Chapter 11 Pre Test

Smith,Crystal

Submitted: 1/28/2011 10:53:19 PM **Grade:** 21.2% **Attempt Number:** 1/3 **Questions Attempted:** 33/33

1. **A client is being admitted to the mental health unit for depression following a battering incident with his significant other. The nurse will document this under Axis IV. After the nurse completes the physical assessment, the nurse may need to place data under Axis:**
   a. V.
   b. III.
   c. II.
   d. I.

   Grade: 0
   User Responses: c.II.
   Feedback: a.Rationale: The nurse may need to place the data under Axis III, which includes general medical conditions, which would include physical needs related to the battering. Axis I is Adult and Child Clinical Disorders and Conditions not attributable to a mental disorder that are a focus of clinical attention. Axis II is used to identify Personality Disorders and Mental Retardation. Axis V is a Global Assessment of Functioning (GAF) and relates how the client is functioning as a biopsychosocial being at a given period in time.
   Cognitive Level: Analysis
   Nursing Process: Assessment
   Client Need: Psychosocial Integrity

2. **The nurse documents that a client had an alcohol dependence problem, but is in remission when she is in a controlled environment. The nurse documents this under the Axis I diagnosis. A utilization review nurse at the facility is reviewing the chart and does not locate any information related to the client's alcohol dependence problem. What action should be taken to support the diagnosis?**
   a. Document the gap in continuity of care based on lack of data.
   b. The client should be assessed and data entered in the record.
   c. Nothing is indicated.
   d. Report the lack of information to the supervisor.

   Grade: 0
   User Responses: c.Nothing is indicated.
   Feedback: a.Rationale: The client should be assessed and date entered in the record in order to provide support for this diagnosis. If the data does not support the diagnosis, it will be taken off the client's problem list. There is a gap in the information, so the nurse must take action to ensure that client data is complete and accurate. Reporting the lack of information to the supervisor will not directly facilitate the need for accurate data. Based on the information above, there is no indication that continuity of care was interrupted.
   Cognitive Level: Analysis
   Nursing Process: Assessment
   Client Need: Psychosocial Integrity

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3. **The nurse uses information from Axis III when planning care to meet the client's:**
   a. Discharge needs.
   b. Medical needs.
   c. Psychiatric needs.
   d. Psychosocial needs.

   Grade: 0
   User Responses: c.Psychiatric needs.
   Feedback: a.Rationale: Clinicians use Axis III to record physical disorders and medical conditions that must be taken into account in planning treatment, or that are relevant to understanding the etiology or worsening of the mental disorder.
   Cognitive Level: Analysis
   Nursing Process: Planning
   Client Need: Physiological Integrity

4. **A client presents to the mental health unit and asks to speak to the nurse. When the nurse first interacts with the client, the nurse will begin:**
   a. The assessment process.
   b. Planning to care for the client.
   c. Implementing nursing interventions.
   d. Evaluating the client's problems.

   Grade: 0
   User Responses: c.Implementing nursing interventions.
   Feedback: a.Rationale: The nursing process begins with the assessment for the purpose of collecting and analyzing objective and subjective data about the client. A comprehensive assessment enables the nurse to make sound clinical judgments and plan appropriate interventions.
   Cognitive Level: Application
   Nursing Process: Assessment
   Client Need: Psychosocial Integrity

5. **The nurse will collect data:**
   a. By involving the client in establishing goals.
   b. By encouraging the client to share his or her problems during group.
   c. By identifying the client's strengths.
   d. Using a systematic process.

Grade: 0
User Responses: c.By identifying the client's strengths.
Feedback: a.Rationale: The nurse collects data in a systematic and ongoing manner. Encouraging the client to share his or her problems during group is a nursing intervention and not related to collecting data. Identifying client strengths occurs after the data is collected. Involving the client in establishing goals is part of the planning component.
Cognitive Level: Application
Nursing Process: Assessment
Client Need: Psychosocial Integrity

6. **The nurse is completing the client's admission information and will include both primary and secondary sources from which of the following entries?**
   a. Client voices he is not a threat to others; mother reports client broke into gun cabinet; client arrested for threatening family members.
   b. Friends of the client report his behavior is "more bizarre than usual."
   c. Client states his mood is sad; at present is sitting in chair in day room, watching TV, and laughing.
   d. The client's family is recommending residential treatment.

Grade: 0
User Responses: c.Client states his mood is sad; at present is sitting in chair in day room, watching TV, and laughing.
Feedback: a.Rationale: The client is the primary source for data. Secondary sources include family, friends, police, mental health personnel, and others who may contribute data to the psychiatric history. "Client voices he is not a threat to others; mother reports client broke into gun cabinet; police report indicates client arrested for threatening family members.": This example uses both primary (client) and secondary sources (mother and police report). "Client states his mood is sad; at present is sitting in chair in day room, watching TV, and laughing.": In this example data is obtained from the just the primary source (the client). "The client's family is recommending residential treatment.": This is neither primary nor secondary data; this is a request and not data about the client. Friends of the client report his behavior is "more bizarre than usual" : This is an example of secondary data because the information about the client's behavior is being supplied by a source other than the client.
Cognitive Level: Application
Nursing Process: Assessment
Client Need: Safe, Effective Care Environment

7. **Which of the following will the nurse use to gather more data necessary to deal with any risk of violence or harm?**
   a. The client's personal history.
   b. The Mental Status Examination.
   c. A physical examination.
   d. Information obtained from a client's sibling.

Grade: 0
User Responses: c.A physical examination.
Feedback: a.Rationale: The primary purpose of the Mental Status Examination is to help the examiner gather more objective data to be used in determining etiology, diagnosis, prognosis, and treatment, and to deal immediately with any risk of violence or harm at the time the client presents for care. Information obtained from a client's sibling and the client's personal history would be included in the psychiatric history. The physical examination includes an assessment of body systems.
Cognitive Level: Analysis
Nursing Process: Assessment
Client Need: Psychosocial Integrity

8. **When conducting a mental status examination, the nurse gathers data related to the client's:**
   a. Personality.
   b. Previous hospitalizations.
   c. Emotional state.
   d. Present symptoms.

Grade: 1
User Responses: c.Emotional state.
Feedback: a.Rationale: The client's emotional state is one of the components of the mental status examination. Data related to the client's previous hospitalizations, personality, and present symptoms are included in the psychiatric history.
Cognitive Level: Analysis
Nursing Process: Assessment
Client Need: Psychosocial Integrity

9. **When conducting a mental status examination, the examiner:**
   a. Selects which components are to be included.
   b. Must assess the client in a specific sequence.
   c. Ensures all components are addressed, but may vary the sequence.
   d. May eliminate some of the categories as needed.

Grade: 1
User Responses: c.Ensures all components are addressed, but may vary the sequence.
Feedback: a.Rationale: The examiner uses observation, listening, and interviewing techniques to assess the client's mental state to obtain information about the client's present mental state. In addition to gathering data the examiner attempts to establish rapport and help the client feel safe. Information may not unfold in a specific sequence.
Cognitive Level: Application
Nursing Process: Assessment
Client Need: Psychosocial Integrity

10. **During the Mental State Examination, the client provides the same response to all questions. The nurse documents the client's characteristic of speech as:**
    a. Circumstantial.
    b. Perseveration.
    c. Blocking.
    d. Orientation.

    Grade: 0
    User Responses: c.Blocking.
    Feedback: a.Rationale: Perseveration is a pattern of repeating the same words or movements despite apparent efforts to make a new response. The client who goes into cumbersome, convoluted, unnecessary detail is demonstrating circumstantiality. Blocking is associated with a pattern of sudden silence in the stream of conversation, for no obvious reason, but is often thought to be associated with intrusion of delusional thoughts or hallucinations. Orientation is related to the individual's awareness and is not a component of speech.
    Cognitive Level: Analysis
    Nursing Process: Assessment
    Client Need: Psychosocial Integrity

11. **During the Mental State Examination, the nurse asks the client to read a story and then talk about it, recalling as many details as possible in order to assess the client's:**
    a. General grasp and recall.
    b. Recall of remote past experiences.
    c. Insight.
    d. Recall of recent past experiences.

    Grade: 0
    User Responses: c.Insight.
    Feedback: a.Rationale: General grasp and recall is assessed by having the client read a story and then repeat the gist of the story to the examiner with as many details as possible. When testing recall of remote past experiences the examiner will ask for a review of the important events in the client's life, then compare the response with information obtained from other sources during the history taking. Recall of recent past experiences is assessed when the client discusses the events leading to the present seeking of treatment. Insight is often tested by asking the client for suggestions for their own treatment; this provides the examiner with information regarding the client's perception whether they feel the need for treatment, and how they explain the symptoms.
    Cognitive Level: Application
    Nursing Process: Assessment
    Client Need: Psychosocial Integrity

12. **A client states "I cannot die, I am invincible." The nurse documents the client's thought content as being consistent with:**
    a. Flight of ideas.
    b. Nihilistic delusions.
    c. Delusions of self-deprecation.
    d. Flat affect.

    Grade: 0
    User Responses: c.Delusions of self-deprecation.
    Feedback: a.Rationale: A client with nihilistic delusions more or less completely denies reality and existence, making statements that allude to the belief that nothing exists, or that everything is lost. Flat affect is indicated by an insufficiently intense emotional display in association with ideas or situations that ordinarily would call for a stronger response and is a component of the client's emotional tone, not content of thought. Delusions of self-deprecation are often seen in connection with severe depression. The client describes feeling unworthy, sinful, ugly, or foul-smelling. Flight of ideas is used to describe a characteristic of speech that consists of rapid, overly productive responses to questions that seem related only by chance associations between one sentence fragment and another.
    Cognitive Level: Analysis
    Nursing Process: Assessment
    Client Need: Psychosocial Integrity

13. **A client is being discharged from the mental health clinic. The nurse can use the client's initial Global Assessment of Functioning (GAF) score to:**
    a. Establish a medication regimen.
    b. Establish a time frame for outpatient care.
    c. Compare with the current score.
    d. Classify the client's clinical diagnosis.

    Grade: 1
    User Responses: c.Compare with the current score.
    Feedback: a.Rationale: The nurse can compare the client's GAF at admission to the level of functioning at discharge and determine the change in the client's condition using a standard assessment tool. The GAF score is not used to establish a timeframe for outpatient care because outpatient care is determined by other factors. The client's clinical diagnosis is not classified by the GAF, the current revision of the Diagnostic and Statistical Manual (DSM) is used as the reference for classifying clinical diagnosis. The GAF is used to rate the client's level of functioning, not to establish the medication regimen.
    Cognitive Level: Evaluation
    Nursing Process: Evaluation
    Client Need: Health Promotion and Maintenance

14. **A client is admitted with a GAF score of 20. The nurse uses this score as data to support which priority need?**
    a. Psychosocial needs.
    b. Safety needs.
    c. Communication needs.
    d. Occupational needs.

    Grade: 0
    User Responses: c.Communication needs.
    Feedback: a.Rationale: A client with a score of 11–20 is demonstrating behavior that indicates there is some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; is frequently violent; a manic excitement) and has safety needs. The higher the score, the more functional the individual is. Once the individual's safety needs are met, the client may be able to begin working on higher order needs.
    Cognitive Level: Analysis
    Nursing Process: Planning
    Client Need: Safe, Effective Care Environment

15. **The nurse assessing a mental health client's level of functioning, using the Global Assessment of Functioning, would ideally use the client's:**
    a. Lowest functional level in the previous 7 days.
    b. Highest functional level since the previous admission.
    c. Highest functional level in the previous 7 days.
    d. Lowest functional level since the previous admission.

    Grade: 0
    User Responses: c.Highest functional level in the previous 7 days.
    Feedback: a.Rationale: Generally, ratings on the GAF Scale reflect the client's lowest level of functioning within the previous 7 days.
    Cognitive Level: Analysis
    Nursing Process: Assessment
    Client Need: Psychosocial Integrity

16. **The psychiatric nurse case manager is auditing a chart to verify that a client's diagnosis is correctly listed and meets criteria according to the symptoms documented in the chart. In this situation, the nurse uses which of the following as a reference tool?**
    a. Millon Clinical Multiaxial Inventory–II (MCMI–II).
    b. Global Assessment of Functioning (GAF).
    c. Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (DSM-IV-TR).
    d. Minnesota Multiphasic Personality Inventory–2 (MMPI–2).

Grade: 1
User Responses: c.Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (DSM-IV-TR).
Feedback: a.Rationale: The DSM-IV-TR represents the current state of knowledge about diagnosing mental disorders. The manual is composed of a list of all the official numeric codes and terms for all recognized mental disorders, along with a comprehensive description of each and specified diagnostic criteria that must be present to make each diagnosis.The GAF reports on the client's overall level of functioning, information that is useful in planning treatment, measuring its impact, and predicting outcomes. The MCMI–II provides valuable assistance in clarifying underlying stable personality features. The MMPI–2 is a personality test that results in a profile that can be interpreted to inform diagnosis and treatment plans, but it is not a global guide to diagnosis.
Cognitive Level: Evaluation
Nursing Process: Evaluation
Client Need: Safe, Effective Care Environment

17. **An advantage of the nurse using the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (DSM-IV-TR) multiaxial system when developing a plan of care is:**
    a. The results of personality testing are discussed.
    b. Adaptive strengths as well as problems are identified.
    c. The results of intelligence testing are described.
    d. Potential side effects of psychotropic medications are identified.

Grade: 0
User Responses: c.The results of intelligence testing are described.
Feedback: a.Rationale: In the DSM-IV-TR multiaxial system, every person is evaluated on five axes, each dealing with a different class of information about the client. DSM-IV-TR's multiaxial assessment is congruent with holistic views of people, recognizes the role of environmental stress in influencing behavior, and requires that the clinician collect data about client adaptive strengths as well as about symptoms or problems. Medication side effects, intelligence tests, and personality tests are not included in the DSM-IV-TR multiaxial system.
Cognitive Level: Synthesis
Nursing Process: Planning
Client Need: Safe, Effective Care Environment

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18. **The nurse is assessing a client identified as "noncompliant with follow-up care." During the assessment, the nurse discovers a primary reason the client does not make it to her appointment is because of difficulties with access to health care services. This information is communicated using the DSM-IV-TR multiaxial system under Axis:**
    a. I.
    b. III.
    c. II.
    d. IV.

    Grade: 0
    User Responses: c.II.
    Feedback: a.Rationale: Axis IV is used to identify psychosocial problems that may affect the diagnosis and treatment of mental disorders, of which problems with access to health care services would be categorized. Axis I includes all of the Adult and Child Clinical Disorders. Axis II contains the personality disorders, maladaptive personality traits, and developmental disorders including mental retardation. Axis III is used to record physical disorders and medical conditions that must be taken into account in planning treatment, or that are relevant to understanding the etiology or worsening of the mental disorder.
    Cognitive Level: Analysis
    Nursing Process: Assessment
    Client Need: Safe Effective Care Environment

19. **A client presents to the mental health unit and tells the nurse he needs to be admitted "right now" because the voices are telling him to "do a bang-bang before high noon and it is now 11:45." When the nurse attempts to obtain information, he just keeps repeating "I need to be admitted" over and over. In view of the client's acute state of distress, the nurse will use which of the following assessments?**
    a. Mini-Mental State Exam.
    b. Thematic Apperception Test (TAT).
    c. State–Trait Anxiety Inventory.
    d. Mental Status Examination.

    Grade: 0
    User Responses: c.State–Trait Anxiety Inventory.
    Feedback: a.Rationale: Because of this client's current state there is not enough time to complete a full MSE, therefore the nurse will use the Mini-Mental State Exam. This exam will enable the nurse to fairly accurately assess and evaluate the client's functioning in a streamlined manner. A complete mental status assessment may be deferred until the client is more calm and able to process. Both the Thematic Apperception Test and State–Trait Anxiety Inventory are psychological tests, but not appropriate for this client at the present time.
    Cognitive Level: Application
    Nursing Process: Assessment
    Client Need: Psychosocial Integrity

20. **The nurse is conducting a Mini-Mental State Examination on a client who reports "just not being able to think clearly" and an increasing awareness of not being able to "remember from one minute to the next." To ensure validity of the examination, the nurse will:**
    a. Have the client also complete the Rorschach Test.
    b. Have the client write out the responses at the same time the nurse records the client's verbal responses.
    c. Ask the client's significant other to verify the responses.
    d. Ask the questions in the order they are listed on the tool.

    Grade: 0
    User Responses: c.Ask the client's significant other to verify the responses.
    Feedback: a.Rationale: For the test to be efficient and valid, the questions must be asked in the order they are listed. The Rorschach Test is not used for the same purpose as the Mini-Mental State Examination. Asking the client's significant other will not ensure validity of the Mini-Mental State Exam, nor will having the client write out the responses at the same time the nurse records the client's verbal responses, as these options would not be appropriate in conducting the Mini-Mental State Exam.
    Cognitive Level: Application
    Nursing Process: Assessment
    Client Need: Psychosocial Integrity

21. **The nurse conducted a Mini-Mental State Examination (MMSE) on a client with a history of right-sided paralysis and difficulty speaking. How will the nurse document the score?**
    a. Document the results of the relevant aspects of the MMSE without a score.
    b. The nurse will not be able to use the MMSE on this client.
    c. The nurse should omit the relevant questions from the examination.
    d. Ask the client's significant other to provide the answers.

    Grade: 0
    User Responses: c.The nurse should omit the relevant questions from the examination.
    Feedback: a.Rationale: There are limitations to using the MMSE with people who have certain disabilities with sight or motor movement related to writing. The nurse will document the results of the relevant aspects of the MMSE without a score, since the client's condition prevents her from completing the entire exam. When a client is not able to perform one of the activities, it may be necessary to conduct a full MSE or to document the results of the relevant aspects of the MMSE without a score. Omitting relevant questions from the MMSE is not an option. The nurse's options in this situation are to either conduct a full MSE or to document the results of the relevant aspects of the MMSE without a score. The client's significant other cannot provide answers; the client is the only source of data for the MMSE.
    Cognitive Level: Analysis
    Nursing Process: Assessment
    Client Need: Psychosocial Integrity

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22. **During mealtime, two clients got into a physical altercation. One of the clients, with a history of multiple somatic complaints, complains of a headache and is given a PRN medication. Two hours later, the client presents at the nurses' station in tears and tells the nurse, "My head hurts so bad, the medicine didn't work, and no one cares." What is the priority action of the nurse?**
    a. Sit with the client until the medication begins to work.
    b. Assess the client for signs of injury.
    c. Ask the client "Why do you feel no one cares?"
    d. Encourage the client to explore his feelings about "no one caring."

    Grade: 0
    User Responses: c.Ask the client "Why do you feel no one cares?"
    Feedback: a.Rationale: Nurses must carefully consider the possibility that a client's somatic symptoms may have a physiologic or a biologic, or—in particular—a neurologic basis. Further assessment is indicated to rule out the possibility of injury or the possibility the client's somatic symptoms may be reflective of a physiological problem. Asking the client "why" he feels no one cares is not correct for several reasons: "Why" questions tend to block therapeutic communication, because this requires the client to defend his feelings. In addition, the effect of PRN medications should be documented. In this situation the medication is ineffective, indicating the nurse must initiate another action to seek resolution to the client's problem. Encouraging the client to explore feelings is not the correct action at this time. The nurse needs to address the client's immediate physical need. Sitting with the client until the medication works is not the correct action as the client was administered the PRN medication 2 hours ago, the medication did not resolve the problem, the nurse must take another action.
    Cognitive Level: Analysis
    Nursing Process: Assessment
    Client Need: Physiological Integrity

23. **During a follow-up visit at the community mental health unit, the nurse observes that a client with a depressive disorder has lost 37 pounds since his visit last month. Further assessment of this client should include:**
    a. A list of dietary preferences.
    b. Praise for his accomplishment.
    c. Appetite and intake.
    d. Medication adjustment.

Grade: 1
User Responses: c.Appetite and intake.
Feedback: a.Rationale: Recent weight loss, although often encountered in depression and schizophrenia, may be due to gastrointestinal disease, carcinoma, Addison's disease, and many other physical disorders. Assessing the client's appetite and intake will provide information which will direct the nurse in planning further intervention or referral if needed. Making a list of dietary preferences is not the best action based on the data provided above. The nurse needs to collect further data related to the significant weight loss. Praising the client is an intervention and not related to the assessment phase of the nursing process. A weight loss of 37 pounds is considered significant. The nurse should collect additional data related to potential causes or contributing factors to the weight loss. There is no data to suggest a medication adjustment is needed.
Cognitive Level: Analysis
Nursing Process: Assessment
Client Need: Physiological Integrity

24. **The nurse-therapist would refer an incarcerated client with a long history of antisocial behaviors to the psychologist for which of the following objective personality tests?**
a. Raven's Progressive Matrices Test.
b. Sentence Completion Test.
c. State–Trait Anxiety Inventory.
d. Minnesota Multiphasic Personality Inventory.

Grade: 0
User Responses: c.State–Trait Anxiety Inventory.
Feedback: a.Rationale: The Minnesota Multiphasic Personality Inventory (MMPI) is a self-administered objective (as opposed to projective) personality test designed to yield a broad examination of personality functioning that is amenable to statistical interpretation, such as profiles of symptoms or psychopathology. The Sentence Completion Test is a projective test designed to elicit conscious associations to specific areas of functioning, thus illustrating the fears, preoccupations, ambitions, and idiosyncrasies of the client. Raven's Progressive Matrices Test is an intelligence test that is designed to provide data on intellectual ability in a relatively culturally unbiased manner. The State-Trait Anxiety Inventory measures state and trait anxiety. State anxiety is conceptualized as a transitory emotional state or condition; trait anxiety refers to relatively stable individual differences in vulnerability to anxiety.
Cognitive Level: Analysis
Nursing Process: Assessment
Client Need: Psychosocial Integrity

25. **In the staff lunchroom of a local hospital, the nurse observed a group of students discussing patients they had during their mental health clinical last week. The nurse's first action in this situation would be to:**
    a. Notify the nursing instructor of the student's actions.
    b. Notify the nursing supervisor
    c. Gently remind the students of the breach of confidentiality.
    d. No action is required; the students are in an appropriate setting.

    Grade: 1
    User Responses: c.Gently remind the students of the breach of confidentiality.
    Feedback: a.Rationale: A primary role of the nurse is to protect client information and maintain confidentiality and support client rights. The client's name should not be discussed out of the treatment area unless it is a secure environment and the discussion is among treatment providers for that client. The staff lunchroom of the hospital is not a secure area; the students are not part of the treatment team as they are no are no longer involved in the clients care.
    Cognitive Level: Application
    Nursing Process: Implementation
    Client Need: Safe, Effective Care Environment

26. **A staff nurse is serving on the forms committee of the hospital mental health unit. The committee has adopted an assessment tool to be used with all admissions to the mental health unit. To ensure that all nurses are using the tool in the same manner, which of the following should be assessed?**
    a. Nursing care plan.
    b. Interrater reliability.
    c. Quality assurance procedures.
    d. A psychiatric audit.
    e. The nursing process.

    Grade: 0
    User Responses: c.Quality assurance procedures.
    Feedback: a.Rationale: Interrater reliability is the process of ensuring that all raters use similar scoring measures and techniques. The psychiatric audit is used to evaluate the quality of mental health services that consumers receive. An audit consists of a review of the client's chart to compare criteria for quality care with actual practice. Quality assurance procedures are implemented to assure that quality is maintained through an ongoing effort to find new and better ways of doing things, and achieving better results, and should involve the entire organization. The nursing process is a systematic process that includes assessment, planning, implementing, and evaluating care provided by nurses to clients.
    Cognitive Level: Analysis
    Nursing Process: Assessment
    Client Need: Safe, effective care environment

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27. **The nurse is conducting a training session for volunteers who will be helping out at the mental health clinic. The current session is "Assisting the client" and gives the following scenario: You are at the front desk during lunchtime and a client comes to the clinic out of breath, saying, "You've got to help me, the FBI is following me, I need a place to hide." Which of the following would be helpful to the volunteer in dealing with this situation?**
    a. Algorithm.
    b. Nursing Plan of Care.
    c. Axis III.
    d. Nursing Audit.

    Grade: 0
    User Responses: c.Axis III.
    Feedback: a.Rationale: Algorithms are behavioral steps, or step-by-step procedures, for the management of common problems using protocols. Algorithms are problem- specific and not designed to meet the comprehensive needs of the client but to provide for the client's immediate priority needs and are useful in areas staffed by paraprofessionals. A nursing plan of care is a process designed to assist the client to wellness, provide skills to prevent further problems, and measures to maintain health from a holistic standpoint. The nursing audit is performed to evaluate the quality of nursing care provided to clients. Axis III is where clinicians record physical disorders and medical conditions that must be taken into account in planning treatment.
    Cognitive Level: Analysis
    Nursing Process: Assessment
    Client Need: Psychosocial Integrity

28. **The nurse is collecting information about the client's previous diagnosis, interventions, and treatment. This information will be documented in the:**
    a. Physical assessment.
    b. Psychiatric history.
    c. Physician's record.
    d. Nursing plan of care.

    Grade: 0
    User Responses: c.Physician's record.
    Feedback: a.Rationale: The psychiatric history includes information about the client's current condition and previous diagnoses, interventions, and treatment, along with a family history. The physical assessment pertains to gathering information related to body systems. The information is used to formulate a plan of care, but is documented in the section on psychiatric history.
    Cognitive Level: Application
    Nursing Process: Assessment
    Client Need: Psychosocial Integrity

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29. **The nurse uses assessment skills:**
    a. To communicate with the health care team.
    b. To evaluate client progress.
    c. To establish client goals.
    d. To engage in a therapeutic interaction.

Grade:	0
User Responses:	c.To establish client goals.
Feedback:	a.Rationale: A nurse's assessment skills are used in the evaluation process, as the nurse compares the client's baseline behavior with the behavior after the intervention. Client goals are established after the assessment is complete and the nurse analyzes the data. Engaging in a therapeutic interaction is part of the implementation process, which is based on the client needs identified after the comprehensive assessment is complete. The nurse communicates with the health care team following an assessment of the client's progress. Cognitive Level: Application Nursing Process: Assessment Client Need: Safe, Effective Care Environment

30. **A nursing assessment is indicated:**
    a. Prior to transferring to another unit.
    b. When implementing the plan of care.
    c. According to institutional policy.
    d. When there is a change in the client's condition.
    e. After transferring to another unit.

Grade: 0
User Responses: c.According to institutional policy.,d.When there is a change in the client's condition.
Feedback: a.Rationale:
When there is a change in the client's condition. An assessment of the client's condition is warranted whenever there is a change in the client's condition to determine if a change in the plan of care is indicated in order to protect or promote the client's well being.

Prior to transferring to another unit. An assessment of the client's condition is warranted whenever there is a change in the client's condition to determine if a change in the plan of care is indicated in order to protect or promote the client's well being. If the client is to be transferred to another unit, there has been some type of change in the client's condition.

After transferring to another unit. An assessment is made upon transfer or admission to a new unit in order to establish a baseline of the client from which further evaluation will be based.

According to institutional policy. Each institution and specific requirements that prescribe when clients are to be assessed, such as each shift, every fifteen minutes, or continuous observation.

When implementing the plan of care. Clients are assessed following implementation or therapeutic intervention for the purpose of evaluating the client's response to the action.

Cognitive Level: Application
Nursing Process: Assessment
Client Need: Safe, Effective Care Environment

31. **The nurse admitting a client to the inpatient mental health setting is prepared to obtain which of the following?**
    a. Plan of care.
    b. Provide information about community resources.
    c. A list of the client's medication and prescriptions.
    d. Psychiatric history and mental status exam.
    e. Referrals to other members of the health care team.

Grade: 1
User Responses: d.Psychiatric history and mental status exam.
Feedback: a.Rationale: The psychiatric history and mental status exam is most often done during initial or early interactions with a client. After the history is obtained, the nurse will develop a plan of care. The nurse can obtain a list of the client's medications at a later stage. Making referrals to other members of the health care team and providing information about community resources is an intervention and not part of the admission process, once priorities of care are established.
Cognitive Level: Application
Nursing Process: Assessment
Client Need: Safe and Effective Care Environment

32. **When assessing a client's psychiatric history, the nurse obtains information about the client's:**
a. Present symptoms.
b. Appearance.
c. General behavior.
d. Attitude.

Grade: 0
User Responses: d.Attitude.
Feedback: a.Rationale: The nurse inquires about the client's present symptoms as part of the psychiatric history. General behavior, appearance, and attitude are components of the mental status assessment.
Cognitive Level: Application
Nursing Process: Assessment
Client Need: Safe and Effective Care Environment

33. **After the nurse gathers information and completes the assessment, the next step in the admission process is to:**
a. Validate the information from other sources with the client.
b. Ask the secondary sources to sign an affidavit.
c. Record the information and document the source.
d. Contact the physician for admission orders.

Chapter 11 Pre Test

Smith,Crystal

Submitted: 1/28/2011 10:53:19 PM Grade: 21.2% Attempt Number: 1/3 **Questions Attempted:** 33/33

Grade:	0
User Responses:	d.Contact the physician for admission orders.
Feedback:	a.Rationale: The client must be assessed upon entry into the system or facility. The information must be recorded, according to institutional policy, and placed in a location for team members to access. Depending on the client's condition and circumstances surrounding the admission, it may not be possible to validate the information with the client. It is not necessary to obtain an affidavit from secondary sources. The physician is not always contacted for admission orders after the assessment is completed because some clients present with admission orders from the physician. Cognitive Level: Application Nursing Process: Assessment Client Need: Safe and Effective Environment of Care

Chapter 11 Pre Test

Smith,Crystal

Submitted: 1/28/2011 10:53:19 PM **Grade:** 21.2% **Attempt Number:** 1/3 **Questions Attempted:** 33/33

Activity Name: Chapter 11 Pre Test

1. b. III.
2. b. The client should be assessed and data entered in the record.
3. b. Medical needs.
4. a. The assessment process.
5. d. Using a systematic process.
6. a. Client voices he is not a threat to others; mother reports client broke into gun cabinet; client arrested for threatening family members.
7. b. The Mental Status Examination.
8. c. Emotional state.
9. c. Ensures all components are addressed, but may vary the sequence.
10. b. Perseveration.
11. a. General grasp and recall.
12. b. Nihilistic delusions.
13. c. Compare with the current score.
14. b. Safety needs.
15. a. Lowest functional level in the previous 7 days.
16. c. Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (DSM-IV-TR).
17. b. Adaptive strengths as well as problems are identified.
18. d. IV.
19. a. Mini-Mental State Exam.
20. d. Ask the questions in the order they are listed on the tool.
21. a. Document the results of the relevant aspects of the MMSE without a score.
22. b. Assess the client for signs of injury.
23. c. Appetite and intake.
24. d. Minnesota Multiphasic Personality Inventory.
25. c. Gently remind the students of the breach of confidentiality.
26. b. Interrater reliability.
27. a. Algorithm.
28. b. Psychiatric history.
29. b. To evaluate client progress.
30. d. When there is a change in the client's condition. and a.Prior to transferring to another unit. and e.After transferring to another unit. and c.According to institutional policy.
31. d. Psychiatric history and mental status exam.
32. a. Present symptoms.
33. c. Record the information and document the source.