Chapter 14 Pre Test

Smith,Crystal

Submitted: 4/23/2011 2:23: 52 PM Grade: 87.5% Attempt Number: 1/3 **Questions Attempted:** 24/24

1. **A nurse is working in a long-term care facility. A coworker makes a disparaging joke about a client with dementia while in the client's presence. How should the nurse respond?**
   a. Assume that the coworker is just relieving stress.
   b. Rephrase the joke to include the coworker.
   c. Encourage the coworker to take some time off from work.
   d. Express immediately that the comment is inappropriate.

   Grade: 1
   User Responses: d.Express immediately that the comment is inappropriate.
   Feedback: a.Rationale: It is important for the nurse to immediately address the inappropriate comment. Care for clients with dementia should be protective, supportive, and respectful and recognize the client's dignity. It is unprofessional to assume that inappropriate behavior is the result of stress. It is not the nurse's role to encourage the coworker to take time off. Rephrasing the joke to include the coworker is inappropriate.
   Cognitive Level: Evaluation
   Nursing Process: Implementation
   Client Need: Psychosocial Integrity

2. **A nurse who works with clients diagnosed with dementia is feeling frustrated and exhausted with her job. What behavior would be most appropriate to address these feelings?**
   a. Discuss concerns during clinical supervision.
   b. Limit client interaction.
   c. Put in for some time off from work.
   d. Start to explore other employment options.

   Grade: 0
   User Responses: c.Put in for some time off from work.
   Feedback: a.Rationale: It is important that the nurse openly discuss feelings of frustration and exhaustion with a clinical supervisor. Increased self-awareness from supervision sessions may allow the nurse to continue to provide optimal care for the client. Vacationing, quitting, and limiting client interaction are avoidance techniques that do not appropriately address the nurse's feelings of frustration and exhaustion.
   Cognitive Level: Evaluation
   Nursing Process: Planning
   Client Need: Psychosocial Integrity

3. **A client diagnosed with delirium is screaming and combative. The staff member assigned to the client runs out of the room and states, "That client is crazy! There is not enough money in world to make me go back in there!" What would be most appropriate action by the nurse?**
   a. Encourage the staff member to wear earplugs and stay out of arm's reach.
   b. Explain that clients who scream and fight tend to scare everyone.
   c. Explain the client's condition and stress that safety is a priority.
   d. Set strict limits on how often the staff member can leave the client unattended.

Grade: 1
User Responses: c.Explain the client's condition and stress that safety is a priority.
Feedback: a.Rationale: It is important to explain to the staff member that the screaming and combativeness are symptoms of the delirium and that client safety is a top priority. Telling the staff member that clients who scream and fight tend to scare everyone minimizes the staff member's concerns. Encouraging the staff member to wear earplugs and sit far away from the client will jeopardize the client's safety. While the staff member should not leave the client unattended, it is better to address concerns regarding the danger in leaving the client unattended.
Cognitive Level: Evaluation
Nursing Process: Implementation
Client Need: Psychosocial Integrity

4. **A nurse asks the client with a cognitive disorder what day of the week it is, what the date, month, and year are, and where the client is currently located. The nurse is attempting to assess:**
   a. Perseveration.
   b. Orientation.
   c. Confabulation.
   d. Delirium.

Grade: 1
User Responses: b.Orientation.
Feedback: a.Rationale: Determining level of orientation is basic assessment for clients with a cognitive disorder. Once level of orientation is established, the nurse can structure the client's environment to support cognitive function. Confabulation and perseveration are symptoms of a cognitive impairment, but the nurse's questions are not designed to elicit this data. Delirium is a cognitive disorder, but more information than is provided by the questions would be needed to support a diagnosis.
Cognitive Level: Evaluation
Nursing Process: Assessment
Client Need: Psychosocial Integrity

5. **Which of the following interventions will the nurse use to support optimal memory in a client with a diagnosis of dementia of the Alzheimer's type?**
   a. Correct verbal discrepancies.
   b. Attempt to trigger semantic memory.
   c. Provide a stimulating environment.
   d. Test the client for episodic memory gaps.

Grade: 1
User Responses: b.Attempt to trigger semantic memory.
Feedback: a.Rationale: Clients with dementia of the Alzheimer's type experience episodic memory loss; therefore, interactions may not be retained, and repetition is necessary. Semantic memory is triggered by the use of repetition and verbal and nonverbal communication techniques. Overstimulation could result in a catastrophic reaction for the client with a dementia diagnosis. Episodic memory is impaired in clients with dementia of the Alzheimer's type, so correction of verbal discrepancies and testing for memory gaps may increase the client's frustration and anxiety level.
Cognitive Level: Synthesis
Nursing Process: Implementation
Client Need: Psychosocial Integrity

6. **What would the nurse recommend for environmental safety when clients have poor memory?**
   a. Scheduling ADLs at the same time every day
   b. Testing the clients for safety knowledge
   c. Placing alarms at all exits
   d. Using orientation cues to decrease agitation

Grade: 1
User Responses: c.Placing alarms at all exits
Feedback: a.Rationale: The client with poor memory cannot accurately appraise the environment and use necessary caution. Alarms at the exits will ensure that the client is not accidentally injured from exposure to the elements. Increasing orientation does not address environmental safety. Use of a consistent schedule will support memory but not address environmental safety. Testing safety knowledge may increase the client's frustration and anxiety level.
Cognitive Level: Application
Nursing Process: Implementation
Client Need: Safe, Effective Care Environment

7. **The onset of delirium differs from the onset of dementia in which way?**
   a. The onset of delirium is rapid and abrupt.
   b. The onset of delirium follows an infection.
   c. The onset of delirium follows a head injury.
   d. The onset of delirium is slow and insidious.

Grade: 1
User Responses: a.The onset of delirium is rapid and abrupt.
Feedback: a.Rationale: The onset of delirium is rapid and abrupt. Dementias are characterized by a slow and insidious onset. The onset of Creutzfeldt-Jakob disease-related dementia is associated with an infection. Head injury is a risk factor for dementia of the Alzheimer's type.
Cognitive Level: Application
Nursing Process: Assessment
Client Need: Psychosocial Integrity

8. **The nurse is listening to a woman with concerns that her father has developed dementia of the Alzheimer's type. The nurse knows an early symptom of Alzheimer's dementia is:**
   a. Forgetfulness.
   b. Focal neurologic signs.
   c. Chorea.
   d. Spontaneous parkinsonism.

Grade: 1
User Responses: a.Forgetfulness.
Feedback: a.Rationale: In the early stage of Alzheimer's dementia, clients often complain of forgetfulness. Spontaneous parkinsonism is a symptom associated with dementia with Lewy bodies. In vascular dementia, the client demonstrates focal neurologic signs, such as one-sided weakness, emotional outbursts, and a stepwise rather than progressive decline in intellectual functioning. Chorea is associated with dementia from Huntington's disease.
Cognitive Level: Application
Nursing Process: Assessment
Client Need: Psychosocial Integrity

9. **A key characteristic of an amnestic disorder is:**
   a. Short-term memory loss.
   b. Long-term memory loss.
   c. Short-term and long-term memory loss.
   d. Hallucinations.

Grade: 1
User Responses: c.Short-term and long-term memory loss.
Feedback: a.Rationale: An amnestic disorder is characterized by both short-term and long-term memory deficits, an inability to recall previously learned information and past events, inability to learn new material, confabulation, apathy, and a bland affect. Hallucinations are false sensory perceptions associated with delirium or the later stages of dementia of the Alzheimer's type.
Cognitive Level: Application
Nursing Process: Assessment
Client Need: Psychosocial Integrity

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10. **Pseudodementia is characterized by:**
    a. Mood changes.
    b. Short-term memory loss.
    c. Reversible cognitive impairments.
    d. A slow onset.

    Grade: 1
    User Responses: c.Reversible cognitive impairments.
    Feedback: a.Rationale: *Pseudodementia* is a term used to describe the reversible cognitive impairments seen in depression. Pseudodementia has an abrupt onset and a rapid clinical course, and the client will often complains about cognitive failures but not a depressed mood.
    Cognitive Level: Analysis
    Nursing Process: Assessment
    Client Need: Psychosocial Integrity

11. **A client is hospitalized for exacerbation of congestive heart failure on a medical–surgical unit and develops delirium. The client states to the nurse that he believes the flowers on the wallpaper are large spiders. This is an example of:**
    a. A hallucination.
    b. A delusion.
    c. An obsession.
    d. An illusion.

    Grade: 0
    User Responses: a.A hallucination.
    Feedback: a.Rationale: A client diagnosed with delirium shows a reduced ability to integrate and distinguish sensory information from hallucinations, dreams, illusions, and imagery. An illusion is a misperception of reality. A hallucination is a false sensory perception, a delusion is a false idea, and an obsession is a recurring thought.
    Cognitive Level: Application
    Nursing Process: Assessment
    Client Need: Psychosocial Integrity

12. **How does the outcome for clients diagnosed with dementia differ from the outcomes of clients diagnosed with delirium and pseudodementia?**
    a. Recovery from dementia is spontaneous.
    b. Recovery occurs when underlying disease is corrected.
    c. Dementia is usually irreversible.
    d. Dementia is usually reversible.

Grade: 1
User Responses: c.Dementia is usually irreversible.
Feedback: a.Rationale: Dementia is generally irreversible. Delirium is generally reversible and can be resolved when the underlying cause is removed. Pseudodementia can be successfully treated and spontaneous recovery is expected.
Cognitive Level: Analysis
Nursing Process: Assessment
Client Need: Psychosocial Integrity

13. **Dementias are classified according to either the cause or the area of neurologic damage. Dementia of the Alzheimer's type is classified as what type of dementia?**
    a. Pseudodementia
    b. Subcortical
    c. Aphasic
    d. Cortical

Grade: 1
User Responses: d.Cortical
Feedback: a.Rationale: Dementia of the Alzheimer's type is a classic cortical dementia. It is classified as such because the area of neurologic damage is cortical. Dementia due to Parkinson's disease or Huntington's disease is classified as subcortical dementia. Pseudodementia is a term used to describe the reversible cognitive impairments seen in depression. Aphasic refers to the loss of language ability, which is a symptom of dementia.
Cognitive Level: Application
Nursing Process: Assessment
Client Need: Psychosocial Integrity

14. **While the actual cause of dementia of the Alzheimer's type remains unknown, several factors are believed to play a role in its development. Identify the factors believed to be related to the development of dementia of the Alzheimer's type.**
    a. Loss of nerve cells, disruption of nerve cell communication, and serotonin and norepinephrine deficits
    b. Loss of nerve cells, increased nerve cell communication, and acetylcholine and serotonin deficits
    c. Loss of nerve cells, disruption of neurofibrillary tangles, and acetylcholine and serotonin deficits
    d. Loss of nerve cells, disruption of nerve cell communication, and acetylcholine and serotonin deficits

Grade: 1
User Responses: d.Loss of nerve cells, disruption of nerve cell communication, and acetylcholine and serotonin deficits
Feedback: a.Rationale: Factors related to the development of dementia of the Alzheimer's type are a loss of nerve cells and a disruption of nerve cell communication, which probably results from acetylcholine and serotonin deficits. Norepinephrine is a neurotransmitter more associated with changes in mood. Neurofibrillary tangles are pathologic changes found in the brains of people diagnosed with dementia of the Alzheimer's type.
Cognitive Level: Analysis
Nursing Process: Assessment
Client Need: Psychosocial Integrity

15. **Delirium is thought to be caused primarily by:**
    a. Brain injury.
    b. Underlying systemic illness.
    c. Genetics.
    d. Vascular insufficiency.

Grade: 1
User Responses: b.Underlying systemic illness.
Feedback: a.Rationale: Delirium is usually caused by an underlying systemic illness such as dehydration, diabetes, hyponatremia, hypercalcemia, thyroid crisis, infection, silent myocardial infarction, drug intoxication, or liver or renal failure. If the cause is removed quickly, complete recovery from delirium can be achieved. Genetics, brain injury, and vascular insufficiency are associated with the etiology of dementias.
Cognitive Level: Application
Nursing Process: Assessment
Client Need: Psychosocial Integrity

16. **The nurse at a long-term care facility is listening to the unlicensed personnel's concerns about confused client behavior that occurs regularly during the afternoon shift on the dementia care unit. An increase in agitated and disoriented behavior is probably due to:**
    a. Psychosis.
    b. Delirium.
    c. Sundowner syndrome.
    d. Anxiety.

Grade: 1
User Responses: c.Sundowner syndrome.
Feedback: a.Rationale: Sundowner syndrome or sundowning is understood as confused behavior when environmental stimulation is low. It is seen in clients with delirium and dementia. The client can become increasingly agitated, disoriented, or even a ggressive/paranoid or impulsive and emotional later in the day and at night. Delirium is a transient cognitive disorder. Psychosis is a symptom of both dementia and deirium. Anxiety is an emotional reaction to stress.
Cognitive Level: Application
Nursing Process: Assessment
Client Need: Psychosocial Integrity

17. **The nurse is admitting a client with a diagnosis of dementia of the Alzheimer's type. Which symptom would the nurse expect to find in the assessment?**
    a. Extremes of psychomotor activity
    b. Fluctuating consciousness
    c. Confabulation
    d. Disturbed sleep–wake cycle

Grade: 0
User Responses: b.Fluctuating consciousness
Feedback: a.Rationale: Confabulation is a common defense used by clients with dementia who cannot remember required information and use fantasy to fill in the memory gaps. Extremes of psychomotor activity, disturbed sleep-wake cycle, and fluctuating consciousness are all symptoms of delirium.
Cognitive Level: Application
Nursing Process: Assessment
Client Need: Psychosocial Integrity

18. **Which of the following abilities should a nurse expect from a client in stage 2 of dementia of the Alzheimer's type?**
    a. Learning new material
    b. Ability to follow a schedule
    c. Reminiscence activities
    d. Orientation to person, place, and time

Grade: 1
User Responses: c.Reminiscence activities
Feedback: a.Rationale: Reminiscence activities are familiar and pleasurable and may support memory functions that are still intact. Learning new material, following a schedule, and orientation are not possible for a person in stage 2 of dementia of the Alzheimer's type.
Cognitive Level: Application
Nursing Process: Assessment
Client Need: Psychosocial Integrity

19. **A client recovering from surgery is experiencing delirium. The client is agitated, unable to stay in bed, and has suffered two falls. What is the most effective intervention for this client?**
    a. Ensure the client is sedated.
    b. Restrain the client only during the night.
    c. Transfer the client to the mental health unit.
    d. Assign a staff member to stay with the client 1:1.

    Grade: 1
    User Responses: d.Assign a staff member to stay with the client 1:1.
    Feedback: a.Rationale: Safety is a priority, as delirium is characterized by fragmented and distorted thinking, illusions, and hallucinations. Assigning a staff member 1:1 to the client will ensure that the client remains free from harm. Sedation and mechanical restraints are the most restrictive interventions and are implemented only as a last resort. The client needs to stay on the medical-surgical unit to enhance his postsurgical recovery.
    Cognitive Level: Analysis
    Nursing Process: Implementation
    Client Need: Safe, Effective Care Environment

20. **A client with a diagnosis of dementia of the Alzheimer's type stage 2 has lost 10 pounds in the last month. The client wanders during the day, is restless at night, and has an insatiable appetite. What is the most effective intervention for this client?**
    a. Assign a staff member to stay with the client at night.
    b. Ensure the client's room is well lit, without shadows, for sleeping.
    c. Restrain the client only during the night.
    d. Assign a staff member to assist the client during meals.

    Grade: 1
    User Responses: d.Assign a staff member to assist the client during meals.
    Feedback: a.Rationale: Without supervision, clients with a diagnosis of dementia are not capable of ingesting adequate amounts of food. Assistance will ensure that the client is ingesting enough calories at mealtime to support metabolic needs. Mechanical restraints are the most restrictive interventions and are only implemented as a last resort for a client whose behavior is unsafe. Night supervision and keeping the sleeping area well lit will address the client's sleep needs, but do not address the client's weight loss.
    Cognitive Level: Analysis
    Nursing Process: Implementation
    Client Need: Physiological Integrity

21. **A client with a diagnosis of dementia of the Alzheimer's type stage 3 has just been admitted to a long-term care facility. The client's wife is crying and says to the nurse, "When will he get better? Why can't the doctor fix him?" The nurse's best therapeutic response is:**
    a. "What are you so worried about?"
    b. "Your husband is not going to get better."
    c. "Don't worry, everything will work out fine."
    d. "Let's schedule a family meeting to discuss your concerns."

    Grade: 1
    User Responses: d."Let's schedule a family meeting to discuss your concerns."
    Feedback: a.Rationale: A family meeting will provide a forum in which to provide education about the illness and discuss strategies for the client's care. Telling the client's wife not to worry and that everything will work out is false reassurance, which is not therapeutic. Asking what she is worried about changes the subject, which is not therapeutic. Telling the client's wife her husband is not getting better is abrupt and does not address her need for more information about her husband's care.
    Cognitive Level: Evaluation
    Nursing Process: Implementation
    Client Need: Psychosocial Integrity

22. **A client has an advanced stage of dementia of the Alzheimer's type. The client presents with agnosia, apraxia, and wandering. Which of the following nursing interventions would be most appropriate for the client during meals?**
    a. Have the client eat in his or her room to avoid distractions.
    b. Ask the client to choose foods from the hospital menu.
    c. Provide the client with the dinner tray, open containers for the client, and hand the client items to ingest.
    d. Provide the client with the dinner tray, but encourage the client to eat independently.

    Grade: 1
    User Responses: c.Provide the client with the dinner tray, open containers for the client, and hand the client items to ingest.
    Feedback: a.Rationale: Providing the client with the dinner tray, opening containers, and handing the client items to ingest will address agnosia (failure to recognize or identify objects despite intact sensory function) and apraxia (impaired ability to carry out motor activities despite intact motor function). The nurse's presence may provide support, which decreases anxiety, fear, and hostility in a client who wanders. In the advanced stages of dementia, a client is unable to make food choices. Apraxia and agnosia will impede the client's ability to independently eat a meal. Eating in his or her own room may increase the client's social isolation and diminish self-esteem.
    Cognitive Level: Application
    Nursing Process: Implementation
    Client Need: Physiological Integrity

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Submitted: 4/23/2011 2:23: 52 PM Grade: 87.5% Attempt Number: 1/3 **Questions Attempted:** 24/24

23. **Which of the following nursing interventions would be most appropriate in helping a client with acute delirium to complete ADLs?**
    a. Tell the client to finish ADLs before 10 a.m.
    b. Allow enough time for the client to complete ADLs as independently as possible.
    c. Provide ADL care for the client, allowing for frequent breaks.
    d. Plan to provide step-by-step encouragement to complete ADLs.

    Grade: 1
    User Responses: c.Provide ADL care for the client, allowing for frequent breaks.
    Feedback: a.Rationale: A client who is acutely delirious may require complete care for ADLs. It is important to balance rest with activity so the client does not become overstimulated. The client's cognitive impairments from the delirium do not support independence, the ability to follow directions, or a time limit.
    Cognitive Level: Application
    Nursing Process: Implementation
    Client Need: Physiological Integrity

24. **A caregiver for a client diagnosed with dementia of the Alzheimer's type is unable to effectively communicate with the client. Which of the following techniques would be most appropriate to teach the caregiver?**
    a. Setting strict time limits and rephrasing misunderstood questions
    b. Using multiple memory cues and giving several directions at once
    c. Encouraging verbal and nonverbal communication while maintaining a calm demeanor
    d. Correcting the client's errors and speaking in a loud, clear voice

    Grade: 1
    User Responses: c.Encouraging verbal and nonverbal communication while maintaining a calm demeanor
    Feedback: a.Rationale: It is important to teach the caregiver that as verbal communication skills decline, nonverbal communication will become more important. A calm demeanor will provide reassurance and allow the client to respond without sensory overload. Correcting errors, speaking in a loud voice, using multiple memory cues or directions, setting time limits, and rephrasing questions may overstimulate the client and increase frustration and anxiety.
    Cognitive Level: Application
    Nursing Process: Implementation
    Client Need: Psychosocial Integrity

Chapter 14 Pre Test

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Activity Name: Chapter 14 Pre Test

1. d. Express immediately that the comment is inappropriate.
2. a. Discuss concerns during clinical supervision.
3. c. Explain the client's condition and stress that safety is a priority.
4. b. Orientation.
5. b. Attempt to trigger semantic memory.
6. c. Placing alarms at all exits
7. a. The onset of delirium is rapid and abrupt.
8. a. Forgetfulness.
9. c. Short-term and long-term memory loss.
10. c. Reversible cognitive impairments.
11. d. An illusion.
12. c. Dementia is usually irreversible.
13. d. Cortical
14. d. Loss of nerve cells, disruption of nerve cell communication, and acetylcholine and serotonin deficits
15. b. Underlying systemic illness.
16. c. Sundowner syndrome.
17. c. Confabulation
18. c. Reminiscence activities
19. d. Assign a staff member to stay with the client 1:1.
20. d. Assign a staff member to assist the client during meals.
21. d. "Let's schedule a family meeting to discuss your concerns."
22. c. Provide the client with the dinner tray, open containers for the client, and hand the client items to ingest.
23. c. Provide ADL care for the client, allowing for frequent breaks.
24. c. Encouraging verbal and nonverbal communication while maintaining a calm demeanor