NR 326 Quiz 1 Week 2
NAME: …….. Clinical GROUP
Score: 26 points (all correct)

- Take the quiz in class when directed.
- Upload the completed quiz in the Quiz 1 dropbox by the end of class when directed.
- Check your quiz w/the Ans Key once it is available (Friday by 5pm); indicate the score on your page 1.
- Upload the corrected quiz w/score in the Quiz 1 dropbox (can upload it via comments) by Friday before midnight.

1. A nurse is monitoring a client in restraints. Which of the following findings should indicate to the nurse that the client is ready to reintegrate into the unit?
   A. The client asks to go the bathroom.
   B. The client follows directions.
   C. The client's vital signs have returned to baseline status.
   D. The client eats all the foods provided during each meal.

2. A client during a therapeutic group session led by the nurse suddenly jumps up, screams, and runs out of the room. What is the nurse's priority of action?
   A. Stay with the other clients and send one of the clients to check on the one who left the room.
   B. Ask the group what they thought about the client's behavior.
   C. Follow the client to determine the cause of the behavior
   D. Ignore the incident as it is an attention-seeking behavior.

3. Which of the following is true about clients admitted for involuntary admission? (SATA)
   A. The client admitted involuntarily has a right to informed consent regarding prescribed psychotropic medications.
   B. The client admitted involuntarily has a different set of laws regarding restraints than a voluntary client.
   C. The client admitted involuntarily can be hospitalized for as long as the provider deems necessary.
   D. The client admitted involuntarily can request to defer a court hearing.

4. A mandatory educational session is conducted on an inpatient mental health unit for all nurses about seclusion and restraints. Seclusion is contraindicated in which of the following clients?
   A. An adolescent client who throws harmful objects at other clients.
   B. A school-age client who attempts to repeatedly bite staff.
   C. An adult client following a suicide attempt.
   D. An older adult client who is manic, screaming, threatening and trying to throw objects at people.

5. A nurse is reviewing the protocol for restraints and seclusion (r/s). Included in the protocol are which of the following? (SATA)

A. Documentation of all interventions that were tried and response of patient, and the progression of nursing care/interventions, leading up to necessary r/s.

B. Documentation of offering fluids, food, comfort/pain assessment, V/S, especially breathing/RR; toileting.

C. Time limits for seclusion or restraints = 4 hours for adults; 2 hours 9-17; 1 hour for 8 and under

D. Use chemical restraints on all clients with a history of anger and aggression when they exhibit escalating behaviors.

6. A nurse is caring for an adolescent client with a history of violent behavior. The client asked the nurse to keep information confidential about the desire to kill several classmates and a school teacher. Which statement by the nurse is the best response?

A. "Because you are a minor, I have to share any information that I feel is important with your parents."

B. "I cannot promise that. I must share this information with other members of the team who are responsible for planning your care."

C. "I will not violate our nurse-client relationship. The information we discuss will remain confidential between us."

D. "I can see that you trust me, but you should share those feelings with your psychiatrist, not me."

7. A nurse on a behavioral health unit is monitoring an adult client who was placed in 4 point restraints. Nursing care for the client in restraint includes which of the following? (SATA)

A. Ensure that a face-to-face assessment has been completed by a physician within 1 hour of placing the client in restraint.

B. Ensure and document offering fluids and toileting to the client.

C. Ensure to maintain the client's dignity and respect.

D. Ensure not to remove restraints from the client demonstrating calm behavior without first obtaining a provider order.

E. Ensure the patient must be sleeping before restraints can be removed and the client lets the nurse know when they are ready to be free from restraints as this is part of recipient rights.

F. Ensure waiting at least 12 hours after restraints are placed, before considering removing restraints.

8. The nurse initiating a therapeutic relationship with clients knows which of the following defense mechanisms are always adaptive and never maladaptive?

A. Suppression and Repression

B. Altruism and Sublimation

C. Undoing and Intellectualization

D. Rationalization and Compensation

9. A client tells a nurse that the nurse is the only one who cares about them, yet the following day, the client refuses to talk to that nurse. This is an example of which of the following defense mechanisms?

A. Compensation

B. Undoing