**Kingdom of Saudi Arabia**

**King Saud University**

**Nursing College**

**Community & Psychiatric Nursing Department**



**1**

**NUR 472**

**Clinical Exam**

|  |  |  |
| --- | --- | --- |
| **Student Name** | **Student number** | **Score** |
|  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Question Number** | **Question** | **Mark** | **Student’s Score** |
| **I** | **Multiple choice** | **12** |  |
| **II** | **Match** | **4** |  |
| **III** | **List** | **4** |  |

**Ruqayah Ali Al Hajji**

**Question I: (10 Marks)**

Multiple Choice, Please choice the best answer:

1. **Nurse Reem is caring for a female client who experience false sensory perceptions with no basis in reality. This perception is known as:**
2. Hallucinations
3. . Delusions
4. Loose associations
5. Neologisms

A. Hallucinations are visual, auditory, gustatory, tactile or olfactory perceptions that have no basis in reality

1. **A client taking the monoamine oxidase inhibitor (MAOI) antidepressant (Marplan) is instructed by the nurse to avoid which foods and beverages?**
2. Aged cheese
3. Milk and green, leafy vegetables
4. Carbonated beverages and tomato products
5. Lean red meats and fruit juices

A. Aged cheese contains the substance tyramine which, when taken with an MAOI, can precipitate a hypertensive crisis. The other foods and beverages do not contain significant amounts of tyramine and, therefore, are not restricted.

1. **Nurse Mona is assigned to care for a client diagnosed with Catatonic**

**Stupor. When Nurse Mona enters the client’s room, the client is found lying on the bed with a body pulled into a fetal position. Nurse Mona should?**

A. Ask the client direct questions to encourage talking  
 B. Rake the client into the dayroom to be with other clients  
 C. Sit beside the client in silence and occasionally ask open-ended question  
 D. Leave the client alone and continue with providing care to the other clients

C. Clients who are withdrawn may be immobile and mute, and require consistent, repeated interventions. Communication with withdrawn clients requires much patience from the nurse. The nurse facilitates communication with the client by sitting in silence, asking open-ended question and pausing to provide opportunities for the client to respond

**4. Nurse should first discuss terminating the nurse-client relationship with a client during the:**

A. Termination phase when discharge plans are being made.

B. Working phase when the client shows some progress.

C. Orientation phase when a contract is established.

D. Working phase when the client brings it up.

**C**. When the nurse and client agree to work together, a contract should be established, the length of the relationship should be discussed in terms of its ultimate termination.

**5. When assessing a female client who is receiving tricyclic antidepressant therapy, which of the following would alert the nurse to the possibility that the client is experiencing anticholinergic effects?**

A. Urine retention and blurred vision

B. Respiratory depression and convulsion

C. Delirium and Sedation

D. Tremors and cardiac arrhythmias

**A**. Anticholinergic effects, which result from blockage of the parasympathetic (craniosacral) nervous system including urine retention, blurred vision, dry mouth & constipation

**6. The nurse understands that the therapeutic effects of typical antipsychotic medications are associated with which neurotransmitter change?**

A. Decreased dopamine level

B. Increased acetylcholine level

C. Stabilization of serotonin

D. Stimulation of GABA

A. Excess dopamine is thought to be the chemical cause for psychotic thinking. The typical antipsychotics act to block dopamine receptors and therefore   
decrease the amount of neurotransmitter at the synapses. The typical antipsychotics do not increase acetylcholine, stabilize serotonin, stimulate GABA.

**7. The home health psychiatric nurse visits a client with chronic schizophrenia who was recently discharged after a prolong stay in a psychiatric hospital. The client lives in a Family home, but has little social interaction. The nurse plan to refer the client to a day treatment program in order to help him with:**

A. Managing his hallucinations

B. Medication teaching

C. Social skills training

D. Meet with the Physician

C.Day treatment programs provide clients with chronic, persistent mental illness training in social skills, such as meeting and greeting people, asking   
questions or directions, placing an order in a restaurant, taking turns in a group setting activity. Although management of hallucinations and medication teaching may also be part of the program offered in a day treatment, the nurse is referring the client in this situation because of his need for socialization skills. Vocational training generally takes place in a rehabilitation facility; the client described in this situation would not be a candidate for this service.

**8. A client has been receiving chlorpromazine (Thorazine), an antipsychotic, to treat his psychosis. Which finding should alert the nurse that the client is experiencing pseudoparkinsonism?**

A. Restlessness, difficulty sitting still, pacing   
B. Involuntary rolling of the eyes   
C. Tremors, shuffling gait, mask like face   
D. Extremity and neck spasms, facial grimacing, jerky movements

**9. A client with manic episodes is taking lithium. Which electrolyte level should the nurse check before administering this medication?**

A. Calcium   
 B. Sodium   
 C. Chloride   
 D. Potassium

**Tremors, shuffling gait, mask like face**

RATIONALE: Pseudoparkinsonism may appear 1 to 5 days after starting an antipsychotic and may also include drooling, rigidity, and pill rolling. Akathisia may occur several weeks after starting antipsychotic therapy and consists of restlessness, difficulty sitting still, and fidgeting. An oculogyric crisis is recognized by uncontrollable rolling back of the eyes and, along with dystonia, should be considered an emergency. Dystonia may occur minutes to hours after receiving an antipsychotic and may include extremity and neck spasms, jerky muscle movements, and facial grimacing.

**10. The nurse is caring for a manic client in the seclusion room, the nurse should review this client every**:

1. 1 hour
2. 30 min
3. 15 min
4. 2 hour

C. The Act requires that a person who is kept in seclusion must be reviewed as clinically

appropriate to his or her condition at intervals of not more than 15 minutes by a registered

nurse

**11. A client who's at high risk for suicide needs close supervision. To best ensure the client's safety, the nurse should:**

A. check the client frequently at irregular intervals throughout the night.   
B. assure the client that the nurse will hold in confidence anything the client says.   
C. repeatedly discuss previous suicide attempts with the client.   
D. disregard decreased communication by the client because this is common in suicidal clients.

**A. check the client frequently at irregular intervals throughout the night.**   
Rationale: Checking the client frequently but at irregular intervals prevents the client from predicting when observation will take place and altering behavior in a misleading way at these times. Option B may encourage the client to try to manipulate the nurse or seek attention for having a secret suicide plan. Option C may reinforce suicidal ideas. Decreased communication is a sign of withdrawal that may indicate the client has decided to commit suicide; the nurse   
shouldn't disregard

**12. A female client is admitted with a diagnosis of delusions of GRANDEUR. This diagnosis reflects a belief that one is:**

A. Being Killed   
**B**. Highly famous and important   
C. Responsible for evil world   
D. Connected to client unrelated to oneself

**B.** A delusion of grandeur is a false belief that one is highly important or famous. A delusion of persecution is a false belief that one is being persecuted. A delusion of reference is a false belief that one is connected to events unrelated to oneself or a belief that one is responsible for the evil in the world.

**Question II: Match between Terms and Stamens (4 marks).**

|  |  |  |  |
| --- | --- | --- | --- |
| # | Term | Statement | Answer # |
| 1 | Acceptance | When same action followed by all nurses of day and night shift toward patients | 4 |
| 2 | False reassurance | Being non – judgmental and non- punitive | 1 |
| 3 | Professional relationship | You will get well | 2 |
| 4 | Consistency | Process of understanding one beliefs , feeling , limitations and how they affects others | 5 |
| 5 | Self-awareness |  |  |

**Question III: List (4 marks).**

1. **List 3 Nursing intervention for patient in risk for Suicide:**
2. **Write the three Phases of Psychiatric Nurse-Patient relationship:**

**Best wishes.**