1 A client is fearful of driving and enters a behavioral therapy program aimed at helping him overcome his anxiety. Using systematic desensitization, he is able to drive down a familiar street without experiencing a panic attack. The nurse recognizes that to continue positive results, the client must participate in which of the following?

- ☐ Biofeedback
- ☑ Frequent practice
- ☐ Positive reinforcement
- ☐ Therapist modeling

2 When assessing the appropriateness of physical restraint for use with a client, a nurse must be aware of which of the following?

- ☐ Restraints may be used for client safety when staffing is inadequate.
- ☐ Judicious use of restraints can enhance client care.
- ☑ The least restrictive means of restraint should be chosen.
- ☐ Restraints decrease the incidence of falls and injuries.

3 A nurse is working with clients in an acute care mental health facility. When planning client care, the nurse should recognize that which of the following are correct uses of seclusion and/or restraint? (Select all that apply.)

- ☐ Chemical restraints should be the first choice of treatment for a client who is out of control.
- ☐ Seclusion and/or restraint should be implemented to maintain therapeutic milieu.
- ☑ In an emergency, the charge nurse may place a client in seclusion and/or restraint.
- ☑ A client may request to be placed in seclusion.
- ☐ Seclusion and/or restraint may be used as a behavior modification technique.

4 A client has a history of using crack cocaine. The nurse should monitor for which of

the following potential signs of drug withdrawal?

- Client is drowsy most of the time.
- Client speaks rapidly and talks constantly.
- Client has tremors of the hands and eyelids.
- Client mistakes the ceiling tiles for a jail cell.

5 A priority intervention to strengthen coping skills and to foster peer interaction for clients with borderline personality disorder is to

- set firm limits.
- promote change.
- remain friendly.
- teach journaling.

6 Which of the following statements by a client who has been abused indicates understanding of the need for a safety plan?

- "I should hide extra money, car keys, clothes, and copies of important documents inside my house."
- "I will feel safe as soon as I have a protective order in place."
- "I will let my neighbor know when I'm in trouble."
- "I need to identify a particular sign that tells me and my kids that it is time to leave."

7 A nurse is caring for a client who is taking risperidone (Risperdal). The nurse should recognize that an increase in which of the following indicates a potential adverse reaction to the medication?

- Blood glucose
- White blood cell count
- Platelet count
- Serum potassium

8 A client presents to the emergency department following ingestion of an unknown quantity of alcohol and lorazepam (Ativan). In planning care for this client, which of the following requires immediate nursing action?

- ☐ Blood pressure 78/56 mm Hg
- ☉ Respiratory rate 8/min
- ☐ Temperature 38.6°C (101.4°F)
- ☐ Pulse 102/min

9 A client diagnosed with antisocial personality disorder begs a nurse to not report a missed curfew hour. The nurse should recognize this behavior as which of the following?

- ☐ A grandiose sense of self-importance
- ☉ An attempt to avoid consequences
- ☐ An effort to get the nurse in trouble
- ☐ A desire to gain sympathy

10 When a nurse is communicating with a client in the manic phase of bipolar disorder, she should help the client evaluate reality by

- ☐ encouraging details of client ideas and statements.
- ☉ remaining neutral and avoiding power struggles.
- ☐ giving in-depth explanations of nursing expectations.
- ☐ allowing the client to set self-limits of behavior.

11 A nurse working on a medical-surgical unit is receiving several new admissions from the emergency department. Which of the following clients should receive priority if only one private room is available?

- ☐ A client experiencing a panic attack and pacing the floor
- ☐ A client who is depressed and who is tearful and sobbing in her pillow
- ☉ A client who is angry and experiencing command hallucinations

- ☐ A client who is bipolar and is in a hypomanic state

12 A nurse is caring for a client with delirium. Which of the following assessment findings requires immediate intervention by the nurse?

- ☉ Decreased level of consciousness
- ☐ Increased confusion at night
- ☐ Sluggish motor activity
- ☐ Inappropriate speech patterns

13 A nurse is performing an assessment on a client who has expressed suicidal intent due to the recent death of her daughter. The client is distraught and confused. Which of the following nursing interventions takes priority?

- ☐ Arrange for one-to-one observation.
- ☉ Instruct the client to take slow, deep breaths.
- ☐ Ask the client to sign a no-suicide contract.
- ☐ Offer opportunity to talk with a spiritual advisor.

14 A nurse is about to interview an adolescent client who has been involved in sexually risky behavior to support her drug habit. For interaction between the client and the nurse to be therapeutic, the nurse must

- ☉ have self-awareness of potential preconceived ideas.
- ☐ convey a message of hope for the future to the client.
- ☐ ask what is happening to make the client act in such a manner.
- ☐ set firm ground rules for each counseling session.

15 During an examination in the emergency department, a nurse notes multiple bruises

on the shoulders and back of an older adult client. Which of the following should be the nurse's priority action?

- ☐ Notify the primary care provider.
- ☑ Ask the client how he sustained the injuries.
- ☐ Arrange for case management referral.
- ☐ Inquire about the client's living arrangements.

16 A nurse should make the assessment that an adult client is experiencing acute mania if the client

- ☐ displays a decreased attention span.
- ☐ retreats to her room to avoid contact with others.
- ☐ writes flowery and lengthy letters to famous people.
- ☑ exhibits disorganization and chaos.

17 A nurse is assessing a client at her 12-week prenatal visit. The client has a history of prior drug abuse. The nurse recognizes that the client should be assessed for a potential relapse when which of the following assessment findings are found?

- ☐ Heightened anxiety
- ☑ Unexplained pain
- ☐ Increased fatigue
- ☐ Lack of empathy

18 Upon admission, a client was combative and uncooperative. His treatment plan includes the use of seclusion. The client is currently cooperative and participating in unit activities. Which of the following should the nurse do with the original treatment plan?

- ☐ Update the treatment plan with the next behavior change.
- ☑ Leave the treatment plan as written to include seclusion.
- ☐ Remove seclusion from the treatment plan.
- ☐ Consult with the treatment team regarding seclusion.