HESI MENTAL HEALTH RN V1-V3 2020 TEST BANK.

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).

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?

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 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 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.

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 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.