Mental Health Ticket To Enter Unit 3

1. Who is at a higher risk for suicide? What places a client at risk for Suicide?
   a. Recent loss or trauma, family history of suicide, chronic illness, substance use, psychiatric disorders, and prior suicide attempts.
   b. Hopelessness, lack of social support, unemployment, and severe anxiety or agitation.

2. A client has a history of suicide attempts and is currently at a high risk of suicide. What would you need to implement or evaluate to assure safety? What question would you ask the patient?
   a. Suicide precautions, remove harmful objects, and (1:1) constant observation.
   b. Do you have thoughts of harming yourself right now?

3. T or F: A high school student recently completed suicide. Other high school students who attend this school are not at an increased risk of suicide.

4. What is the Columbia Assessment and what does it measure?
   a. Columbia Suicide Severity Rating Scale (C-SSRS)
   b. Suicidal ideation, behavior, intent, and severity of risk.

5. T or F: A client comes to the primary care provider and the nurse does a PHQ-9. The score is 12. The nurse does not need to ask if the patient is suicidal.

6. A client is having passive thoughts of suicide, depression, and feelings of hopelessness. "I'm useless, I shouldn't have survived". Which answer is the best open-ended statement?

   a. Why do you feel this way? You have so much to live for.
   b. What I hear you saying is you feel like you have no value.
   c. It's normal to have feelings of hopelessness when you are depressed.
   d. Many patients feel that way when they are depressed.

7. What is seasonal affective disorder and what is helpful for treatment?
   a. Seasonal depression due to decreased sunlight in the fall/winter.
   b. Light therapy, vitamin D supplementation, exercise, and antidepressants.

8. You are instructed by the provider to teach the patient and their family about major depressive disorder. What should you educate?

a. Warning signs of worsening depression or suicide, and when to seek help
b. Treatment- therapy, medication, and lifestyle changes.
c. Depression is a medical illness, not a weakness.
d. Importance of medication adherence and the risk of stopping suddenly.

9. T or F: A patient has a change in behavior after multiple days of treatment in the inpatient setting after starting on an antidepressant. You noticed the person went from poor hygiene and sadness to now clean, cheerful, relaxed, and no longer depressed. The nurse knows this person is at an increased risk of suicide and needs to monitor the patient by implementing safety checks.

10. What is SigeCaps?

Sleep changes, Interest loss, Guilt, Energy loss, Concentration problems, Appetite changes, Psychomotor changes, and Suicidal thoughts.

11. What are the symptoms of depression in adolescents? What are somatic symptoms?

a. Withdrawal, decline in school performance, and changes in sleep/appetite.

b. Headaches, fatigue, and stomachaches.

12. What is postpartum depression, and when does it begin? What is postpartum blues, and when does it begin?

a. Persistent sadness and impaired bonding that begins within 4 weeks to 1 year after delivery.

b. Mood swings and irritability, beginning 2-3 days after delivery and resolving within 2 weeks.

13. What is Electroconvulsive Therapy (ECT)? What education would you give the patient?

a. Controlled electrical current that induces seizure

b. Fasting before treatment is required and may cause short-term memory loss.

14. What is the difference between bipolar 1 and bipolar 2 disorder?

a. Bipolar I: Most severe and may need hospitalization.

b. Bipolar II: Least severe and typically doesn’t need hospitalization.

15. What is the therapeutic range while taking Lithium? What are the signs and symptoms of Lithium toxicity?

a. Range 0.6-1.2 mEq/L

b. Tremors, confusion, GI upset, polyuria, and seizures.

16. What is Steven-Johnson syndrome? What mood stabilizer can cause this?

a. A severe skin reaction with rash, blistering, and mucosal involvement.

b. Lamotrigine

17. What are some symptoms of mania?

Decreased need for sleep, pressured speech, flight of ideas, and increased activity.

18. A patient on the floor with bipolar 1 disorder is experiencing mania. What are some nursing interventions the nurse should implement in the plan of care?

Provide a safe, low-stimulation environment.

19. What is the difference between tangential thoughts and flight of ideas?

Tangential thoughts- Goes off-topic and never returns to the original point.

Flight of ideas- Rapidly shifting from one topic to another.

20. What medical conditions can contribute to symptoms like mental health disorders?

Diabetes, epilepsy, HIV/AIDS, sleep apnea, iron deficiency, and steroids.