HESI Mental Health RN Questions and Answers from V1-V3 Test Banks and Actual Exams (LatestUpdate 2023) Complete Guide Rated A+

• During admission to the psychiatric unit, a female client is extremely anxious and states thatshe is worried about the sun coming up the next day. What intervention is most important for the RN to implement during the admission process?

- Assist the client in developing alternative coping skills.
- Remain calm and use a matter of fact approach.
- Ask the client why she is so anxious
- Administer a PRN sedative to help relieve her anxiety.

• A female client is brought to the emergency department after police officers found her disoriented, disorganized, and confused. The RN also determines that the client is homelessand is exhibiting suspiciousness. The client's plan of care should include what priority problem?

- Acute confusion.
- Ineffective community coping
- Disturbed sensory perception.
- Self-care deficit.

• The occupational health nurse is working with a female employee who was just notified thather child was involved in a MVA and taken to the hospital. The employee states, "I can't believe this. What should I do?" Which response is best for the RN to provide in this crisis?

- Tell me what you think should happen.
- How serious was the collision?

- What do you think you should do?
- Call for transportation to the hospital.

• A client tells the RN that he has an IQ of 400+ and is a genius and an inventor. He also reports that he is married to a female movie star and thinks that his brother wants a sexual relationship with her. What is the priority nursing problem for admission to the psychiatric unit?

- Ineffective sexual patterns.
- Impaired environmental interpretation.
- Disturbed sensory perception.
- Compromised family coping.

• The RN is providing care for a client diagnosed with borderline personality disorder who hasself-inflicted lacerations on the abdomen. Which approach should the RN use when changing this client's dressing?

- Provide detailed thorough explanations when cleansing wound.
- Perform the dressing change in a non-judgmental manner.
- Ask in a non-threatening manner why the client cut own abdomen.
- Request another staff member assist with the dressing change.

• While sitting in the day room of the mental health unit, a male adolescent avoids eye contact,looks at the floor, and talks softly when interacting verbally with the RN. The two trade places,and the RN demonstrates the client's behaviors. What is the main goal of this therapeutic technique?

- Initiate a non-threatening conversation with the client.
- Dialog about the ineffectiveness of his

interactions. C. Allow the client to identify the way heinteracts.

D. Discuss the client's feelings when he responds.

• An antidepressant medication is prescribed for a client who reports sleeping only 4 hoursin the past 2 days and weight loss of 9 lbs within the last month.

Which client goal is most important to achieve within the first three days of treatment?

- Meet scheduled appointment with dietitian. B. Sleep at least 6 hours a night.
  C. Understands the purpose of the medication regimen.
  D. Describes the reasons for hospitalization.

- When preparing to administer to domestic violence screening tool to a female client,which statement should the RN provide?

- If your partner is abusing you, I need to ask these questions.
- State law mandates that I ask if you are a victim of domestic violence.
- The HCP provider needs to know if you are experiencing any domestic abuse.
- All clients are screened for domestic abuse because it is common in our society.

- A young adult female visits the mental health clinic complaining of diarrhea, headache, and muscle aches. She is afebrile, denies chills, and all laboratory findings are within normal limits.During the physical assessment, the client tells the RN that her sister thinks she is neurotic and calls her a hypochondriac. Which response is best for the RN to provide?

- Unless your sister has a medical education, ignore her comments.
- I can hear that your sister comments are over-whelming you.
- Do you think it's possible that you might be a hypochondriac?
- Besides your sister's comments, what in your life is troubling you?

- The RN is leading a group on the inpatient psychiatric unit. Which approach should theRN use during the working phase of group development?

- Establishing a rapport with group members.
- Clarifying the nurse's role and clients' responsibilities.
- Discussing ways to use new coping skills learned.

- Helping clients identify areas of problem in their lives.

- A male client with schizophrenia is demonstrating echolalia, which is becoming annoying toother clients on the unit. What intervention is best for the RN to implement?

- Isolate the client from the other clients.
- Administer PRN sedative.
- Avoid recognizing the behavior. D. Escort the client to hisroom.

- A client is admitted for bipolar disorder and alcohol withdrawal, depressive phase. Based onwhich assessment finding will the RN withhold the clonidine (Catapres) prescription?

- Blood pressure readings of 90/62 mmHg to 92/58 mmHg.
- Pulse rate of 68-78 BPM.
- Temperature of 99.5-99.7 F.
- Respiration rate of 24 breaths per minute.

- The RN on the evening shift receives report that a client is scheduled for electroconvulsivetreatment (ECT) in the morning. Which intervention should the Rn implement the evening before the scheduled ECT?

- Hold all bedtime medications.
- Keep the client NPO after mid-night.
- Implement elopement precautions.
- Give the client an enema at bedtime.

- A client with Bulimia and depression who is taking phenelzine (Nardil) 90 mg daily is admitted to an acute care hospital for uncontrolled hypertension. What dietary choices shouldthe RN instruct the client to avoid?

- Pan-seared catfish.
- Peperoni pizza.
- Deep fried shrimp.
- Beef trips with gravy.

• A mental health worker is caring for a client with escalating aggressive behavior. Whichaction by the mental health worker warrants immediate intervention by the RN?

- Is attempting the physically restrain the patient.
- Remains at a distance of 4 feet from the client.
- Tells the client to go to the quiet area of the unit.
- Is using a load voice to talk to the client.

• A client who recently experienced the death of a significant other arrives at the mental healthcenter. The client reports loss of interest in usual activities, expresses a wish to be with the decreased significant other, has been eating very little, and has not slept in several days. Which client statement is most important for the RN to explore at this time?

- Not sleeping for several days.
- Wishing to be with spouse.
- Lack of interest in usual activities.
- Eating very little.

• A middle aged adult with major depressive disorder suffers from psychomotor retardation,hypersomnia, and motivation. Which intervention is likely to be most effective in returning this client to a normal level of functioning?

- Provide education on methods to enhance sleep.
- Teach the client to develop a plan for daily structured activities.
- Suggest that the client develop a list of pleasurable activities.
- Encourage the client to exercise.

- When developing a plan of care for a client admitted to the psychiatric unit followingaspiration of a caustic material related to a suicide attempt, which nursing problem has the highest priority?

  - Impaired comfort.
  - Risk for injury.
  - Ineffective breathing pattern.
  - Ineffective coping.

- A female client on a psychiatric unit is sweating profusely while she vigorously does push- ups and then runs the length of the corridor several times before crashing into furniture in the sitting room. Picking herself up, she begins to toss chairs aside, looking for a red one to sit in. When another client objects to the disturbance, the client shouts, "I am the boss here. I do what Iwant." Which nursing problem best supports these observations?

  - Deficient diversional activity related to excess energy level.
  - Risk for other related violence related to disruptive behavior.
  - Risk for activity intolerance related to hyperactivity.
  - Disturbed personal identity related to grandiosity.

- A RN is preparing the physical environment to interview a new client for admission to themental health unit. Which environmental setting facilitates the best outcome of the interview?

  - Dim the lights in the room to help the patient feel calm.
  - Sit within two feet of the client to enhance level of safety and security.
  - Reduce the noise level in the room by turning off the television and radio.
  - Position table between the client and the RN for extra personal space.

- An older homeless client visits the psychiatric clinic to obtain a prescription renewal foralprazolam (Xanax). During the health assessment, the client complains of chest pain. Which action should the RN take first?

- Refer the client to the cardiology unit.
- Obtain the client Blood pressure.
- Assess the client for substance abuse.
- Determine if Xanax was takenrecently.

- The mother of an 8-month-old infant with profound mental and physical disabilities tellshe RN how depressed she is because she realized that her child will never achieve normal growth and development milestones. How should the RN respond to the mother?

- Ask the mother if she has ever thought about harming herself or her child.
- Reassure the mother that her child will achieve some growth and developmentmilestones.
- Determine if the mother has other children who do not have developmental disabilities.
- Encourage the mother to write thoughts and feelings in journal.

- Several clients with chronic mental illness and multiple substance abuse histories live in agroup residential home and attend daycare mental health facility where group and individual therapies are provided. The RN finds the common bathroom at the facility with sputum on the walls, urine in the sink and on the floors, and the toilet stopped up with tissue, paper towels, andfeces. What is the priority issue that the RN should address?

- Medication non-compliance.

- Number of bathroom facilities.
- Infection control.
- Acting out behaviors.

- A client with schizophrenia is admitted to the psychiatric care unit for aggressive behavior,auditory hallucinations, and potential for safe harm. The client has not been taking medications as prescribed and insists that the food has been poisoned and refuses to eat. Whatintervention should the RN implement?

- Assure the client that all food served in the hospital is safe to eat.
- Tell the client that irrational thinking is a symptom of schizophrenia.
- Obtain an order for a tube feeding for the client.
- Provide the client with food in unopened containers.

- The RN is providing education about strategies for a safety plan for a female client who is avictim of intimate partner violence. Which strategies should be included in the safety plan? (SOA)

- Purchase a gun to use for protection.
- Establish a code with family and friends to signify violence.
- Take a self-defense course that retaliates the abuser with injury. D. Have a bag ready that has extra clothes for self and children. E. Plan an escape route to use if the abuser blocks the

main exit.

- The RN is admitting a male client who take lithium carbonate (Eskalith) twice a day.Which information should the RN report to the HCP immediately?

  - Short term memory loss.
  - Five pound weight gain
  - Decreased affect
  - Nausea and vomiting.

- A male client who is admitted with delirium tremens is dehydrated and experiencing auditoryhallucinations. He has a bruised, swollen tongue and is confused. In developing a plan of care, which action should the RN include to ensure the client is physiologically stable?

  - Encourage oral fluids.
  - Monitor vital signs.
  - Keep the room dark.
  - Apply ice to his tongue.

- A RN is teaching a client about initiation of a prescribed abstinence therapy using Disulfiram(Antabuse). What information should the client acknowledge understanding?

- Admit to others that he is a substance abuser.
- Remain alcohol free for 12 hours prior to first dose.
- Attend monthly meetings of alcoholics anonymous.
- Completely sustain from heroin or cocaine use.

- The RN is working with a male client at a community mental health center when the clientreports hearing voices that tell him to get a knife from the kitchen and hurt himself. What intervention is most important for the RN to implement?

- Don't allow the client to go into the kitchen until the hallucination has subsided.
- Report the behavior to the client's case workers so that the family can benotified.
- C. Assign the UAP to remain with the client at all times.

D. Document the behavior in the client's record and notify the HCP.

- A homeless client who reports feeling sad and depressed tells the mental health nurse that in the past 2 days she has only had 4 hours of sleep. Which action is most important for the RN to implement within the first 24 hours after treatment is initiated?

- Allow sleep.
- Ensure client attend groups addressing coping skills for dealing with depression.