Chapter 05: Settings for Psychiatric Care

MULTIPLE CHOICE

1. Planning for patients with mental illness is facilitated by understanding that inpatient hospitalization is generally reserved for patients who:
a. present a clear danger to self or others.
b. are noncompliant with medications at home.
c. have no support systems in the community.
d. develop new symptoms during the course of an illness.

ANS: A
Hospitalization is justified when the patient is a danger to self or others, has dangerously decompensated, or needs intensive medical treatment. The incorrect options do not necessarily describe patients who require inpatient treatment.

DIF: Cognitive Level: Comprehension (Understanding) REF: 56
TOP: Nursing Process: Planning MSC: NCLEX: Safe, Effective Care Environment

2. A patient is hospitalized for a reaction to a psychotropic medication and then is closely monitored for 24 hours. During a predischarge visit, the case manager learns the patient received a notice of eviction on the day of admission. The most appropriate intervention for the case manager is to:
a. cancel the patients discharge from the hospital.
b. contact the landlord who evicted the patient to discuss the situation.
c. arrange a temporary place for the patient to stay until new housing can be arranged.
d. document that the adverse medication reaction was feigned because the patient had nowhere to live.

ANS: C
The case manager should intervene by arranging temporary shelter for the patient until suitable housing can be found. This is part of the coordination and delivery of services that falls under the case manager role. The other options are not viable alternatives.

DIF: Cognitive Level: Application (Applying) REF: 56
TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

3. A multidisciplinary health care team meets 12 hours after an adolescent is hospitalized after a suicide attempt. Members of the team report their assessments. What outcome can be expected from this meeting?
a. A treatment plan will be formulated.
b. The health care provider will order neuroimaging studies.
c. The team will request a court-appointed advocate for the patient.
d. Assessment of the patients need for placement outside the home will be undertaken.

ANS: A
Treatment plans are formulated early in the course of treatment to streamline the treatment process and reduce costs. It is too early to determine the need for alternative post-discharge living arrangements. Neuroimaging is not indicated for this scenario.

DIF: Cognitive Level: Application (Applying) REF: 56
TOP: Nursing Process: Outcomes Identification
MSC: NCLEX: Safe, Effective Care Environment

4. The relapse of a patient diagnosed with schizophrenia is related to medication noncompliance. The patient is hospitalized for 5 days, medication is restarted, and the patients thoughts are now more organized. The patients family members are upset and say, Its too soon for discharge. Hospitalization is needed for at least a month. The nurse should:
a. call the psychiatrist to come explain the discharge rationale.
b. explain that health insurance will not pay for a longer stay for the patient.
c. call security to handle the disturbance and escort the family off the unit.
d. explain that the patient will continue to improve if medication is taken regularly.

ANS: D
Patients no longer stay in the hospital until every vestige of a symptom disappears. The nurse must assume responsibility to advocate for the patients right to the least restrictive setting as soon as the symptoms are under control and for the right of citizens to control health care costs. The health care provider will use the same rationale. Shifting blame will not change the discharge. Calling security is unnecessary. The nurse can handle this matter.

DIF: Cognitive Level: Application (Applying) REF: 59
TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

5. A nurse assesses an inpatient psychiatric unit, noting that exits are free from obstruction, no one is smoking, the janitors closet is locked, and all sharp objects are being used under staff supervision. These observations relate to:
a. management of milieu safety.
b. coordinating care of patients.
c. management of the interpersonal climate.
d. use of therapeutic intervention strategies.

ANS: A
Members of the nursing staff are responsible for all aspects of milieu management. The observations mentioned in this question directly relate to the safety of the unit. The other options, although part of the nurses concerns, are unrelated to the observations cited.

DIF: Cognitive Level: Application (Applying) REF: 56
TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

6. The following patients are seen in the emergency department. The psychiatric unit has one bed available. Which patient should the admitting officer recommend for admission to the hospital? The patient who:
a. is experiencing dry mouth and tremor related to side effects of haloperidol (Haldol).
b. is experiencing anxiety and a sad mood after a separation from a spouse of 10 years.
c. self-inflicted a superficial cut on the forearm after a family argument.
d. is a single parent and hears voices saying, Smother your infant.

ANS: D
Admission to the hospital would be justified by the risk of patient danger to self or others. The other patients have issues that can be handled with less restrictive alternatives than hospitalization.

DIF: Cognitive Level: Analysis (Analyzing) REF: 56
TOP: Nursing Process: Analysis| Nursing Process: Diagnosis
MSC: NCLEX: Safe, Effective Care Environment

7. A student nurse prepares to administer oral medications to a patient diagnosed with major depressive disorder, but the patient refuses the medication. The student nurse should:
a. tell the patient, Ill get an unsatisfactory grade if I dont give you the medication.
b. tell the patient, Refusing your medication is not permitted. You are required to take it.
c. discuss the patients concerns about the medication, and report to the staff nurse.
d. document the patients refusal of the medication without further comment.

ANS: C
The patient has the right to refuse medication in most cases. The patients reason for refusing should be ascertained, and the refusal should be reported to a unit nurse. Sometimes refusals are based on unpleasant side effects that can be ameliorated. Threats and manipulation are inappropriate. Medication refusal should be reported to permit appropriate intervention.

DIF: Cognitive Level: Application (Applying) REF: 59
TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

8. A nurse surveys the medical records for violations of patients rights. Which finding signals a violation?

a. No treatment plan is present in record.
b. Patient belongings are searched at admission.
c. Physical restraint is used to prevent harm to self.
d. Patient is placed on one-to-one continuous observation.

ANS: A
The patient has the right to have a treatment plan. Inspecting a patients belongings is a safety measure. Patients have the right to a safe environment, including the right to be protected against impulses to harm self that occur as a result of a mental disorder.

DIF: Cognitive Level: Application (Applying) REF: 56
TOP: Nursing Process: Evaluation MSC: NCLEX: Safe, Effective Care Environment

9. Which principle takes priority for the psychiatric inpatient staff when addressing behavioral crises?
a. Resolve behavioral crises using the least restrictive intervention possible.
b. Rights of the majority of patients supersede the rights of individual patients.
c. Swift intervention is justified to maintain the integrity of the therapeutic milieu.
d. Allow patients opportunities to regain control without intervention if the safety of other patients is not compromised.

ANS: A
The rule of using the least restrictive treatment or intervention possible to achieve the desired outcome is the patients legal right. Planned interventions are nearly always preferable. Intervention may be necessary when the patient threatens harm to self.

DIF: Cognitive Level: Application (Applying) REF: 56
TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

10. To provide comprehensive care to patients, which competency is more important for a nurse who works in a community mental health center than a psychiatric nurse who works in an inpatient unit?
a. Problem-solving skills
b. Calm and caring manner
c. Ability to cross service systems
d. Knowledge of psychopharmacology

ANS: C
A community mental health nurse must be able to work with schools, corrections facilities, shelters, health care providers, and employers. The mental health nurse working in an inpatient unit needs only to be able to work within the single setting. Problem-solving skills are needed by all nurses. Nurses in both settings must have knowledge of psychopharmacology.

DIF: Cognitive Level: Analysis (Analyzing) REF: 54
TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

11. A suspicious and socially isolated patient lives alone, eats one meal a day at a nearby shelter, and spends the remaining daily food allowance on cigarettes. Select the community psychiatric nurses best initial action.
a. Report the situation to the manager of the shelter.
b. Tell the patient, You must stop smoking to save money.
c. Assess the patients weight; determine the foods and amounts eaten.
d. Seek hospitalization for the patient while a new plan is being formulated.

ANS: C
Assessment of biopsychosocial needs and general ability to live in the community is called for before any action is taken. Both nutritional status and income adequacy are critical assessment parameters. A patient may be able to maintain adequate nutrition while eating only one meal a day. Nurses assess before taking action. Hospitalization may not be necessary.

DIF: Cognitive Level: Application (Applying) REF: 54
TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

12. A patient diagnosed with schizophrenia has been stable in the community. Today, the spouse reports the patient is expressing delusional thoughts. The patient says, Im willing to take my medicine, but I forgot to get my prescription refilled. Which outcome should the nurse add to the plan of care?
a. Nurse will obtain prescription refills every 90 days and deliver them to the patient.
b. Patients spouse will mark dates for prescription refills on the family calendar.
c. Patient will report to the hospital for medication follow-up every week.
d. Patient will call the nurse weekly to discuss medication-related issues.

ANS: B
The nurse should use the patients support system to meet patient needs whenever possible. Delivery of medication by the nurse should be unnecessary for the nurse to do if the patient or a significant other can be responsible. The patient may not need more intensive follow-up as long as he or she continues to take the medications as prescribed. No patient issues except failure to obtain medication refills were identified.

DIF: Cognitive Level: Application (Applying) REF: 54
TOP: Nursing Process: Planning MSC: NCLEX: Safe, Effective Care Environment

13. A community mental health nurse has worked for 6 months to establish a relationship with a delusional, suspicious patient. The patient recently lost employment and stopped taking medications because of inadequate money. The patient says, Only a traitor would make me go to the hospital. Which solution is best?
a. Arrange a bed in a local homeless shelter with nightly onsite supervision.
b. Negotiate a way to provide medication so the patient can remain at home.
c. Hospitalize the patient until the symptoms have stabilized.
d. Seek inpatient hospitalization for up to 1 week.

ANS: B
Hospitalization may damage the nurse-patient relationship even if it provides an opportunity for rapid stabilization. If medication can be obtained and restarted, the patient can possibly be stabilized in the home setting, even if it takes a little longer. A homeless shelter is inappropriate and unnecessary. Hospitalization may be necessary later, but a less restrictive solution should be tried first because the patient is not dangerous.

DIF: Cognitive Level: Analysis (Analyzing) REF: 54
TOP: Nursing Process: Planning MSC: NCLEX: Safe, Effective Care Environment

14. A community psychiatric nurse facilitates medication compliance for a patient by having the health care provider prescribe depot medications by injection every 3 weeks at the clinic. For this plan to be successful, which factor will be of critical importance?
a. Attitude of significant others toward the patient
b. Nutritional services in the patients neighborhood
c. Level of trust between the patient and the nurse
d. Availability of transportation to the clinic

ANS: D
The ability of the patient to get to the clinic is of paramount importance to the success of the plan. The depot medication relieves the patient of the necessity to take medication daily, but if he or she does not receive the injection at 3-week intervals, noncompliance will again be the issue. Attitude toward the patient, trusting relationships, and nutrition are important but not fundamental to this particular problem.

DIF: Cognitive Level: Analysis (Analyzing) REF: 54
TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

15. Which assessment finding for a patient living in the community requires priority intervention by the nurse? The patient:
a. receives Social Security disability income plus a small check from a trust fund.
b. lives in an apartment with two patients who attend day hospital programs.
c. has a sibling who is interested and active in care planning.
d. purchases and uses marijuana on a frequent basis.

ANS: D

Patients who regularly buy illegal substances often become medication noncompliant. Medication noncompliance, along with the disorganizing influence of illegal drugs on cellular brain function, promotes relapse. The remaining options do not suggest problems.

DIF: Cognitive Level: Analysis (Analyzing) REF: 55
TOP: Nursing Process: Planning MSC: NCLEX: Psychosocial Integrity

16. A patient tells the nurse at the clinic, I havent been taking my antidepressant medication as directed. I leave out the midday dose. I have lunch with friends and dont want them to ask me about the pills. Select the nurses most appropriate intervention.
a. Investigate the possibility of once-daily dosing of the antidepressant.
b. Suggest to the patient to take the medication when no one is watching.
c. Explain how taking each dose of medication on time relates to health maintenance.
d. Add the following nursing diagnosis to the plan of care: Ineffective therapeutic regimen management, related to lack of knowledge.

ANS: A
Investigating the possibility of once-daily dosing of the antidepressant has the highest potential for helping the patient achieve compliance. Many antidepressants can be administered by once-daily dosing, a plan that increases compliance. Explaining how taking each dose of medication on time relates to health maintenance is reasonable but would not achieve the goal; it does not address the issue of stigma. The self-conscious patient would not be comfortable doing this. A better nursing diagnosis would be related to social stigma. The question asks for an intervention, not analysis.

DIF: Cognitive Level: Application (Applying) REF: 56
TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

17. A community psychiatric nurse assesses that a patient diagnosed with a mood disorder is more depressed than on the previous visit a month ago; however, the patient says, I feel the same. Which intervention supports the nurses assessment while preserving the patients autonomy?
a. Arrange for a short hospitalization.
b. Schedule weekly clinic appointments.
c. Refer the patient to the crisis intervention clinic.
d. Call the family and ask them to observe the patient closely.

ANS: B
Scheduling clinic appointments at shorter intervals will give the opportunity for more frequent assessment of symptoms and allow the nurse to use early intervention. If the patient does not admit to having a crisis or problem, a referral would be useless. The remaining options may produce unreliable information, violate the patients privacy, and waste scarce resources.

DIF: Cognitive Level: Analysis (Analyzing) REF: 56
TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

18. A patient hurriedly tells the community mental health nurse, Everythings a disaster! I cant concentrate. My disability check didnt come. My roommate moved out, and I cant afford the rent. My therapist is moving away. I feel like Im coming apart. Which nursing diagnosis applies?
a. Decisional conflict, related to challenges to personal values
b. Spiritual distress, related to ethical implications of treatment regimen
c. Anxiety, related to changes perceived as threatening to psychological equilibrium
d. Impaired environmental interpretation syndrome, related to solving multiple problems affecting security needs

ANS: C
Subjective and objective data obtained by the nurse suggest the patient is experiencing anxiety caused by multiple threats to security needs. Data are not present to suggest Decisional conflict, Spiritual distress caused by ethical conflicts, or Impaired environmental interpretation syndrome.

DIF: Cognitive Level: Analysis (Analyzing) REF: 56

TOP: Nursing Process: Diagnosis| Nursing Process: Analysis
MSC: NCLEX: Psychosocial Integrity

19. Which patient would a nurse refer to partial hospitalization? An individual who:
a. spent yesterday in the 24-hour supervised crisis care center and continues to be actively suicidal.
b. because of agoraphobia and panic episodes needs psychoeducation for relaxation therapy.
c. has a therapeutic lithium level and reports regularly for blood tests and clinic follow-up.
d. states, Im not sure I can avoid using alcohol when my spouse goes to work every morning.

ANS: D
This patient could profit from the structure and supervision provided by spending the day at the partial hospitalization program. During the evening, at night, and on weekends, the spouse could assume supervision responsibilities. The patient who is actively suicidal needs inpatient hospitalization. The patient in need of psychoeducation can be referred to home care. The patient who reports regularly for blood tests and clinical follow-up can continue on the same plan.

DIF: Cognitive Level: Analysis (Analyzing) REF: 55
TOP: Nursing Process: Planning MSC: NCLEX: Safe, Effective Care Environment

20. Which employers health plan is required to include parity provisions related to mental illnesses?
a. Employer with more than 50 employees
b. Cancer thrift shop staffed by volunteers
c. Daycare center that employs 7 teachers
d. Church that employs 15 people

ANS: A
Under federal parity laws, companies with more than 50 employees may not limit annual or lifetime mental health benefits unless they also limit benefits for physical illnesses.

DIF: Cognitive Level: Comprehension (Understanding) REF: 60
TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

MULTIPLE RESPONSE

1. A nurse can best address factors of critical importance to successful community treatment for persons with mental illness by including assessments related to which of the following? Select all that apply.
a. Housing adequacy and stability
b. Income adequacy and stability
c. Family and other support systems
d. Early psychosocial development
e. Substance abuse history and current use

ANS: A, B, C, E
Early psychosocial developmental history is less relevant to successful outcomes in the community than the assessments listed in the other options. If a patient is homeless or fears homelessness, focusing on other treatment issues is impossible. Sufficient income for basic needs and medication is necessary. Adequate support is a requisite to community placement. Substance abuse undermines medication effectiveness and interferes with community adjustment.

DIF: Cognitive Level: Application (Applying) REF: 56
TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

2. A community member asks a nurse, People diagnosed with mental illnesses used to go to a state hospital. Why has that changed? Select the nurses accurate responses. Select all that apply.
a. Science has made significant improvements in drugs for mental illness, so now many people may live in their communities.
b. A better selection of less restrictive settings is now available in communities to care for individuals with mental illness.
c. National rates of mental illness have declined significantly. The need for state institutions is actually no

longer present.
d. Most psychiatric institutions were closed because of serious violations of patients rights and unsafe conditions.
e. Federal legislation and payment for treatment of mental illness have shifted the focus to community rather than institutional settings.

ANS: A, B, E
The community is a less restrictive alternative than hospitals for the treatment of people with mental illness. Funding for treatment of mental illness remains largely inadequate but now focuses on community rather than institutional care. Antipsychotic medications improve more symptoms of mental illness; hence, management of psychiatric disorders has improved. Rates of mental illness have increased, not decreased. Hospitals were closed because funding shifted to the community. Conditions in institutions have improved.

DIF: Cognitive Level: Analysis (Analyzing) REF: 53
TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment