is taking lithium carbonate. which of the following findings places the client a risk for lithium toxicity?

a) Calcium 10.0
b) WBC 6,0000
c) Sodium 132 mEq/L
d) Aspartame aminotransferase 40 units/L

25.A nurse in acute care facility is planning care for a client who has history of alcohol use disorder and is admitted while intoxicated. Which of the following interventions should the nurse plan for the client?

a) Monitor for orthostatic hypotension
b) Administer methadone hydrochloride
c) Implement seizure precautions
d) Acidify the client's urine

26.A nurse is developing a safety plan for a client who's experience intimate partner abuse. Which of the following items should the nurse include in the plan that will provide immediate safety for the client and her children?

a) The phone numbers for law enforcement agencies
b) A code phrase to use when it is time to leave the house
c) The phone number of the local shelter
d) A referral to a support group

27.A nurse is caring for a client report that he is angry with his partner because she thinks he is just trying to gain attention. When the nurse attempts to talk to the client, he becomes angry and tells her to leave. Which of the following defense mechanisms is the client demonstrating?

a) Denial
b) Rationalization
c) Displacement
d) Compensation

28.A nurse is observing a newly licensed nurse administer and IM medication to a client who is manic and refused the medication. Which of the following actions should the nurse take first?

a) Stop the newly licensed nurse from administering medication
b) Call the provider for an alternate medication room
c) Report the occurrence to the nurse manager
d) Talk to the newly licensed nurse about the incident

29.A nurse is planning care for a client who demonstrates prolonged depression related to the loss of her partner six months ago. Which of the following actions should the nurse take?

a) Explain that it can take a year or more to learn to live with loss
b) Discourage the client from reliving the events surrounding her loss
c) Suggest that the client avoid social interactions that remind her of her partner
d) Direct the client to maintain an unstructured daily routine

30.A nurse in a long-term care facility is assessing a client who has dementia. Which of the following findings should the nurse identify as a risk for this client?

a) Outside doors have locks
b) The bed is in the low position
c) Hallways are long distances
d) The room has an area rug

31.A nurse is providing behavioral therapy for a client who has obsessive-compulsive disorder. The client repeatedly checks that the doors are locked at night. Which of the following instructions should the nurse give the client when using thought stopping technique?

a) "Ask a family member to check the locks for you at night"
b) "Keep a journal of how often you check the locks each night"
c) "Snap a rubber band on your wrist when you think about checking the locks"
d) "Focus on abdominal breathing whenever you go to check the locks"

32.A nurse in an inpatient mental health facility is assessing a client who has schizophreniaand is taking haloperidol. Which of the following clinical findings is the nurse's priority?

a) Insomnia
b) Urinary hesitancy
c) Headache
d) High fever

33.A nurse is caring for a client who has Alzheimer's disease. Which of the following findings should the nurse expect?

a) Failure to recognize familiar objects
b) Altered level of consciousness
c) Excessive motor activity
d) Rapid mood swings

34.A nurse in a mental health facility is interviewing a new client. Which of the following outcomes must occur if the nurse is to establish a therapeutic nurse-client relationship?

a) The nurse is seen as an authority figure
b) A written contract is established to clarify the steps of the treatment plan
c) The nurse maintains confidentiality unless the client's safety is compromised
d) The nurse is seen as a friend

35.A nurse is teaching a client who has a new prescription for disulfiram. Which of the following statements by the client indicates an understanding of the teaching?

a) "If I cut myself, I can clean the wound with isopropyl alcohol"
b) "I can wear my cologne on special occasions"
c) "When I bake my favorite cookies, I can use pure vanilla extract for flavoring"
d) "I can continue to eat aged cheese and chocolate"

36.A nurse is planning care for a client who has narcissistic personality disorder. Which of the following actions is appropriate for the nurse to include in the plan of care?

a) Ask the client to sign a no-suicide contract
b) Remain neutral when communicating with the client
c) Request an antipsychotic medication from the provider
d) Provide the client with high-calorie finger foods

37.A nurse is reviewing the laboratory report of a client who is taking carbamazepine for bipolar disorder Which of the following laboratory results should the nurse report to the provider?

a) Urine specific gravity 1.029
b) Platelets 90,000/mm
c) Urine pH 5.6
d) RBC 4.7/mm

38.A nurse is providing teaching about relapse prevention to a client who has schizophrenia. Which of the following statements by the client indicates an understanding of the teaching?

a) "I should avoid being around others if I think I'm having a relapse"
b) "I should let my counselor know if I am having trouble sleeping"
c) "I shouldn't worry about the voices because they are a part of my illness"
d) "I should increase my carbohydrate intake to maintain my energy level"

39.A nurse is assessing a client for negative manifestations of schizophrenia. Which of thefollowing findings should the nurse expect?

a) Echopraxia
b) Delusions
c) Anergia
d) Tangentiality