NR 326 Quiz 2 Week 4

NAME: ……. Clinical GROUP instructor & site: JM Pontiac

General DATE: …….

- Take the quiz in class when directed.
- Upload the completed quiz in the Quiz 1 drop box 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 drop box (can upload it via comments) by Friday before midnight.**

1. The Registered Nurse (RN) knows which of the following statements is true?
   A. Suicide is inherited, or "runs in families."
   B. Suicide always happens in an impulsive moment.
   C. The majority of people who ultimately kill themselves have a history of previous attempt.
   D. You cannot stop a suicidal person if they are fully intent on dying.

2. Which of the following are indications for ECT?
   A. Anxiety disorder that is not responsive to medication.
   B. Acute intoxication withdrawal related to a substance use disorder not responsive to medication.
   C. Bipolar disorder with rapid cycling not responsive to medication.
   D. Dysphoric disorder not responsive to medication.

3. A nurse knows to include teaching for Transcranial Magnetic Stimulation (TMS) to include which of the following?
   A. TMS is indicated for clients who have schizophrenia spectrum disorders."
   B. "I will provide post anesthesia care following TMS."
   C. "TMS treatments usually last 5-10 min."
   D. "I will schedule the client for daily TMS treatments for 4- 6 weeks."

4. Which of the following client statements should the nurse expect from a client demonstrating factitious disorder imposed on another?
   A. "I had to pretend I was injured in order to get disability benefits"
   B. "I know that my abdominal pain is caused by a malignant tumor."
   C. "I needed to make my son sick so that someone else would take care of him for a while."
   D. "I became deaf when I heard my daughter's husband abandoned her."

5. Which of the following is a correct statement when attempting to distinguish clinical depression from normal grieving?
   A. In clinical depression, anhedonia is prevalent.
   B. In normal grieving, the person always has generalized feelings of trauma.
   C. The person who is clinically depressed relates feelings of guilt to a specific loss.
   D. In normal grieving, there is a persistent state of dysphoria.

6. Which of the following statements by a newly licensed nurse indicates understanding of Electroconvulsive Treatment (ECT) indications?

A. “ECT is the recommended initial treatment for bipolar disorder.”
B. “ECT is contraindicated for clients who have suicidal ideation.”
C. “ECT is prescribed to prevent relapse of bipolar disorder.”
D. “ECT is effective for clients who are experiencing severe mania not responsive to medication therapy.”

7. Which of the following statements is true about Selegiline?
   A. Transdermal selegiline is contraindicated for clients taking mirtazapine or olanzapine.
   B. Transdermal selegiline is contraindicated for clients taking bupropion or fluoxetine.
   C. Transdermal selegiline is contraindicated for clients taking benzodiazepine or haloperidol.
   D. Transdermal selegiline is contraindicated for clients taking carbamazepine or oxcarbazepine

8. A client is prescribed Bupropion. Which of the following are contraindicated for use of this medication?
   A. Severe mania and Psychosis
   B. Eating disorders and Seizure disorders
   C. Respiratory disorders and vascular disease
   D. Schizophrenia and Bipolar disorder

9. Which of the following should a nurse include in the plan of care for a client on active suicide precautions?
   A. Document the client’s behavior every hour.
   B. Don’t assign the client too close to the nurses’ station.
   C. Ensure that the client swallows their medication.
   D. Allow the client to keep only 2 desired personal items in their room.

10. The nursing priority of care for a client admitted with an exacerbation of Major Depressive Disorder includes which of the following?
    A. Discontinue all medications suddenly to see the effects on level of depression and maintain a safe environment.
    B. Assist the client with removing the feelings of guilt and improve problem solving skills.
    C. Expect the therapeutic effects of medications to be immediate and monitor the client’s ability to perform activities of daily living.
    D. Assess the client’s risk for suicide and implement immediate suicide safety precautions.

11. Which of the following questions will the nurse ask the client on the PH-Q 9 or geriatric depression screening tool?
    A. "Are you having thoughts that are racing and feel like you are able to solve everyone's problems?"
    B. “Are you having thoughts that you would be better off dead or of hurting yourself in some way?”
    C. "Are you having constant thoughts about stealing something and feel like you can get away with just about anything?"