DO NOT WRITE ON THE TEST

Select the best answer record your answers on the attached answer sheet.

1. The nurse is assigned to care for a client who is experiencing Altered Thought Processes. The nurse is told that the client believes that the food is being poisoned. Which type of communication technique does the nurse plan to use to encourage the client to discuss feelings?
   a. Using open ended questions and silence.
   b. Offering opinions about the necessity of adequate nutrition.
   c. Telling the client about the importance of eating.
   d. Focusing on self-disclosure regarding food preferences.

2. A client who has just been sexually assaulted is very quiet and calm. The nurse identifies this behavior as indicative of which defense mechanism?
   a. Denial.
   b. Projection.
   c. Rationalization.
   d. Intellectualization.

3. Laboratory work is prescribed on a client who has been experiencing delusions. When the laboratory technician approaches the client to obtain a specimen of the client's blood, the client begins to shout, "You're all vampires. Let me out of here!" The nurse who is present at the time makes which of the following most appropriate responses?
   a. "The technician is not going to hurt you but is going to help you."
   b. "What makes you think that the technician is a vampire?"
   c. "The technician will leave and come back later for your blood."
   d. "It must be fearful to think others want to hurt you."

4. A client is admitted to a psychiatric unit for treatment of psychotic behavior. The client is at the locked exit door and is shouting, "Let me out. There's nothing wrong with me. I don't belong here." The nurse identifies this behavior as:
   a. Projection.
   b. Denial.
   c. Regression.
   d. Rationalization.

5. The nurse employed in a psychiatric unit is assigned to care for a client admitted to the unit 2 days ago. On review of the client's record, the nurse notes that the admission was an informal voluntary admission. Based on this type of admission, the nurse expects which of the following?
   a. The client will be very resistant to treatment measures.
   b. The client's family will be very resistant to treatment measures.
   c. The client will be angry and will refuse care.
   d. The client will participate in the treatment plan.

6. A client is admitted to the psychiatric nursing unit. When collecting data from the client, the nurse notes that the client is admitted by involuntary status. Based on this type of admission, the nurse most likely expects that the client:
   a. Presents a harm to self.
   b. Requested the admission.
   c. Consented to the admission.
   d. Provided written application to the facility for admission.

7. The client was involuntarily admitted to the psychiatric unit because of episodes of extremely violent behavior. The client is demanding to be discharged from the hospital. The licensed
practical nurse (LPN) sees that the RN does not allow the client to leave. The LPN understands that which of the following represents the legal ramifications associated with the RN's behavior.

a. The RN will be charged with imprisonment.
b. The RN will be charged with assault.
c. The RN will be charged with slander.
d. No charge will be made against the RN Because the RN's actions are reasonable.

8. An 18-year-old woman is admitted to an inpatient unit with the diagnosis of anorexia nervosa. A behavioral approach is used as part of the treatment plan. The nurse understands that the purpose of this approach is to:

a. Help the client identify and examine dysfunctional thought and beliefs.
b. Emphasize social interaction with clients who withdraw.
c. Provide a supportive environment.
d. Examine conflicts and past issues.

9. The nurse is assisting in conducting a group therapy session and a client with manic disorder is monopolizing the group. The most appropriate nursing action is which of the following?

a. Suggest that the client stop talking and try to listen to others.
b. Ask the client to leave.
c. Tell the client to stop monopolizing the group.
d. Refer the client to another group.

10. A client is admitted to the hospital with a diagnosis of major depression- severe, single episode. The nurse collects data on the client and identifies that a major concern is the client's altered nutrition related to poor nutritional intake. The most appropriate nursing intervention related to this concern is:

a. Explain to the client the importance of a good nutritional intake.
b. Weigh the client three times per week, before breakfast.
c. Report the nutritional concern to the psychiatrist and obtain a nutritional consult as soon as possible.
d. Consult with the nutritionist, offer the client several small frequent meals per day, and schedule brief nursing interactions with the client during these times.

11. Disulfiram (Antabuse) is prescribed for a client with a problem related to alcohol. The nurse understands that this medication works on the principle of which of the following therapies?

a. Desensitization.
b. Self-control therapy.
c. Milieu therapy.
d. Aversion therapy.

12. A depressed client is ready for discharge. The nurse feels comfortable that the client has a good understanding of the disease process when the client states:

a. "I'll never let this happen to me again. I won't let my boss or my job or family get to me!"
b. "It's important for me to eat well, exercise, and to take my medication. If I begin to lose my appetite or not sleep well, I've got to get in to see my doctor.
c. "I've learned I am a good person and that I am worthy of giving and receiving love. I don't need anyone; I have myself to rely on!"
d. "I don't know what happened to me. I've always been able to make decisions for myself and for my business. I don't ever want to feel so weak or vulnerable again!"

13. The nurse collects data on a client with the admitting diagnosis of bipolar affective disorder —mania. The symptom presentation that requires the nurse's immediate intervention is:

a. The client's outlandish behavior and inappropriate dress.
b. The client's grandiose delusions of being a royal descendent of King Arthur.
c. The client's nonstop physical activity and poor nutritional intake.
d. The client's constant, incessant talking, which includes sexual innuendoes and teasing staff.
14. A male client with delirium becomes agitated and confused in his room at night. The best initial intervention by the nurse is:
   a. Use a nightlight and turn off the television.
   b. Keep the television on during the night and a soft light.
   c. Move the client next to the nurse's station.
   d. Play soft music during the night, and maintain a well-lit room.

15. The client is admitted is to the inpatient unit and is being considered for electroconvulsive therapy (ECT). The client's mother begins to cry and states, "My son's brain will be destroyed. How can the doctor do this to min?" The nurse's best response is:
   a. "It sounds as though you need to speak to the psych."
   b. "Your son has decided to have this treatment. You should be supportive of him."
   c. "Perhaps you'd like to see the ECT room and speak to the staff."
   d. "It sounds as though you may have some concerns about the ECT procedure. Why don't we sit down together and discuss any concerns you may have."

16. The client is unwilling to go out of the house for fear of "doing something crazy in public." Because of this fear, the client remains homebound except when accompanied outside by the spouse. The nurse analyzes this information and determines that the diagnosis is:
   a. Social phobia.
   b. Agoraphobia.
   c. Claustrophobia.
   d. Hypochondria.

17. The manic male client announces to everyone the dayroom that a stripper is coming to perform this evening. When the psychiatric aide firmly states that this will not happen, the manic client becomes verbally abusive and threatens physical violence to the aide. Based on the analysis of this situation, the nurse determines that the most appropriate next action is to:
   a. With assistance, escort the manic client to his room and administer haloperidol (Haldol) PRN.
   b. Tell the client that smoking privileges are revoked for 24 hours.
   c. Orient the client to time, person and place.
   d. Tell the client that the behavior is not appropriate.

18. The nurse is assisting in preparing a teaching plan for the client who is taking lithium carbonate (Eskalith). Which of the following in not a component of the teaching plan?
   a. Lithium blood levels must be monitored very closely.
   b. Stop taking the medication if excessive diarrhea, vomiting, or diaphoresis occurs.
   c. Take the lithium with meals.
   d. Decrease fluid intake while taking the lithium.

19. The client with a psychotic disorder is being treated with haloperidol (Haldol). Which of the following indicates the presence of a toxic effect of this medication?
   a. Hypotension.
   b. Nausea.
   c. Excessive salivation.
   d. Blurred vision.

20. Buspirone Hydrochloride (BuSpar) is prescribed for a client with an anxiety disorder. The nurse instructs the client that which of the following is characteristic of this medication?
   a. The medication can produce a sedating effect.
   b. Tolerance can occur.
   c. The medication is addicting.
   d. Dizziness and nervousness may occur.
21. The nurse is caring for a hospitalized client who has been taking clozapine (Clozaril) for the treatment of a schizophrenic disorder. The nurse evaluates the laboratory studies that have been prescribed for the client. Which of the following laboratory studies does the nurse specifically review to monitor for an adverse reaction associated with the use of this medication?
   a. WBC count.
   b. Platelet count.
   c. Cholesterol level.
   d. Blood urea nitrogen.

22. Neuroleptic malignant syndrome is suspected in a client who is taking chlorpromazine (Thorazine). Which of the following medications does the nurse prepare in anticipation of being prescribed to treat this adverse reaction related to the use of chlorpromazine?
   a. Phytonadione (vitamin K).
   b. Bromocriptine (Parlodel).
   c. Enalapril mateate (Vasotec).
   d. Protamine sulfate.

23. Fluoxetine hydrochloride (Prozac) is prescribed for the client. The nurse provides instructions to the client regarding the administration of the medication. Which of the following statements if made by the client indicates an understanding regarding the administration of the medication?
   a. "I should take the medication right before bedtime."
   b. "I should take the medication with my evening meal."
   c. "I should take the medication at noon time with an antacid."
   d. "I should take the medication in the morning when I first arise."

24. A client receiving thioridazine (Mellaril) complains of feeling very "faint" when trying to get out of bed in the morning. The nurse recognized this complaint as a symptom of:
   a. Psychosomatic symptoms.
   b. Cardiac dysrhythmias.
   c. Respiratory insufficiency.
   d. Postural hypotension.

25. Fluphenazine (Prolixin) is administered to a client daily. The nurse prepares a plan of care for the client. Which of the following does the nurse include in the plan of care?
   a. Monitor the blood pressure every 2 hours.
   b. Review the WBC results daily.
   c. Offer a frequent snack between meals.
   d. Offer hard candy or gum periodically.
PSYCHIATRIC NURSING COMPETENCY TEST

ANSWER WORKSHEET

Name: ___________________________ Date: ___________________________

1. ___________________________ 14. ___________________________

2. ___________________________ 15. ___________________________

3. ___________________________ 16. ___________________________

4. ___________________________ 17. ___________________________

5. ___________________________ 18. ___________________________

6. ___________________________ 19. ___________________________

7. ___________________________ 20. ___________________________

8. ___________________________ 21. ___________________________

9. ___________________________ 22. ___________________________

10. ___________________________ 23. ___________________________

11. ___________________________ 24. ___________________________

12. ___________________________ 25. ___________________________

13. ___________________________

Total Score: _______________________

Passing Score: 20/25=80%