1 . The nurse is caring for the client who was violently raped 3 months ago and has a diagnosis of rape-trauma syndrome. Which assessment findings, associated with rape-trauma syndrome, should the nurse anticipate? Select all that apply.

A. Anorexia
B. Nightmares
C. Hypertension
D. Fears and phobias
E. Sexual promiscuity

ANSWER: A,B,D

A. Rape-trauma syndrome symptoms include physiological symptoms such as loss of appetite.
B. Rape-trauma syndrome symptoms may include nightmares of the attack occurring again.
C. While hypertension may be a result of long term stress, it is not recognized as a symptom of rape-trauma syndrome.
D. Rape-trauma syndrome symptoms include fears and phobias; these usually arise due to the victim's feelings of being unable to protect him- or herself from the assault. Fears may include the fear that the assailant might try to find the victim again.
E. Fear of sexual encounters rather than sexual promiscuity is a recognized symptom of rape-trauma syndrome.

2. The client is being admitted to the ICU with drug overdose that resulted in extreme hypertension and an unstable cardiac rhythm. The client suddenly becomes physically combative and is kicking, shoving, throwing items in the room, and threatening staff. The charge nurse calls a behavioral situation code, and 4-point restraints are applied by the team. Which intervention is most important for the nurse to implement next?

A. Have staff members who were harmed complete an incident report.
B. Contact the health care provider to obtain an order for restraint use.
C. Document the client's behavior and action taken in the nurse's notes.
D. Check that the client's wrist restraints are tightly secured to the HOB.

ANSWER: B

A. Staff members who are injured should be seen by the employee health service and an incident report completed, but this is not the next intervention.
B. If physical restraints are initiated, a physician or licensed independent practitioner must prescribe the restraints, assess the client, and evaluate the

need for restraints within 1 hour of the restraints being placed. The restraints could be placed immediately for client self-protection and protection of others.

C. It is more important to contact the HCP first. Although documentation is important, the nurse would also include inibnnation about contacting the HC P.
D. The client should be restrained in the supine position with arms restrained so that one arm is flexed up and the other is extended at the side of the bed. The HOB should be elevated 30 degrees to decrease the risk of aspiration. Extending both arms overhead can impair circulation.

3. The nurse is unavoidably late in changing the dressing on the client's leg. The client reacts by becoming verbally aggressive and telling the nurse, "None of you can be trusted. You all just make promises you never intend to keep." Which should be the nurse's initial action?

A. Alert other staff to the client's apparent escalation.
B. Ask why the client is overreacting to the situation.
C. Leave the room until the client has regained control.
D. Apologize to the client for being late with the treatment.

ANSWER: D

A. If the client does not de-escalate with an apology and the nurse‘s presence, then the nurse should alert the staff.
B. Asking a why question is challenging the client and can cause the client to become defensive or increase the client's distress.
C. The nurse should not leave but first validate the client's distress and then attempt to communicate with the client.
D. By apologizing for being late with the treatment, the nurse is validating the client's distress and acknowledging his or her role in creating the situation.

4. The client is admitted to the ED with multiple lacerations and broken bones after being assaulted. The client's spouse barges into the client's ED room with a gun and states, "I'm going to kill you and anyone else who gets in my way." Which action should be taken by the nurse initially?

A. Yell for help to distract the person's attention away from the client.
B. Firmly state, "You don't want to hurt anyone else. Let's talk about it."
C. Use gestures to alert another nurse to clear others who may be nearby.
D. Use a nonaggressive posture and tone to state, "Put the gun on the floor."

ANSWER: D

A. A technique for de-escalating is to redirect and or divert the person's emotions. Yelling does not redirect emotions; it may startle the person, and the nurse or the client could be shot.
B. The nurse is assuming that the client's spouse is the person who assaulted the client, which may be incorrect. Telling the client what to do is a block to therapeutic communication.
C. Gesturing that could be observed by the person holding the gun may escalate the situation. If the person barged into the room, others may already be aware of the situation, clearing the area and notifying security.
D. The nurse should initially talk to the client's spouse using a nonaggressive posture and tone of voice to diffuse the situation.

5. The nurse observes that the client diagnosed with intermittent explosive disorder is becoming aggressive and that lorazepam was prescribed. The client is now exhibiting a tense posture, a clenched fist, and a defiant affect. Prioritize the nurse's actions to de-escalate the client's aggression.

A. Call other staff for assistance.
B. Attempt to talk the client down.
C. Apply wrist restraints.
D. Offer client choice of taking medication voluntarily.
E. Provide alternate use of physical energy, such as suggesting punching a pillow.

ANSWER: B, E, D, A, C

B. Attempt to talk the client down. Talking the client down may promote a trusting relationship and help to diffuse the client's anger and determine the underlying cause.

E. Provide alternate use of physical energy, such as suggesting punching a pillow. This activity provides an effective means for the client to release tension associated with high levels of anger.

D. Offer client choice of taking medication voluntarily. Lorazepam (Ativan) or another tranquilizing medication may calm the client and prevent violence from escalating.

A. Call other staff for assistance. Client and staff safety are of primary concern if the behavior continues to escalate. Sufficient staff to indicate a show of strength may be enough to de-escalate the situation, and the client may agree to take the medication.

C. Apply wrist restraints. The client who does not have internal control over his or her own behavior may require external controls, such as mechanical restraints. in order to prevent harm to self or others.

6. The nurse is to administer haloperidol 2 mg IV now to the hospitalized client. A vial of haloperidol 5 mg/mL is available. How many milliliters of medication should the nurse administer?_____ mL (Record your answer rounded to the nearest tenth.)

ANSWER: 0.4

Use a proportion formulation to calculate the dose. Then multiply the extremes (outside values) and means (inside values) to solve for

X. 5 mg :1 mL::2 mg : XmL;

5X=2;

X= 0.4

The nurse should administer 0.4 mL haloperidol (Haldol).

7. Staff are debriefing following the client's violent episode. Which information should be included in the debriefing session? Select all that apply.

A. Client's coping mechanisms post-event
B. The client's history of violent behavior
C. Adherence to instructional policies and procedures
D. Staff 's feelings regarding the effectiveness of the team
E. Staff's ability to respond to the client therapeutically post-event

ANSWER: C,D,E

A. The client's coping mechanisms are not generally pertinent to the post-event debriefing.
B. A history of violence is not generally pertinent to the post-event debriefing.
C. The staff debriefing should include whether everyone adhered to facility policies and procedures; this will help to identify the need for additional/remedial staff training.
D. The staff debriefing should include team effectiveness; this will help to identify readiness to respond and manage the event and the need for additional/remedial staff training.
E. The staff debriefing should include the staff's ability to respond to the client therapeutically post-event. This will help to identify the need for additional/remedial staff training.

8. The client has been placed in restraints for violent behavior. Which statement best indicates the nurse's understanding of the risk for client injury while being restrained?

A. "Can you arrange to order the client's favorite sandwich for his lunch?"

B. “I need to make sure the restraints’ release mechanisms are working properly.”
C. “I need someone to continuously monitor the client and relieve me for a few minutes.”
D. “The client’s feet feel a little cool, but they have a good pulse. I’ll get a pair of socks.”

ANSWER: C

A. While nutrition is an important consideration, the most important action regarding client safety while in restraints is monitoring.
B. While the proper working of the restraints is important. it cannot be achieved without appropriate client monitoring.
C. The client must be constantly monitored when in restraints in order to assess for and prevent any type of client injury.
D. Assessing for adequate circulation is important, but it cannot be monitored effectively if the client is not being observed constantly.

9. The nurse is preparing to document the client’s violent episode. Which statements should be included specifically about the violent episode? Select all that apply.

A. Client’s wife called during the escalation cycle.
B. Client refused to voluntarily enter into seclusion.
C. Client stated, “All of you are just evil people.”
D. Attempts to identify the cause of client’s agitation failed.
E. Five staff members responded to “Emergency Code.”
F. Client asked to leave seclusion room after 30 minutes.

ANSWER: B, C. D. F

A. The fact that the client‘s wife telephones during the event does not reflect on the circumstances of the event, and so it does not need to be documented.
B. Documentation of the client's violent cycle must include observations of client behavior during the entire cycle.
C. Documentation of the client's violent cycle must include observations of client behavior. including client statements, during the entire cycle.
D. Documentation of the client’s violent cycle must include all nursing interventions used and the client’s response to the interventions.
E. Tire number of individuals responding to the emergency need not be documented.
F. Documentation of the client’s violent cycle must include how the client was reintegratcd into the unit’s milieu.

10. The client with Alzheimer's disease becomes Increasingly agitated and states, "I must go and clean out the barn!" Which nursing response is most therapeutic?

A. "What makes you think that the barn needs to be cleaned?"
B. "So you've cleaned a ham. Tell me, did you live on a farm?"
C. "It's awfully hot today; maybe you should wait until tomorrow."
D. "There are no barns around here. Would you like something to eat?"

ANSWER: B

A. While redirecting the client's attention is appropriate, asking the client this question may be interpreted as argumentative or challenging and may escalate the client's agitation.
B. Rather than attempting to reorient the agitated, cognitively impaired client, asking the client to describe feelings or memories related to the situation may effectively divert the client's attention to a less problematic focus.
C. Explaining that it is hot to the client may be seen as an obstacle to therapeutic communication.
D. Stating there are no barns here and attempting to redirect the client's attention may be viewed as merely putting an obstacle in the client's way.

11 . The experienced nurse determines that the new nurse's actions are therapeutic when managing the cognitively impaired client whose agitated behavior is escalating. Which nursing actions should have occurred? Select all that apply.

A. Saying, "Mr. Smith, will you look at me, please?"
B. Saying, "You seem upset. How can I help you?"
C. Presenting the client with detailed expectations.
D. Turning off the television in the room to decrease noise.
E. Saying, "Getting so angry will not help you get what you want."
F. Speaking as loud as the client to ensure that the client hears what is being said.

ANSWER: A, B, D

A. Calling the client by name and achieving eye contact may have a calming effect for a cognitively impaired, agitated client.
B. Acknowledging the client's agitation may help the client regain control.
C. Complex explanations and extensive conversation are likely to be interpreted as more sensory stimuli to the agitated client.
D. Decreasing the stimuli in the area may have a calming effect on the client.

E. The client is not capable of rational thought; telling the client that being angry will not get the client what the client wants may be interpreted as a challenge to the client.
F. Speaking in a loud tone may serve to escalate the client's agitation.

12. The new nurse is working with the cognitively impaired client who has a history of violent behavior. Which statement, made by the new nurse, reflects an immediate need for follow-up by the mentor?

A. “My first concern is the safety of all those on the unit.”
B. “I know to turn off the television when the client starts pacing the floor.”
C. “When the client started getting aggressive ,I tried talking the client down.”
D. “I’m going to try and assign the same staff to work with the client each shift.”

ANSWER: C

A. Safety of all on the unit is a major concern and does not require follow up.
B. Minimizing external stimuli and the use of sound judgment are important in providing a therapeutic milieu for an agitated client and do not require follow-up.
C. The mentor should follow up when the new nurse attempts to talk to the agitated client. Until the client regains control, talking will be interpreted as external stimulation. As the client becomes calmer and more secure, attempts can then be made to redirect the client’s attention and behavior.
D. Surrounding the client with the same staff every day will be beneficial for the client and does not require follow-up.

13. The nurse is developing the plan of care for the client diagnosed with schizophrenia who is having an alcohol-induced crisis. Which specific client outcome best reflects the primary goal of crisis intervention for this client?

A. Client will be successfully detoxified within 20 days.
B. Client will return to his or her part-time job within 20 days.
C. Client will state two effective coping mechanisms prior to discharge.
D. Client will demonstrate self-administration of medications prior to discharge.

ANSWER: B

A. Detoxification is directed toward treatment of the underlying condition, alcohol abuse, and is not focused on the goal of crisis intervention.

B. The primary goal of crisis intervention is to return the client to his or her pre crisis level of functioning. Returning to work is the most appropriate outcome directed toward that goal.
C. The client should be demonstrating the use of effective coping mechanisms, not just stating them.
D. The client's ability to self-administer medication is necessary for treating schizophrenia but is not a goal specific to the crisis situation.

14. Staff members have expressed fear of the client who has a history of violent behavior. Which response made by the lead nurse would be most beneficial in addressing the staff's expressed concerns?

A. "Let's not prejudge him. His medication should help him control his behavior."
B. "I will be very attentive to his behavior, monitoring it for any signs of escalation."
C. "It may be hard, but we need to appear calm and nonthreatening but alert to his behavior."
D. "As staff we are all trained to manage violent clients, and we can handle any crisis behavior."

ANSWER: C

A. This response focuses on the client and fails to address the concerns expressed by the staff members.
B. The concerns expressed by the staff are not taken into consideration. The lead nurse's response does not appear to value the staff's opinions.
C. When dealing with potentially violent clients, although it may be very difficult, it is imperative to present a calm, relaxed, nonthreatening demeanor. This option both addresses the staff concerns and offers direction regarding client management.
D. This response fails to address the concerns expressed and a means of controlling the feared behavior.

15. The newly admitted client is expressing anger with increasing intensity. Which therapeutic site should the nurse recommend to the client for gaining control over the increasing anger?

A. The client's own private room down the hall
B. The unit's common television dayroom
C. An outdoor sheltered client smoking area
D. An out-of the-way corner near the nursing station

ANSWER: D

A. The client’s room is not visible to the staff; the safety of everyone on the unit would be a concern.
B. The dayroom is not quiet; stimulation can increase the agitation and anger.
C. An outside area is not visible to the staff; the safety of the client and others using the smoking area would be a concern.
D. A quiet location that is visible to the staff is best. A quiet environment is critical for client descalation.

16. The client with a history of aggressive behavior to ward staff and peers states to the nurse, “Everyone is just so touchy; I don’t see where I’m being too aggressive.” Which nursing action should be included in the therapeutic plan of care to best effect a difference in perceptions?

A. Refamiliarize the client with the rules of the unit.
B. Introduce nonaggressive interpersonal behaviors to the client.
C. Promote dialogue between the staff and client to discuss the staff’s perceptions of aggressive behavior.
D. Encourage the staff to show patience to the client because the client may have poor aggression control.

ANSWER: C

A. Refamiliarizing the client with unit rules is not an inappropriate option; it may have little impact on the client's aggressive behavior.
B. Provrdlng alternate behaviours IS an appropnate option but is not the most therapeutic because the various perceptions need to be addressed first.
C. Research has shown that staff and clients often have different perceptions of aggressive behaviors and of how to control or reduce aggression. Thus, promoting a dialogue between the client and the staff can clarify the different perceptions.
D. Suggesting “patience" is not appropriate because the client’s aggressive behavior is a risk for injury to the milieu.

17. The client is placed in seclusion for exhibiting violent behavior. Which should be the nurse’s primary goal of this seclusion?

A. Assist the client in regaining self-control
B. Assure the safety of the client and others
C. Regain control over the unit’s environment
D. Provide a consequence for the client’s behavior

ANSWER: B

A. Regaining self—control is an outcome rather than the goal of seclusion.
B. The primary goal of seclusion is always safety of the client and others by decreasing environmental stimuli.
C. Unit control is an outcome rather than the goal of seclusion.
D. Seclusion should never be used as punishment for behavior.

18. The client is experiencing withdrawal symptoms leading to sleep deprivation. The nurse should recognize that the client is at greatest risk for violent behavior due to which assessment finding?

A. Poor coping mechanisms
B. Physical pain from withdrawal
C. A sense of guilt/shame regarding family
D. Anxiety over lack of access to the substance of choice.

ANSWER: D

A. While the lack of coping skills may result in violent behavior, the primary cause is likely no access to drug/alcohol.
B. While inadequately managed physical pain resulting from withdrawal may result in violent behavior, the primary cause is likely no access to drug/alcohol.
C. While a sense of guilt or shame regarding family may result in violent behavior, the primary cause is likely no access to drug alcohol.
D. The client hospitalized for chemical dependency is at risk for developing violent behavior due to anxiety related to a loss of access to the drug of choice.

19. The client on the mental health unit is becoming increasingly short-tempered with others; the client approaches the nurse's desk and, pounding on the counter, yells, "I want out of here now!" After the incident, the nurse documents the violent behaviors. Place an X in the column for each of the client's violent behaviors.

Violent Behaviors	Client's Violent Behaviors
Confusion	
Irritability	
Boisterousness	
Verbal threats	
Attacks on objects	

Violent Behaviors	Client's Violent Behaviors
Confusion	
Irritability	X
Boisterousness	X
Verbal threats	
Attacks on objects	X

Violent behaviors displayed by the client include short-tempered (irritability), yelling (boisterousness), and pounding on the desk (attacks on objects). There is no evidence of confusion or making verbal threats.

20. The nurse educator is orienting new nursing staff to the behavioral care unit when one nurse asks, "How will I know which clients are potentially violent?" Which response by the nurse educator is best?

A. "Just be alert and aware of your client's behavioral clues."
B. "The client prone to violence will usually tell you they are angry about something."
C. "As you plan care, review the clients' charts to determine who has a history of violence."
D. "Your orientation will include an iii-service on violent clients and how to identify them."

ANSWER: C

A. Suggesting that the staff be alert and aware does not effectively address the staff's concerns about identifying potential violent clients.

B. The staff needs to be aware of potential violence well before the client verbally expresses the anger.
C. The two most significant predictors of violence are a history of violence and impulsivity. Thus, reviewing the client's chart for this information is best.
D. Telling the nurse that the information will be provided during iii-service education does not answer the nurse's question.

21 . The client who recently emigrated from Iran is on the mental health unit and has been placed in seclusion. The nurse assesses that the client is now calm and ready to be assimilated back into the mental health milieu. Which action by the nurse demonstrates cultural insensitivity?

A. Gives the client a thumbs-up gesture
B. Avoids looking at the clock or a watch
C. Has the NA bring the client a cup of tea
D. Offers to bring the client the book of Quran

ANSWER: A

A. Although a thumbs-up gesture may mean "good job" in the U.S., it is considered an offensive gesture by persons from many Middle Eastern countries. It is comparable to a raised middle finger in the U.S.
B. If it appears that the nurse is fixated on time, the nurse may not be trusted.
C. Tea is the most common beverage consumed by Iranians.
D. Islam is practiced by the majority of Iranians.

22. The nurse manager, concerned about the potential for staff harm on a behavioral health unit, is assessing the unit's milieu. 'Which milieu situation should the nurse manager address because it is a predictive factor for violence?

A. Two clients have a history of spousal abuse.
B. Several clients have lost smoking privileges.
C. The unit is currently at less than full client capacity.
D. The nurse from a medical unit is assigned to work on the unit.

ANSWER: D

A. A history of violent behavior is considered a predictor of potential violence, but it is a client- oriented and not a milieu-oriented factor.
B. While revocation of privileges may contribute to the potential for violence, it is a client-oriented and not a milieu-oriented factor.
C. Unit overcrowding, and not less than capacity, is considered an environmental predictor of violence.
D. Staff inexperience is a significant environmental predictor of violent behavior of clients. The nurse manager should address this situation.

23. Multiple clients are being cared for on the behavioral health unit. In which circumstances should the nurse plan the therapeutic use of seclusion and/or restraints? Select all that apply.

A. The client asks to be placed in seclusion.
B. The client expresses the likelihood of self-injury.
C. The staff feels the client is likely to harm others-
D. A legally detained client is threatening to “escape.”
E. The staff identifies seclusion as a consequence of the client’s behavior.
F. The client’s threatening behavior is negatively affecting the therapeutic milieu.

ANSWER: A,B,C,D

A. The client requesting to be placed in seclusion is a reason to therapeutically employ seclusion.
B. The likelihood of harming self or others is one of the reasons to therapeutically employ seclusion and/or restraints.
C. If the staff feels as though the client is likely to harm others, a plan of therapeutic use of seclusion and/or restraints should be utilized to protect others.
D. An involuntarily detained client who threatens to escape should be placed in seclusion or restraints as a method of therapeutic use. The client is being legally detained.
E. Neither seclusion nor restraints should ever be used as punishment for the client’s behavior.
F. While the client’s behavior may result in disruption to the milieu, seclusion and restraints are therapeutic only after all alternative interventions have been tried.

24. The client has been violent toward other clients on a mental health unit, and interventions have failed. During the application of restraints, which action by the team leader will gain the greatest cooperation from the client?

A. Showing sympathy by apologizing for the need to restrain the client
B. Dispassionately explaining why and how the restraints will be applied
C. Affording the client one last opportunity to avoid restraints by “behaving”
D. Offering to remove the restraints as soon as the client can “control the anger”

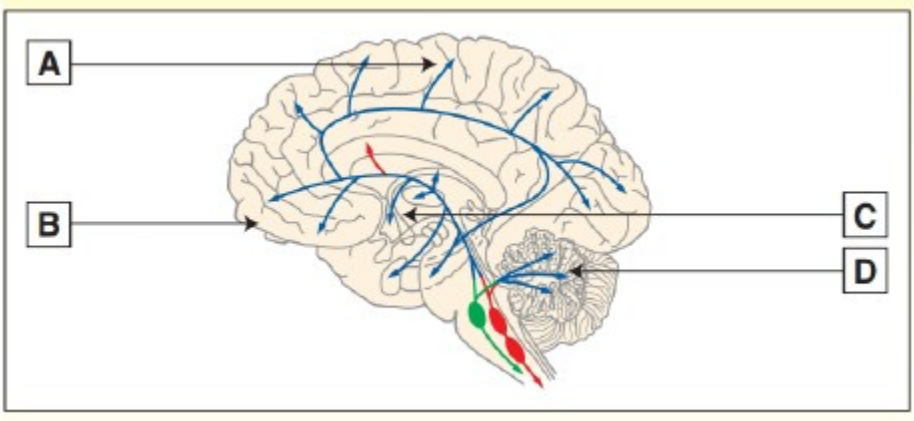
ANSWER: B

A. To apologize would give the client the impression that the client is being mistreated. The nurse should not view the application of

restraints as something to be sorry for; it is in the client's best interest to be assisted in the process of regaining control.

B. By providing an explanation of what is to happen and why, the client may resist less or, in some instances, decide to alter the behavior, especially once an understanding of the intervention is achieved. A dispassionate explanation avoids the nurse's emotions being misinterpreted by the client.
C. Once the decision is made that restraints are the appropriate intervention, the client is not given an opportunity to negotiate out of their application.
D. Offering a situation when the restraints can be removed will not have much impact on securing the client's cooperation in actually applying the restraints.

25. The client who sustained a brain injury from an MVA is now experiencing aggression, impulsivity and poorjudgment. In teaching the family, which area of the brain illustrated should the nurse identify as being affected?



A. Line A
B. Line B
C. Line C
D. Line D

ANSWER: B

A. The cortex (line A) controls motor functions.
B. An inability to modulate judgment, aggression, and impulsivity results from a failure of control systems in the prefrontal cortex (line B) and limbic systems.
C. The hypothalamus (line C) controls temperature and fluid regulation.
D. The cerebellum (line D) controls balance.

26. The client has been placed in involuntary seclusion. Which assessment observation best indicates to the nurse the client's readiness to leave involuntary seclusion?

A. The client calmly stating," I have control over my anger now."
B. BP is 110/64 mm Hg; P is 82 bpm and regular; R is 16 bpm and regular.
C. Client is observed sitting in seclusion room doorway asking staff for a drink.
D. Medical record states, "Seclusion of 45 minutes resulted in improved control."

ANSWER: C

A. While the client's statement is a positive indicator of regained control, it is not as definitive as observed behavior regarding exposure to increased stimulation.
B. VS may indicate physical calmness, but they are not as definitive as observed behavior regarding exposure to increased stimulation.
C. The client is showing the ability to tolerate the stimulation provided by being in the doorway and still appropriately asking for needs to be met. The reintegration of the client into the milieu should be done gradually so as to monitor the client's ability to handle increased stimulation.
D. While past behavior may indicate a pattern, it is not as definitive as observed behavior regarding exposure to increased stimulation.

27. The client is visibly upset, pounding on the desk at the nurses' station and shouting," You're the nurse, so you have to fix this now." What should be the nurse's primary rationale for recognizing that the client is a danger to staff and other clients?

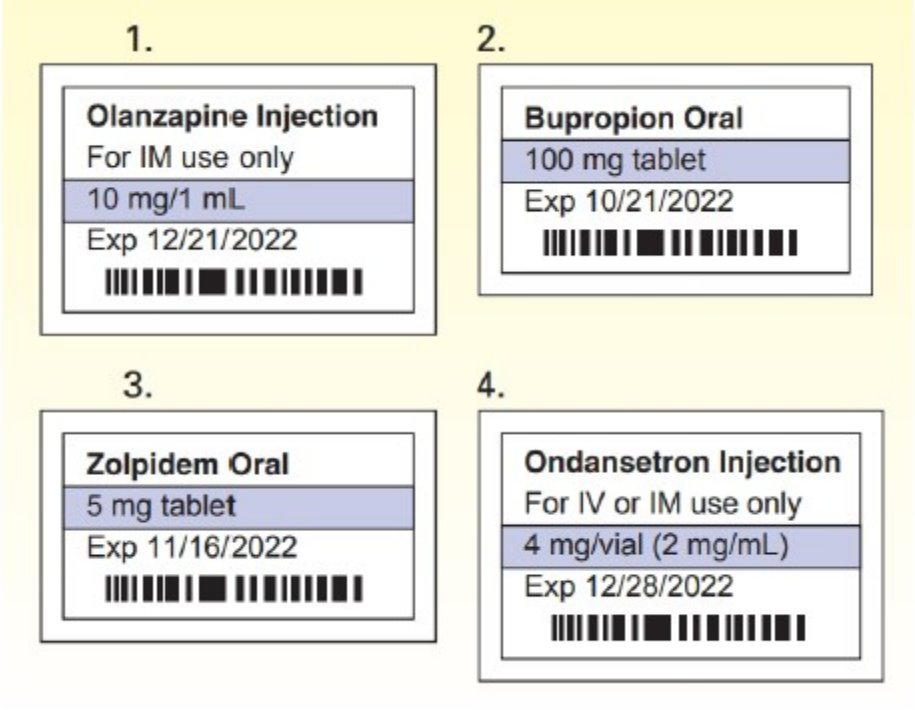
A. The client is verbally threatening the nurse to fix the situation now.
B. The client does not acknowledge his or her role in the problem-solving process.
C. The client has no apparent ability to recognize that he or she is acting inappropriately-
D. The client's main strategy for meeting personal needs and wants is intimidation and anger.

ANSWER: D

A. Hitting the desk is a threatening gesture, but the client has not verbally threatened the nurse.
B. It is inappropriate to assume that the client does not acknowledge his or her role in the problem- solving process.

C. There is no information to assume that the client does not recognize that he or she is acting inappropriately.
D. For some, intimidation and anger are the primary strategies for obtaining needs and goals and for achieving feelings of mastery and control. The nurse should recognize that the client is a danger to staff and others when using intimidation and anger.

28. The client on a medical nursing unit is acutely agitated, getting out of bed unassisted despite having a high risk for falling, and is now hitting and biting staff. Which medication prescribed prn should the nurse administer to help calm the client?



ANSWER: A

A. Olanzapine (Zyprexa) is an antipsychotic and mood stabilizer. It antagonizes dopamine and serotonin type 2 in the CNS. It is useful in helping to control acute agitation. The initial dose would be 0.5 mg, and the dose should be increased cautiously because it produces hypotension.
B. Bupropion (Wellbutrin, Zyban) is an antidepressant that decreases neuronal reuptake of dopamine in the CNS; it is also used for smoking cessation.
C. Zolpidem (Ambien) is a sedative/hypnotic that produces CNS depression and is used for sleep.
D. Ondansetron (Zofran) is an antiemetic that blocks serotonin at vagal nerve terminals and in the CNS; it would not be useful in controlling agitation.

29. The nurse is planning care for the client who has a cognitive deficit and a history of violence following head trauma- What is the primary effect of a cognitive deficit that can contribute to the client having a catastrophically violent reaction?

A. The client's ability to process information, including instructions, is limited-
B. The client has a decreased ability to interpret and tolerate sensory stimuli.
C. The staff has a more difficult time providing appropriate milieu boundaries.
D. The staff's attention is oftentimes diverted to other, more manipulative clients.

ANSWER: B

A. The client with a cognitive deficit is not necessarily unable to process information.
B. A cognitive deficit results in a decreased ability to interpret and tolerate sensory stimuli, which in turn can trigger a catastrophic reaction.
C. The staff having a more difficult time providing milieu boundaries is not always true.
D. The staff's attention is not oftentimes diverted to a more manipulative client.

30. When debriefing the unit's staff after the client's catastrophic reaction, the nurse stresses the need for the staff to remain calm during the event. Which statement should be the basis for the nurse's comment?

A. The client's safety is at jeopardy if the staff is feeling threatened.
B. An agitated staff will not be able to manage the situation as effectively.
C. The client will sense the staff's agitation, and aggressive behavior will escalate.
D. An agitated staff response is indicative of a need for additional crisis-control training.

ANSWER: C

A. Although an agitated staff member may find it more difficult to keep the client's safety in mind, it is not the primary reason to remain calm.
B. Although an agitated staff member may not be as in control of the situation, it is not the primary reason to remain calm.
C. Presence of other agitated people leads to increased agitation for the client.

D. A staff member's ineffective behavior would require additional training, but it is not the primary reason to remain calm.

31 . The indigent client with both emotional and physical diagnoses has just attended a discharge planning session with the nurse. Which client behavior shows the greatest commitment to the client's self-management?

A. Correctly stating the medications prescribed and the administration schedule
B. Asking to stay with a relative until an affordable place to live can be found
C. Researching the names of and calling contact people at local support centers
D. Promising the nurse to keep the scheduled follow-up appointments at the clinic

ANSWER: C

A. Stating the medications prescribed and the administration schedule does not demonstrate that the client can actually carry out the correct administration schedule.
B. Asking to stay with a relative does not Show as much commitment to self—improvement as does the correct option.
C. Telephoning contacts at support services shows both an understanding of and a willingness to utilize the services. Research has shown that beginning client linkage to services prior to discharge has a positive effect on client outcomes.
D. Making promises does not necessarily indicate that the client will follow through with these.

32. The client is admitted to an ED with facial bruises, a broken arm, and rib fractures. The client states, "I fell down the stairs." During assessment, the nurse notes bruises and lacerations in various stages of healing. Which nursing questions are appropriate? Select all that apply.

A. "Has anyone hurt you?"
B. "Are you afraid of anyone at home?"
C. "Have you been falling down a lot lately?"
D. "Have you had any fainting spells or times that you have been weak?"
E. "I noticed you have more bruises. Can you tell me how they happened?"
F. "You look abused. Why haven't you reported that you have been abused?"

ANSWER: A,B,C, D, E

A. Asking if anyone hurt the client is exploring the possibility of abuse and an appropriate question.
B. Asking if the client is afraid of anyone at home is exploring the possibility of abuse and an appropriate question.
C. Neurological or cardiovascular alterations, such as TIAs or low BP or pulse rate, can also result in falls. Asking about the frequency of falls is appropriate.
D. Neurological or cardiovascular alterations, such as This or low BP or pulse rate, can also result in falls. Asking about fainting spells and weakness is appropriate.
E. Whenever a person presents with multiple injuries in various stages of healing, the possibility of abuse should be explored. Having the client explain how these happened may help determine the source.
F. Asking why the client has not reported abuse is insensitive and presumptuous.

33. The nurse in the ED is admitting an agitated young adult who tried to jump from a bridge after taking a hallucinogenic drug at a party. What should be the nurse's initial action?

A. Call the mental health unit to arrange for inpatient treatment.
B. Give medications to reverse the effects of the hallucinogenic drug.
C. Stay with the client to protect the client from self-harm until relieved.
D. Call hospital security so security staff is present to protect staff from injury.

ANSWER: C

A. inpatient treatment may be prescribed, but this is not the initial action.
B. There are no reversal agents for hallucinogenic drugs. Medications can be administered to decrease agitation.
C. Hallucinogenic drugs alter perception; the client should not be left unattended.
D. Although the client is agitated, there is no evidence of violence against others, but the potential exists.

34. The nurse is caring for an unresponsive toddler in a PICU. The child's parent was arrested for alleged child abuse but released on bail. The parent is pounding at the door, belligerent, and demanding to visit the child. Which is the most appropriate nursing plan of action?

A. Allow the parent to enter the room and see the child.
B. Tell the parent that the HCP wants to speak with the parent first.
C. Contact Social Services to report the parent's abusive behavior.
D. Initiate the emergency response system for behavioral situations.

ANSWER: D

A. Without clear orders, the nurse must not allow contact between the parent and child.
B. There is no indication that the HCP wishes to speak with the parent. The HCP does not decide who has access to the child.
C. A report to Social Services should have already been filed because the parent had previously been arrested for alleged child abuse.
D. The nurse's primary responsibility is the safety of the child and others. The nurse would initiate the hospital's emergency response system for behavioral situations to a secure a supervisor, security staff, and others.

35. The nurse is reviewing the medical records of children who have been abused. Which main common characteristic of parents who abuse children is the nurse most likely to identify?

A. History of mental illness
B. Violent behavior patterns
C. Isolation of parent or family
D. Parent older than 40 years of age

ANSWER: C

A. Approximately 10% of parents who abuse children have a diagnosis ofa mental illness.
B. Most parents who abuse seem relatively the same as other parents and are not necessarily violent.
C. Extensive research has shown that abusive parents and families are frequently more socially isolated and have fewer support systems than those families in which abuse does not occur.
D. Abuse is typically linked with a younger, not older, parent.

36. The nurse is collecting information from the family in which Munchausen Syndrome by Proxy (MSP) is suspected. Which finding should the nurse expect?

A. The abusing parent is likely the father.
B. The abusing parent and child have a strong bond.
C. The abusing parent has little medical knowledge.
D. The child will provide insight into what is occurring.

ANSWER: B

A. The mother is most likely to be the abusing parent in MSP, not the father.
B. MSP is a pattern of behavior in which care-takers deliberately exaggerate or fabricate or induce physical or mental health problems in others. It is a form of child abuse that is one of the most difficult to confirm because the relationship between the abuser and the child appears strong, and the parent will rarely leave the child.

C. The abusing parent usually has some degree of medical knowledge and seemingly becomes very attached to those providing care for the child.

37. The nurse is caring for the toddler who has been hospitalized for observation because of apnea spells that have led to cardiac arrest at home three times in the past 6 months. The nurse suspects Munchausen Syndrome by Proxy (MSP) and contacts the "CF, who does not believe that this is a correct assessment of the condition of the child or of the family dynamics. What should the nurse do?

A. Contact the head of the department of pediatrics to report the incident.
B. Consult with the clinical charge nurse as to what action should be taken.
C. Call a case conference involving physicians, nurses, and social workers.
D. File a variance report indicating the HCP was notified but took no action.

ANSWER: B

A. The chain of command should be used first. Contacting the pediatric department head may be necessary if the nurse and charge nurse are unable to identify a policy or method by which to proceed.
B. Nurses are mandated reporters of any suspected child abuse. This form of child abuse is one of the most difficult to confirm, and court-ordered video surveillance may be necessary. Therefore, to talk with the charge nurse would be most appropriate. Typically with MSP, there are covert pieces of evidence that would point to such a diagnosis, but hard evidence is difficult to identify.
C. Calling a case conference may be the method by which health care professionals share information about this family, but the charge nurse should be notified first.
D. Filing a variance report is inappropriate. There is no indication that the HCP took no action, only that the HCP disagrees with the nurse's diagnosis of MSP; the suspected abuse should be further investigated.

38. The NA is helping the ED nurse admit a woman who is the victim of spousal abuse and marital rape. The NA asks the nurse what should be done with the woman's torn and soiled clothing. What is the nurse's best response?

A. "Place items in a plastic bag and avoid blood and body fluid contact."
B. "Ask the woman what she wants done with her clothing; she may want them discarded."

C. “These may be needed by the police. I will remove them and place in separate paper bags."
D. “Fold each article of clothing and leave them with her; she can decide later about disposal."

ANSWER: C

A. Moisture in a plastic bag will cause mold and mildew and destroy the evidence.
B. Asking the woman what she wants done with her clothing is inappropriate- Assault is a criminal offense, and evidence should be preserved.
C. To preserve the evidence, items are placed in separate paper bags, labeled, and released with appropriate documentation to the requesting police officer. The nurse specially trained to deal with possible criminal offenses should handle the clothing.
D. The nurse specially trained to deal with possible criminal offenses should handle the clothing. The items should not be returned to the woman or discarded.

39. The older, disheveled client is admitted to the ED with hypertension, severe dehydration, and malnourishment. During the admission interview, the daughter notes that she and her husband, who is temporarily out of work, have been living with the client. Which nursing action is most important?

A. Report the suspected elder abuse to Adult Health Protective Services.
B. Ask additional questions of the client in private without the family present.
C. Ask the daughter whether her father has been eating and taking his medication.
D. Call the resource hotline to ask whether abuse and neglect should be considered.

ANSWER: B

A. A careful history is crucial to elicit accurate information. Insufficient information has been obtained to report suspected abuse.
B. Additional questions should be asked of the client in private to elicit information about abuse, maltreatment, or neglect.
C. Questioning the daughter may be appropriate, but it is most important to collect information from the client.
D. The resource hotline can be used by health care workers to seek answers to questions about abuse and neglect, but obtaining additional information from the client is most important.

40. The 28-year-old is being seen in the ED with injuries after being assaulted by her live-in boyfriend. The client acknowledges that this is not the first time that she has been assaulted and that she is afraid. Which client action indicates that an out- come for the client has been achieved?

A. Elects to return to her boyfriend to make amends
B. Accepts arrangements made with a women ’s shelter
C. Verbalizes plans for staying at the hospital overnight
D. Asks the nurse to report the assault to Adult Health Protective Services

ANSWER: B

A. Electing to return to the boyfriend poses a threat to client safety.
B. Accepting an arrangement at a women’s shelter is a positive outcome for this client.
C. The woman’s injuries are not such that she requires hospitalization. If the woman has insurance, third-party payers may not approve hospitalization that is based solely on abuse.
D. The nurse has a legal obligation to report the abuse whether or not the client requested this.