VERSION 13

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. Wafarin
    b. Fluoxetine
    c. Calcium carbonate
    d. Acetaminophen
2. 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
3. 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"

4. A nurse in an inpatient mental health facility is assessing a client who has schizophrenia and is taking haloperidol. Which of the following clinical findings is the nurse's priority?
   a. Insomnia
   b. Urinary hesitancy
   c. Headache
   d. High fever
5. 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
6. 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
7. 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"
8. 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
9. 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^3
   c. Urine pH 5.6
   d. RBC 4.7/mm^3
10. 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"
11. A nurse is assessing a client for negative manifestations of schizophrenia. Which of the following findings should the nurse expect?
    a. Echopraxia
    b. Delusions
    c. Anergia
    d. Tangentiality
12. A nurse is preparing for an interprofessional team meeting regarding a newly admitted client who has major depressive disorder. Which of the following findings obtained during the initial assessment is the priority to report to other disciplines?

a. Poor problem-solving skills
b. Markedly neglected hygiene
c. Significant weight loss
d. Psychomotor retardation

13. A nurse is preparing to administer methylphenidate 25 mg PO to a school age child who has ADHD. Available is methylphenidate 10mg/5mL liquid. How many mL should the nurse administer? (Round to nearest tenth)
    a. 12.5
14. A nurse is caring for a school age child who has a fractured arm. The child has other injuries that cause the nurse to suspect abuse. Which of the following actions is appropriate for the nurse to take when assessing the child's situation?
    a. Ask the parents directly if the child's fracture is due to physical abuse
    b. Direct the parents to the waiting room before interviewing the child
    c. Interview the child with the provider and social worker present
    d. Ask clarifying questions as the child explains how the injuries occurred
15. A nurse is assisting with obtaining consent for a client who has been declared legally incompetent. Which of the following actions should the nurse take?
    a. Ask the charge nurse to obtain informed consent
    b. Contact the facility social worker to obtain consent
    c. Request that the client's guardian sign the consent
    d. Explain implied consent to the clients family
16. A nurse in a mental health facility is reviewing a client's medical record. Which of the following actions should the nurse take first? (Click on the exhibit button for additional information about the client. There are 3 tabs that contain separate categories of data)
    a. Teach the client about nutritional needs
    b. Initiate 0.9% sodium chloride with 40 mEq potassium chloride
    c. Administer acetaminophen 500 mg PO
    d. Encourage the client to attend group therapy sessions
17. A nurse is assessing a client who has delirium. Which of the following findings requires immediate intervention by the nurse?
    a. Rapid mood swings
    b. Command hallucinations
    c. Impaired memory
    d. Inappropriate speech patterns
18. A nurse is developing a teach plan for the family of an older adult client who is to receive transcranial magnetic stimulation. Which of the following information should the nurse include n the teaching plan?
    a. The client is at risk for aspiration during treatment
    b. The client will experience a seizure during treatment
    c. The client will require intubation after treatment
    d. The client might have a headache after treatment
19. A nurse is obtaining a medical history from a client who is requesting a prescription for bupropion for smoking cessation. Which of the following assessment findings in the client's history should the nurse report to the provider?
    a. Recent head injury
    b. Hypothyroidism
    c. Knee arthroplasty 1 month ago
    d. Hepatitis B infection
20. A nurse is developing a plan of care for a client who has paranoid personality disorder. Which of the following actions should the nurse include in the plan?
    a. Provide written information about the client's treatment plan
    b. Monitor the client for splitting behaviors
    c. Encourage countertransference when developing the nurse-client relationship
    d. Isolate the client from social or group interactions