c. Denial

The nurse should expect the client to initially deny the reality of the diagnosis. This is a protective reaction that serves to protect the client from psychological pain.

d. Anger

The nurse should expect the client to exhibit anger during the grief process; however, there is another response that is expected first.

32. A nurse is caring for a client with Alzheimer Disease and becomes agitated while refusing morning hygiene care. Which of the following actions should the nurse take? CORRECT

a. Talk to the client from two arm-lengths away.

The nurse should talk calmly and quietly to the client to decrease her agitation. The nurse should remain one to two arm-lengths away to provide her with a sense of personal space and maintain safety if she becomes aggressive.

b. Obtain assistance to restrain the client for safety.

The nurse should identify that the client's refusal of care is not a justification for restraints. The nurse should apply restraints only if her behavior becomes a threat to her safety or the safety of others.

c. Firmly state to the client that morning care will be performed.

The nurse should recognize that the client has a right to refuse care. Telling her that care will be performed, despite refusal, can increase her anxiety and agitation.

d. Call the provider to request a prescription for an antipsychotic medication.

c. The client is 50 years of age

d. The client is female

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

a. Identify the client's usual coping style

b. Help the client focus on a wide variety of topics regarding the crisis

c. Tell the client that his life will soon return to normal

d. Encourage the client to display anger toward the cause of the crisis

29. A nurse is caring for a client who has schizophrenia and is 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. Focustheclient on reality-based topics

30. 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

31. 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. The client demonstrates that he is oriented to person, place, and time

d. The client is able to follow commands

43. A nurse is caring for a client who states, “Things will never work out.” Which of the following responses should the nurse 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.”

44. A nurse in an emergency department is caring for a client who reports a recent sexual assault by her partner. Which of the following statements is the priority for the nurse make?

a. “I want you to know that you are in a safe place here.”

b. “I can contact a support person for you.”

c. “A trained sexual-assault nurse will be assigned to your care.”

d. “I can provide information about an advocacy group in your area”

45. After assessing a client in a crisis situation, a nurse determines 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

46. 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

B. Impulsive decision making
C. Delayed reflexes
D. Restlessness
E. Need for reassurance

A nurse is caring for a client who has body dysmorphic disorder. Which of the following actions should the nurse plan to take first?

A. Assessing the client's risk for self harm
B. Instilling hope for positive outcomes
C. Encouraging the client to participate in group therapy sessions
D. Encouraging the client to participate in treatment decisions

A nurse is caring for a client who has acute stress disorder and is experiencing severe anxiety. Which of the following statements should the nurse make?

A. "Tell me about how you are feeling right now."
B. "You should focus on the positive things in your life to decrease your anxiety."
C. "Why do you believe you are experiencing this anxiety?"
D. "Let's discuss the medications your provider is prescribing to decrease your anxiety."

A nurse working on an acute mental health unit is caring for a client who has PTSD. Which of the following findings should the nurse expect? (Select all that apply)

A. Difficulty concentrating on tasks
B. Obsessive need to talk about the traumatic event
C. Negative self-image
D. Recurring nightmares
E. Diminished reflexes

A nurse is involved in a serious and prolonged mass casualty incident in the emergency department. Which of the following strategies should the nurse use to help prevent developing a trauma-related disorder? (Select all that apply)

The nurse should ask questions about the past few days when assessing the client's recent memory.

"What is today's date?"

The nurse should ask the client about the current date when assessing the client's orientation.

A nurse is administering an oral sedative to a client who is receiving care following an involuntary admission. The client states, "I'm not taking any more medication." Which of the following actions should the nurse take?

Administer the medication by another route.

It is beyond the nurse's scope of practice to administer a medication by a route other than what was prescribed by the provider.

3. A nurse is collecting an admission history for a client who has acute stress disorder (ASD). Which of the following information should the nurse expect to collect?
   D. The client expresses a sense of unreality about the traumatic incident. The client who has ASD often expresses dissociative manifestations regarding the event, which includes a sense of unreality.

4. A nurse is caring for a client who has derealization disorder. Which of the following findings should the nurse identify as an indication of derealization?
   C. The client states that the furniture in the room seems to be small and far away.

5. A nurse in an acute mental health facility is planning care for a client who has dissociative fugue. Which of the following interventions should the nurse add to the plan of care?
   D. Work with the client on grounding techniques. Grounding techniques, such as stomping the feet, clapping the hands, or touching physical objects, are useful for clients who have a dissociative disorder and are experiencing manifestations of derealization.

Chapter 19 – Eating Disorders

1. A nurse is preparing to obtain a nursing history from a client who has a new diagnosis of anorexia nervosa. Which of the following questions should the nurse to include in the assessment? (select all that apply.)
   A. "What is your relationship like with your family?" A nursing history of a client who has anorexia nervosa should include an assessment of family and interpersonal relationships.
   C."Would you describe your current eating habits?"
   E. "Can you discuss your feelings about your appearance?"

2. A nurse is caring for an adolescent client who has anorexia nervosa with recent rapid weight loss and a current weight of 90 lb. Which of the following statements indicates the client is experiencing the cognitive distortion of catastrophizing?
   A. "Life isn't worth living if I gain weight." this statement reflects the cognitive distortion of catastrophizing because the client's perception of her appearance or situation is much worse than her current condition.

3. A nurse is performing an admission assessment of a client who has bulimia nervosa with purging behavior. Which of the following is an expected finding? (select all that apply.)
   B. Hypokalemia
   D. slightly elevated body weight. Most clients who have bulimia nervosa maintain a weight within a normal range or slightly higher.

Question: 22 of 50

SHOW HINT

A nurse is providing teaching to the family of a client who has Alzheimer's disease about donepezil. Which of the following statements should the nurse include in the teaching?

- "Donepezil can improve cognitive functioning during the earlier stages of the disease."
- "Donepezil cures the disease process if it is started upon first recognition of dementia."
- "Donepezil provides long-term reversal of memory loss in the last phase of the disease."
- "Donepezil accelerates the breakdown of acetylcholine within the client's brain."

Question: 23 of 50

SHOW HINT

A nurse is assessing a client who has binge-eating disorder. Which of the following findings should the nurse expect?

- Amenorrhea
- Abdominal pain
- Restricted caloric intake
- Frequent use of laxatives

32) A nurse is teaching the partner of a client who has bipolar disorder how to identify manifestations of acute mania. Which of the following findings should the clients partner report to the provider?

-Obsessive attention to detail
During the manic phase of bipolar disorder, a client's behavior becomes disorganized and chaotic, which renders the client unable to focus on detail.

-Inability to sleep
During acute mania, the client is extremely active and does not sleep, which can lead to relapse. Therefore, the nurse should instruct the partner to report this finding.

-Reports of fatigue
Although the client who is experiencing acute mania may eventually become exhausted, there is a characteristic unawareness of fatigue during this phase.

-Isolation from others
Clients in the manic phase of bipolar disorder often talk and joke incessantly and are highly interactive.

33) A nurse is talking with a client who has beginning chemotherapy. The client tells the nurse that she is mourning the loss of her hair. Which of the following actions should the nurse take first?

-Recommend the client shave her hair.
The nurse can recommend that the client shave her hair. However, there is another action the nurse should take first.

-Suggest wearing a scarf to cover her hair loss.
The nurse should suggest wearing a scarf to the client to cover her hair loss as a part of anticipatory grieving. However, there is another action the nurse should take first.

-Discuss the importance of hair with the client.
The first action the nurse should take using the nursing process is to assess the client's needs. The experience of anticipatory grieving begins with acknowledging the importance of the expected loss.

-Provide information on resources for obtaining a wig.
The nurse should provide the client with information on resources for obtaining a wig. However, there is another action the nurse should take first.

34)A nurse is caring for four clients in an inpatient mental health facility. Which of the following clients can give informed consent?

-A 17-year-old client who lives with friends
Individuals younger than 18 years of age can only provide informed consent if they are married, pregnant, parents, or emancipated.

-A 50-year-old client who has a blood alcohol level of 0.08
A client who is intoxicated cannot legally give informed consent.

-A 35-year-old client who has major depressive disorder
A client who has major depressive disorder is capable of making health care decisions unless the client is determined to be legally incompetent.

-A 65-year-old client who just received a dose of morphine
A client who has just received morphine, an opioid analgesic, is functionally incompetent due to the medication's effect on the CNS.

35) A nurse is caring for an older adult client who is experiencing delirium. Which of the following intervention should the nurse include in the clients plan of care?

-Offer the client various choices for meal selection.
Clients who have delirium may become easily frustrated when presented with too many decisions to make.

-Assign different nursing personnel for each shift.
Clients who have delirium should have consistent caregivers.

-Permit the client to perform daily rituals to decrease anxiety.
Allowing clients who have delirium to practice daily rituals will decrease frustration and anxiety.

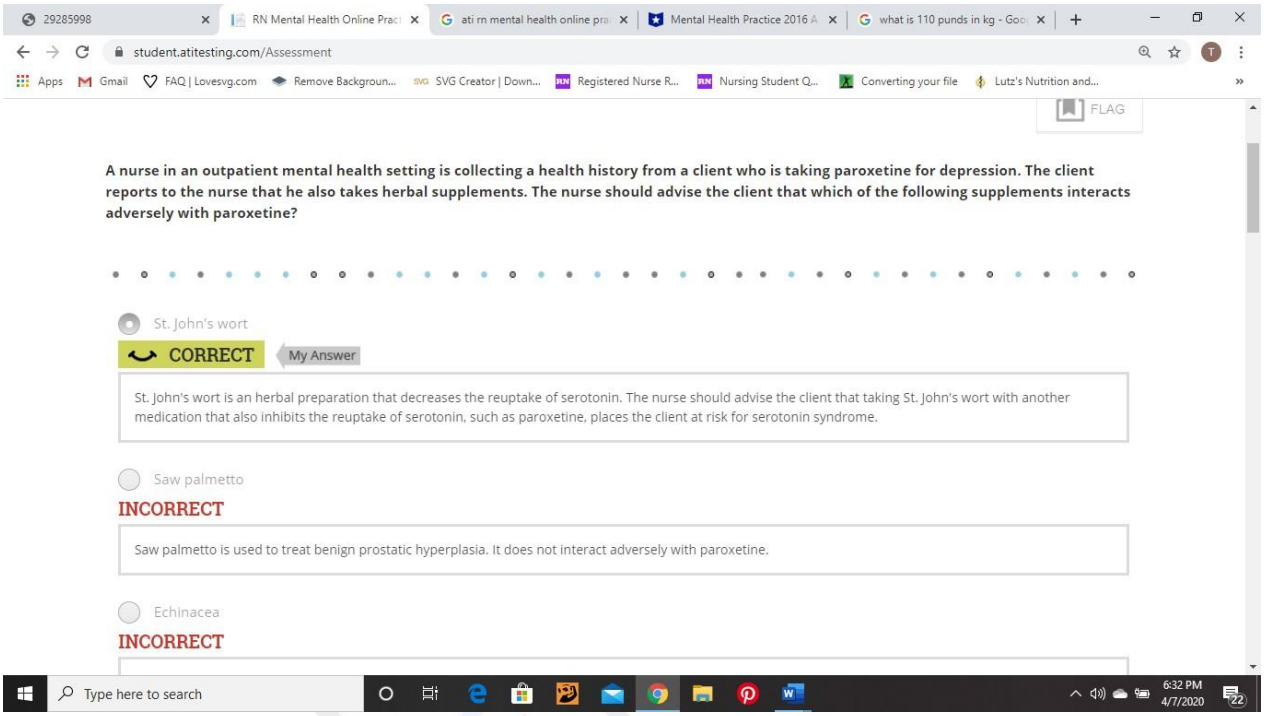
-Maintain an environment that has low lighting.
Clients who have delirium should have a well-lit environment to decrease shadows and minimize misinterpretation of stimuli.

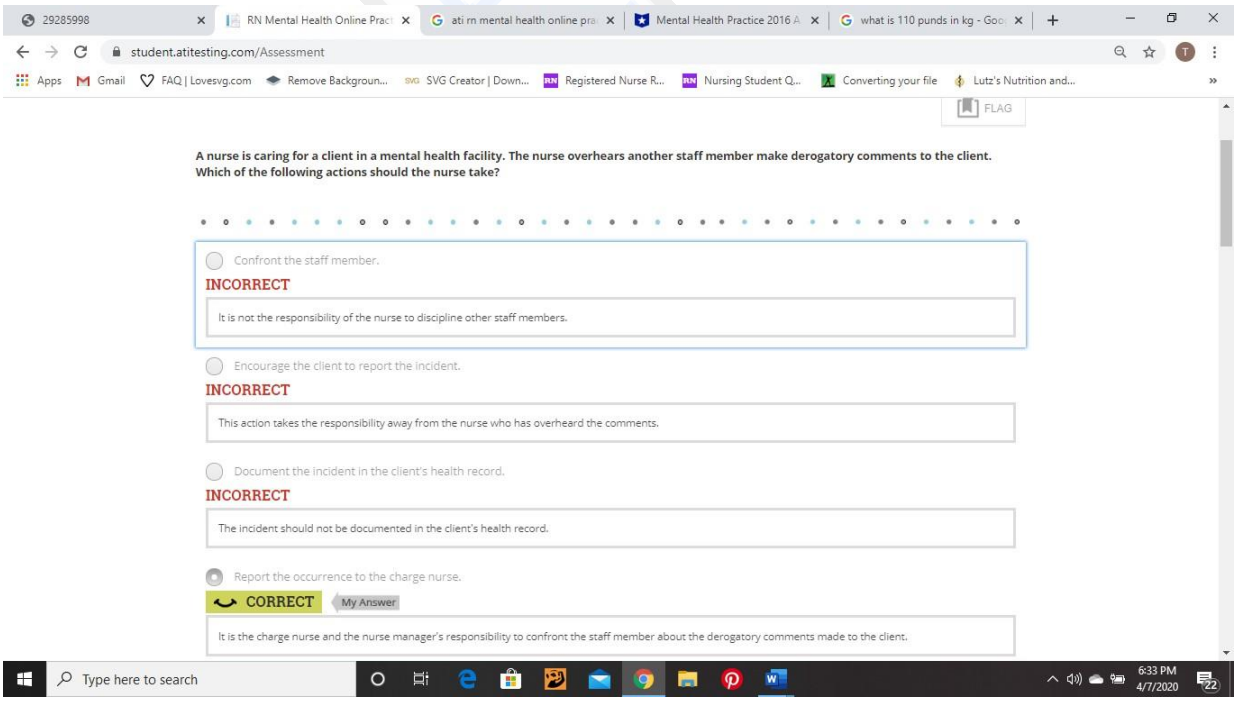
36) A nurse is assessing a client who is experiencing opioid withdrawal. Which of the following manifestations should the nurse expect?

-Sedation
The nurse should expect the client experiencing opioid withdrawal to have insomnia.

-Rhinorrhea
The nurse should expect the client who is experiencing opioid withdrawal to have rhinorrhea and flu-like manifestations such as yawning, sneezing, and abdominal pain.

-Bradycardia
The nurse should expect the client experiencing opioid withdrawal to have tachycardia.





Urinary retention is an anticholinergic effect of amitriptyline. Therefore, the nurse should monitor for this as an adverse effect.

c.

d.

Loose stools

An overdose of amitriptyline can result in anticholinergic effects and the client is more likely to experience constipation rather than loose stools.

Fever

Fever is not an adverse effect of an overdose of amitriptyline.

Dyspnea

Dyspnea is not an adverse effect of an overdose of amitriptyline.

55. A nurse is caring for a client who has alcoholic cardiomyopathy. Which of the following laboratory findings should the nurse expect

a. Increased creatine phosphokinase (CPK)

An increase in CPK, a muscle enzyme released when muscle tissue is damaged, occurs with cardiomyopathy.

b.

c.

d.

Increased low-density lipoproteins (LDL)

LDL does not increase when a client is experiencing alcoholic cardiomyopathy.

Decreased fasting blood glucose (FBG)

FBG does not decrease when a client is experiencing alcoholic cardiomyopathy.

Decreased aspartate aminotransferase (AST)

AST does not decrease when a client is experiencing alcoholic cardiomyopathy.

56. A nurse is teaching a client who has a depressive disorder about fluoxetine. Which of the following information should the nurse include in the teaching

X = 1.5

STEP 7: Round if necessary.

STEP 8: Reassess to determine whether the amount to administer makes sense. If there are 5 mg/mL and the prescription reads 7.5 mg, it makes sense to administer 1.5 mL. The nurse should administer diazepam 1.5 mL IV bolus.

Desired Over Have

STEP 1: What is the unit of measurement the nurse should calculate? mL

STEP 2: What is the dose the nurse should administer? Dose to administer = Desired 7.5 mg

STEP 3: What is the dose available? Dose available = Have 5 mg

STEP 4: Should the nurse convert the units of measurement? No

STEP 5: What is the quantity of the dose available? 1 mL

STEP 6: Set up an equation and solve for X.

Desired x Quantity/Have = X

7.5 mg x 1 mL/5 mg = X mL

1.5 = X

STEP 7: Round if necessary.

STEP 8: Reassess to determine whether the amount to administer makes sense. If there are 5 mg/mL and the prescription reads 7.5 mg, it makes sense to administer 1.5 mL. The nurse should administer diazepam 1.5 mL IV bolus.

Dimensional Analysis

STEP 1: What is the unit of measurement the nurse should calculate? mL

STEP 2: What is the quantity of the dose available? Quantity 1 mL

STEP 3: What is the dose available? Dose available = Have 5 mg

STEP 4: What is the dose the nurse should administer? Dose to administer = Desired 7.5 mg

STEP 5: Should the nurse convert the units of measurement? No

STEP 6: Set up an equation and solve for X.

X = Quantity/Have x Conversion (Have)/Conversion (Desired) x Desired/

X mL = 1 mL/5 mg x 7.5 mg/

X = 1.5

STEP 7: Round if necessary.

STEP 8: Reassess to determine whether the amount to administer makes sense. If there are 5 mg/mL and the prescription reads 7.5 mg, it makes sense to administer 1.5 mL. The nurse should administer diazepam 1.5 mL IV bolus.

60. A nurse is caring for a client who is taking clozapine. For which of the following findings should the nurse withhold the medication?

a. The client reports a sore throat.

Clozapine can lead to a potentially fatal blood disorder known as agranulocytosis. Agranulocytosis is a severe drop in a client's WBCs, which leaves the client highly susceptible to infection. The nurse should withhold the medication for any indications of infection and notify the provider.

b. The client reports being constipated for 2 days.

Constipation is an expected adverse effect of clozapine. Increasing fluid and fiber intake or the administration of stool softeners will decrease the risk for constipation.

c. The client reports feeling dizzy when getting out of bed.

Orthostatic hypotension is an expected adverse effect of clozapine. Encouraging the client to rise slowly when transitioning from a sitting to a standing position will help to prevent falls and will increase client safety.

d. The client has gained 1.4 kg (3 lb) in the past month.

Weight gain is an expected adverse effect of clozapine. Following a calorie-controlled diet and participating in regular exercise can help minimize weight gain.

Rationale:

Several atypical antipsychotic medications can cause significant weight gain, so the client should be advised to maintain a balanced diet and adequate exercise. Option B is important with lithium, a mood stabilizer. Options C and D are less common than weight gain.

16. The nurse admits a client with depression to the mental health unit. The client reports difficulty concentrating, has lost 10 pounds in 2 weeks, and is sleeping 12 hours a day. Which outcome is most important for the client to meet by discharge?

A. Tries to interact with a few peers and staff.

B. Reports feeling better and less depressed.

C. Sits attentively with peers in group therapy.

D. Easily awakens for morning medications.

Rationale:

The client is experiencing symptoms of depression, and the outcome by discharge for this client would be that the client reports feeling better and less depressed. The client may interact with peers and staff and sit attentively in groups without any improvement in depression. Difficulty awakening is usually caused by the medication regimen for depression, so awakening is not an indication of

the client's symptoms as age-related. Setting goals for the nursing care plan is a function of the nurse, although the nurse can collaborate with the treatment team.

49. A 22-year-old client is admitted to the psychiatric unit from the medical unit following a suicide attempt with an overdose of diazepam. When developing the nursing care plan for this client, which intervention would be most important for the nurse to include?

A. Assist client to focus on personal strengths.
B. Set limits on self-defacing comments.
C. Remind the client of daily activities in the milieu.
D. Assist the client to identify why he or she was self-destructive.

Rationale:

Encouraging the client to focus on his or her strengths helps the client become aware of positive qualities, assists in improving self-image, and aids in coping with past and present situations. Although nursing actions should assist the client in decreasing self-defacing comments and informing the client of daily activities in the milieu, these interventions are not priorities at this time. Option D is not as important as assisting the client to overcome the depression, which resulted in the overdose, and asking "why" is not therapeutic.

50. A client mumbles out loud whether anyone is talking to her or not, and the client also mumbles in group when others are talking. The nurse determines that the client is experiencing hallucinations. Which intervention should the nurse implement?

A. Respond to the client's feelings rather than the

32. Which client statement suggests to the nurse that the client is using the defense mechanism of projection to deal with anxiety related to admission to a psychiatric unit?

- I am here because the police thought I was doing something wrong

33. 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 the 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 disturbances, the client shouts," I am the boss here. I do what I want." Which nursing problem best supports these observations?

- Risk for other related violence related to disruptive

34. What is the most important goal for a client diagnosed with major depression who has been receiving an antidepressant medication for two weeks?

- not attempt to commit suicide

35. Alcohol-Pancreatitis health assessment of history of alcohol dependency WHAT ELSE WOULD BE A CONCERN?

- pancreatitis

36. Anorexia Nervosa-syncope Syncope is a clinical feature of?

- Abuse-BAL-

37. Admission A female client with a history of drinking who was admitted 8 hours ago after receiving treatment for minor abrasions occurred from a fall at home. The nurse determines the client's blood alcohol level (BAL) was not analyzed on administration, What action should the nurse take?

- Blood alcohol level- ask the client about alcohol quantity, frequency, and time of the last drink.

38. IPV- difficulty leaving victim of intimate partner violence what 3 things should you do?

- establish a code with family and friends to signify violence
- plan an escape route to use if the abuser blocks main exit