ATI MENTAL HEALTH 2020 B NGN QUESTIONS

1. A nurse is caring for a client who is experiencing opioid withdrawal. Which of the following medications should the nurse expect to administer?

A. Naltrexone

B. Bupropion

C. Varenicline

D. Phenobarbital

Answer:

A. Naltrexone

The nurse should expect to administer naltrexone, an opioid antagonist, to a client who is experiencing opioid withdrawal.

2. A nurse is collecting data from a client who is experiencing alcohol withdrawal. Which of the following findings should the nurse expect?

A. Elevated blood pressure

B. Decreased heart rate

C. Slurred speech

D. Rhinorrhea

Answer:

A. Elevated blood pressure

Hypertension is an expected finding of alcohol withdrawal and can occur within 4 to 12 hr of cessation of alcohol ingestion.

3. A nurse is planning to collect data from a group of clients. A nurse should expect that which of the following clients is likely to exhibit speech pattern alterations?

A. A client who has antisocial personality disorder

B. A client who has dependent personality disorder

C. A client who has bulimia nervosa

D. A client who has schizophrenia

Answer:

D. A client who has schizophrenia

The nurse should expect a client who has schizophrenia to exhibit alterations in behavior, alterations in perception, and alterations in their speech pattern. Speech pattern alterations include associative looseness, clang association, neologisms, and echolalia.

4. A nurse is collecting data from a client with a history of cocaine use. Which of the following findings is an indication that the client is experiencing cocaine toxicity?

A. Hypothermia

B. Piloerection

C. Somnolence

D. Seizures

Answer:

D. Seizures

The nurse should expect a client who is experiencing cocaine toxicity to experience seizures. Other findings include severe anxiety, hallucinations, and paranoid thoughts.

5. A nurse on a mental health unit is caring for four clients who have schizophrenia. Which of the following clients should the nurse see first?

A. A client who has anergia

B. A client who demonstrates blunted affect

C. A client who demonstrates concrete thinking

D. A client who is experiencing command hallucinations

Answer:

D. A client who is experiencing command hallucinations

Because command hallucinations are a risk factor for violence, the greatest risk to this client is injury to self or others. Therefore, the nurse should see this client first.

6. A nurse is caring for a client who is undergoing behavioral therapy for PTSD. The nurse should identify that which of the following findings indicates an improvement in the clients condition?

A. The client reports about techniques they use to promote sleep.

B. The client shows limited emotion when discussing witnessing a traumatic event.

C. The client states that they no longer feel like they can trust their partner.

D. The client avoids situations that might trigger memories of past trauma.

Answer:

D. The client avoids situations that might trigger memories of past trauma.

Clients who have PTSD frequently experience disrupted sleep. Therefore, reporting about techniques they use to promote sleep demonstrates that the client's condition has improved.

7. A nurse is reinforcing teaching with a client who has a new prescription for phenelzine. The nurse should instruct the client that eating foods containing in tyramine can cause which of the following adverse reactions with this medication?

A. Hypertensive crisis

B. Serotonin syndrome

C. Hearing loss

D. Urinary incontinence

Answer:

A. Hypertensive crisis

Tyramine can cause severe hypertension in clients who are taking phenelzine, a monoamine oxidase inhibitor. Manifestations include palpitations, stiff neck, headache, nausea, vomiting, and elevated temperature.

8. A nurse is caring for a client who has dementia. Which of the following actions should the nurse take?

A. Keep the client's room dark at night.

B. Alternate the client's caregivers on a routine basis.

C. Stand in front of the client when speaking.

D. Remove personal belongings from the client's room.

Answer:

C. Stand in front of the client when speaking.

The nurse should stand in front of the client when speaking to them to maintain eye contact and maximize the client's understanding of the conversation.