Chapter 32 Pre Test

Smith,Crystal

Submitted: 5/2/2011 4:42:37 PM **Grade:** 16.7% **Attempt Number:** 1/3 **Questions Attempted:** 18/18

1. **Which of the following foods would the nurse teach the client to include in a low-tyramine diet for MAOIs?**
   a. Peanuts
   b. Aged cheeses
   c. Banana peels
   d. Milk

   Grade: 1
   User Responses: d.Milk
   Feedback: a.Rationale: Banana peels, peanuts, and aged cheeses contain tyramine, while milk does not.
   Client Need: Application
   Nursing Process: Implementation
   Client Need: Physiological Integrity

2. **The client tells the nurse that side effects always interfere with adhering to a medication regimen. The client says, "I try to ignore the side effects but, sooner or later, they get so bad that I just quit taking the medication." What nursing intervention would be recommended for this client who has been recently started on olanzapine (Zyprexa)?**
   a. Teaching the client about effective ways to treat tardive dyskinesia.
   b. Advice on how to stay positive and not worry about potential side effects.
   c. Group medication teaching with other clients who have successfully managed side effects.
   d. Assurance that the new medication is unlikely to cause any side effects.

   Grade: 0
   User Responses: d.Assurance that the new medication is unlikely to cause any side effects.
   Feedback: a.Rationale: The client has been ignoring side effects instead of reporting them and learning to cope with them. The experiences of other clients with managing side effects would provide the client with successful strategies. Assuring that the client will have no side effects would be false reassurance. There are not many effective treatment strategies for tardive dyskinesia. Staying positive and not worrying may reinforce the client's past unsuccessful strategy of not reporting the side effects.
   Client Need: Analysis
   Nursing Process: Implementation
   Client Need: Physiological Integrity

3. **Which of the following would indicate the need for further teaching in a client taking citalopram (Celexa) for the treatment of depression?**
   a. I will resume taking St. John's wort when I am discharged.
   b. I will not have to obtain routine blood levels for this medication.
   c. I will use reminders to help to take the medication daily.
   d. I will report to the prescriber if suicidal thoughts occur.

Grade: 0
User Responses: d.I will report to the prescriber if suicidal thoughts occur.
Feedback: a.Rationale: St. John's wort is an herbal medication similar to an MAOI and can interact negatively with the SSRI citalopram. Blood levels are not taken with citalopram. The client should report suicidal thoughts and use reminders.
Client Need: Analysis
Nursing Process: Implementation
Client Need: Physiological Integrity

4. **The client on risperidone (Risperdal) asks why the nurse wants the client to lie down to have the blood pressure taken. What is the correct nursing response?**
   a. "Sometimes your medication can cause the blood pressure to drop when changing from a lying to a standing position."
   b. "Your medication causes a higher reading while standing, thus making the reading while lying down more accurate."
   c. "At times, medications can cause blood pressure to be erratic and the blood pressure while standing rises unevenly."
   d. "There is less chance that you could get injured on the equipment if you remain in bed."

Grade: 0
User Responses: d."There is less chance that you could get injured on the equipment if you remain in bed."
Feedback: a.Rationale: Postural hypotension is a possible side effect of antipsychotic medications, so the blood pressure is taken in the supine as well as the standing positions.
Client Need: Application
Nursing Process: Implementation
Client Need: Physiological Integrity

5. **A mother with severe depression is taking an SSRI during pregnancy and asks the nurse if the baby will have any reaction to the medication after birth. What is the correct nursing response?**
   a. SSRIs are relatively safe during pregnancy, and the baby will not have any symptoms after birth.
   b. The baby may have cognitive slowing and sedation.
   c. The baby may experience brief, mild symptoms of discontinuation.
   d. The baby may need medication to counteract the withdrawal symptoms.

Grade: 0
User Responses: d.The baby may need medication to counteract the withdrawal symptoms.
Feedback: a.Rationale: The baby may have mild, transient symptoms of SSRI discontinuation, including jitteriness and sleep disturbance. The nurse cannot guarantee that the baby will be completely symptom free. Discontinuation of an SSRI should not lead to cognitive slowing, sedation, or the need for treatment in the newborn.
Client Need: Analysis
Nursing Process: Implementation
Client Need: Physiological Integrity

6. **A client with schizophrenia is fearful that medication will make the illness worse and not better. Which of the following interventions would be most helpful to this patient?**
   a. Participation in self-managing medications as early as possible on the inpatient unit.
   b. Use of reminders for knowing when and how to take medications.
   c. Participation in group medication teaching with clients whose schizophrenia has improved.
   d. Explanation of why the client's illness could never get any worse than it already is.

Grade: 0
User Responses: d.Explanation of why the client's illness could never get any worse than it already is.
Feedback: a.Rationale: Actually discussing fears and seeing improvement in other clients with similar issues may provide the client with hope and willingness to partner in treatment. Telling the client that the illness could not get any worse takes away the client's hope and self-worth. While the use of reminders and participation in managing one's own medications are useful strategies for adherence, they do not address the client's current issue of lack of hope.
Client Need: Analysis
Nursing Process: Implementation
Client Need: Psychosocial Integrity

7. **The client on an antidepressant is worried because the client fears having the side effect of dystonia that another client experienced earlier in the day. What nursing response is therapeutic?**
   a. Even though the side effect looks scary, it is not uncomfortable.
   b. The medication that you are taking does not lead to that side effect.
   c. Dystonias are easily treated and never occur twice in a person.
   d. Having a side effect is better than potentially killing yourself.

Grade: 0
User Responses: d.Having a side effect is better than potentially killing yourself.
Feedback: a.Rationale: Dystonia is an EPSE that is associated with antipsychotic medication and typically not with antidepressants. Dystonias are easily treated but may reoccur and are uncomfortable for the client. Telling a client that having a side effect is better than the illness closes the conversation for helping the client to cope with side effects.
Client Need: Analysis
Nursing Process: Implementation
Client Need: Physiological Integrity

8. **The nurse would document which of the following findings as a symptom of tardive dyskinesia?**
   a. Blurred vision
   b. Rigidity
   c. Inability to sit still
   d. Involuntary lip smacking

Grade: 1
User Responses: d.Involuntary lip smacking
Feedback: a.Rationale: Tardive dyskinesia is characterized by coordinated, arrhythmic, involuntary movements. Rigidity is a symptom of parkinsonism. Inability to sit still may be a symptom of akathisia. Blurred vision may be a sign of an anticholinergic side effect.
Client Need: Application
Nursing Process: Assessment
Client Need: Physiological Integrity

9. **Which of the following assessment activities lend greater objectivity to the assessment of EPSEs? Select all correct answers.**
   a. Use of the Millon Clinical Multiaxial Inventory
   b. Use of a video camera for comparison over time
   c. Use of the Abnormal Involuntary Movement Scale
   d. Use of the Simpson Neurological Rating Scale
   e. Use of the Thematic Apperception Test

Grade: 0
User Responses: e.Use of the Thematic Apperception Test
Feedback: a.Rationale:
Use of the Simpson Neurological Rating Scale. This is an assessment tool for EPSEs.

Use of the Abnormal Involuntary Movement Scale. This is an assessment tool for iatrogenic movements from medications.

Use of a video camera for comparison over time. Videotaping the exam allows for objective comparison of the movement changes over time.

Use of the Millon Clinical Multiaxial Inventory. This is a scale for personality traits.

Use of the Thematic Apperception Test. This is a scale for exploring the client's emotional and interpersonal issues.
Client Need: Application
Nursing Process: Assessment
Client Need: Physiological Integrity

10. **A client who has been prescribed paliperidone (Invega) asks the nurse if taking benztropine (Cogentin) would help avoid some of the side effects that the client's friends have had while taking antipsychotic medications. What is the correct nursing response?**
    a. No one on paliperidone should get the kind of side effects that benztropine treats.
    b. It is better to let your prescriber bring up medication changes instead of your suggesting medications.
    c. Many clients never develop these symptoms, and benztropine does have some risks.
    d. Taking benztropine prophylactically with second generation antipsychotic medications is a recommended practice.

Grade: 0
User Responses: d.Taking benztropine prophylactically with second generation antipsychotic medications is a recommended practice.
Feedback: a.Rationale: Many people on second-generation antipsychotic medications never get EPSEs. All medications have potential negative side effects and interactions. Clients should partner with the treatment team in making decisions about medications. EPSEs are possible with this medication.
Client Need: Analysis
Nursing Process: Implementation
Client Need: Psychosocial Integrity

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11. **In helping a client who has been on a benzodiazepine for sleep problems for years, the nurse would need to know that which of the following factors might occur with a reduction of the benzodiazepine?**
    a. Delusions
    b. Over-sedation
    c. Rebound insomnia
    d. Anorexia

    Grade: 0
    User Responses: d.Anorexia
    Feedback: a.Rationale: Due to receptor site changes, rebound insomnia can occur when a client's benzodiazepine is reduced. Delusions, anorexia, and over-sedation should not occur.
    Client Need: Application
    Nursing Process: Assessment
    Client Need: Physiological Integrity

12. **Which of the following would be a nursing strategy to help reinforce medication teaching in a client with chronic schizophrenia?**
    a. Direct the client to ask the prescriber about anything that was not understood during the nurse's teaching.
    b. Have the client teach family members about the medication.
    c. Have the client repeat what was learned a few days later.
    d. Direct the client to remember what was learned because it is important.

    Grade: 0
    User Responses: d.Direct the client to remember what was learned because it is important.
    Feedback: a.Rationale: Having to teach something is an effective strategy for reinforcing new learning. A few days after the teaching would be too long an interval between the teaching and the return demonstration. Directing someone to remember something does not ensure that the person will remember. The client should ask the nurse at that time about anything that was not understood.
    Client Need: Application
    Nursing Process: Implementation
    Client Need: Psychosocial Integrity

13. **Which of the following findings would indicate to the nurse that benztropine (Cogentin) is effective in the client on an antipsychotic medication?**
    Select all correct answers.
    a. Fewer tremors
    b. Fewer hallucinations
    c. No lip-smacking or tongue protrusion
    d. No delusions
    e. No rigidity

Grade: 0
User Responses: e.No rigidity
Feedback: a.Rationale:
No rigidity. Benztropine is used to treat parkinsonism as a side effect of an antipsychotic medication.

Fewer tremors. Benztropine is used to treat parkinsonism as a side effect of an antipsychotic medication.

No delusions. Benztropine does not impact delusions.

Fewer hallucinations. Benztropine is not prescribed to treat hallucinations.

No lip-smacking or tongue protrusion. Benztropine is not effective for tardive dyskinesia.
Cognitive Level: Analysis
Nursing Process: Evaluation
Client Need: Physiological Integrity

14. **Assessing the effectiveness of psychiatric medications requires the nurse to ask questions primarily about which of the following?**
    a. Motivation, ability and level of formal education
    b. Target symptoms of the disorder and side effects
    c. Cultural background and desire to change
    d. Family functioning and appetite

Grade: 0
User Responses: d.Family functioning and appetite
Feedback: a.Rationale: Psychiatric medications are effective if they ameliorate the symptoms of the disorder and have tolerable side effects. Questions about the other areas may be useful in some situations but are not the primary focus of what should be assessed for medication efficacy.
Cognitive Level: Analysis
Nursing Process: Evaluation
Client Need: Physiological Integrity

15. **Which of the following would indicate that the client's antipsychotic medication is not effective, given that the client has taken it for one week of treatment during an acute episode?**
    a. The client attends group therapy and participates minimally.
    b. The client thinks that the medication is poison.
    c. The client hears voices that are manageable.
    d. The client likes to sit and watch television.

Grade: 0
User Responses: d.The client likes to sit and watch television.
Feedback: a.Rationale: After a week, the paranoid delusions should lessen. The client's thinking that the medication is poison indicates the medication is not effective. After a week, the client may continue to have manageable hallucinations, participate minimally, and watch television.
Cognitive Level: Analysis
Nursing Process: Evaluation
Client Need: Physiological Integrity

16. **A client with chronic schizophrenia states an inability to remember to take medications despite the use of pill boxes and reminders. What might the nurse discuss with the client and treatment team as the best acceptable strategy for adherence?**
a. Long-term hospitalization
b. The use of depot injections
c. Teaching on the effectiveness of medication
d. Free medication samples

Grade: 0
User Responses: d.Free medication samples
Feedback: a.Rationale: Depot injections are administered weekly, bi-weekly, or monthly so that the client does not have to remember to take pills. Hospitalization is not warranted at this point. The client's issue is with memory and not with knowledge of effectiveness or cost.
Client Need: Analysis
Nursing Process: Implementation
Client Need: Psychosocial Integrity

17. **Which of the following factors would be most likely to lead to nonadherence to a medication regimen for the client with schizophrenia?**
a. Lack of social skills with peers
b. Active recovery and sobriety
c. Never having experienced any side effects
d. Auditory hallucinations related to not trusting the treatment

Grade: 1
User Responses: d.Auditory hallucinations related to not trusting the treatment
Feedback: a.Rationale: Severe symptoms of schizophrenia are factors that contribute to nonadherence. A lack of social skills with peers is not directly related to adherence. Past negative experiences, such as side effects, may contribute to nonadherence. Sobriety should help with adherence.
Client Need: Analysis
Nursing Process: Assessment
Client Need: Psychosocial Integrity

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18. **Which of the following cultural beliefs would be most likely to contribute to lack of medication adherence?**
    a. A belief that a supportive family can help
    b. A belief that learning contributes to healing
    c. A belief that nothing but prayer can heal
    d. A belief that alcohol is sinful

Grade: 0
User Responses: d.A belief that alcohol is sinful
Feedback: a.Rationale: If a client believes that only prayer can heal, the client will not be open to using other strategies such as medication. A belief in a supportive family can be beneficial, as would be a belief in learning. Although a belief that alcohol is sinful may not concur with beliefs of the treatment team, it should not interfere with medication adherence.
Client Need: Analysis
Nursing Process: Assessment
Client Need: Psychosocial Integrity

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Activity Name: Chapter 32 Pre Test

1. d. Milk
2. c. Group medication teaching with other clients who have successfully managed side effects.
3. a. I will resume taking St. John's wort when I am discharged.
4. a. "Sometimes your medication can cause the blood pressure to drop when changing from a lying to a standing position."
5. c. The baby may experience brief, mild symptoms of discontinuation.
6. c. Participation in group medication teaching with clients whose schizophrenia has improved.
7. b. The medication that you are taking does not lead to that side effect.
8. d. Involuntary lip smacking
9. d. Use of the Simpson Neurological Rating Scale and c.Use of the Abnormal Involuntary Movement Scale and b. Use of a video camera for comparison over time
10. c. Many clients never develop these symptoms, and benztropine does have some risks.
11. c. Rebound insomnia
12. b. Have the client teach family members about the medication.
13. e. No rigidity and a.Fewer tremors
14. b. Target symptoms of the disorder and side effects
15. b. The client thinks that the medication is poison.
16. b. The use of depot injections
17. d. Auditory hallucinations related to not trusting the treatment
18. c. A belief that nothing but prayer can heal