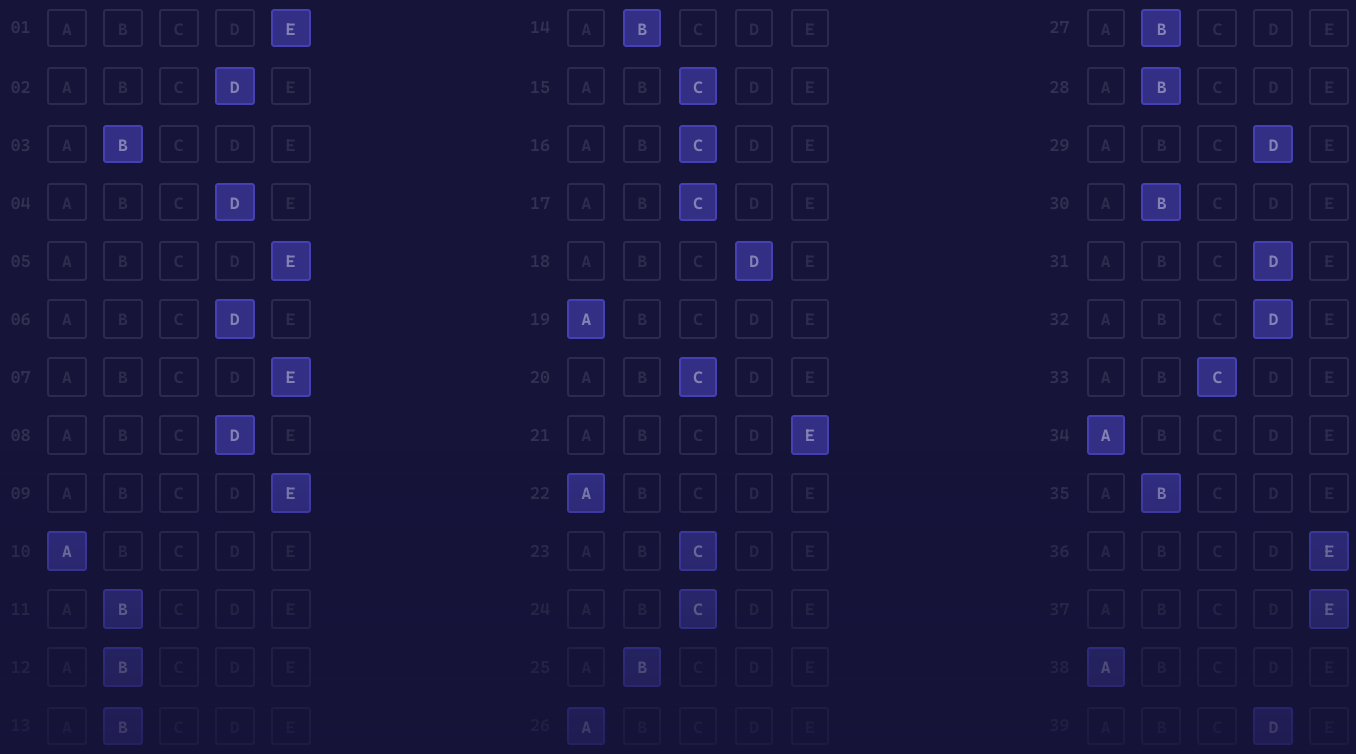
MOMETRIX
SMARTER PREP. BETTER RESULTS.




PRACTICE QUESTIONS

## American Nurses Credentialing Center (ANCC)

# 03FT

Psychiatric-Mental Health Nursing - Field Test

| EDITION | QUESTIONS | FORMAT |
| --- | --- | --- |
| Demo | 9 | Limited Edition PDF |

WEB www.mometrix.net

SUPPORT support@mometrix.net

# Before you begin

## What this is

9 practice questions for American Nurses Credentialing Center (ANCC) `03FT`, each with its answer key and an explanation. Answer a question before you read its key — the explanation is worth more once you have committed.

## If something looks wrong

Send us three things and we will check it:

- the exam code, `03FT`
- the question number
- the email address on your order

Write to **support@mometrix.net**. We reply within one business day.

mometrix.net

**QUESTION 1** SINGLE CHOICE

A nurse is assessing a newly admitted client who reports hearing voices telling him to harm himself. Which nursing action is the priority in the immediate aftermath of this assessment?

A Document the client's statements verbatim in the chart

**B Initiate suicide precautions and ensure a safe environment**

C Request a psychiatric medication consultation

D Encourage the client to describe the voices in detail

**ANSWER B**

**WHY** Safety is the priority. When a client reports command hallucinations directing self-harm, the nurse must first initiate suicide precautions and remove environmental hazards. Assessment depth, documentation, and medication consultation follow once safety is established.

**QUESTION 2** SINGLE CHOICE

A client taking a monoamine oxidase inhibitor (MAOI) for depression reports a sudden, severe occipital headache with a blood pressure of 210/120 mm Hg. The nurse should first suspect which food–drug interaction?

**A Aged cheese**

B Citrus fruit

C White rice

D Low-fat milk

**ANSWER A**

**WHY** Aged cheese contains tyramine, which can trigger a hypertensive crisis in clients taking MAOIs. The classic presentation is sudden severe headache (often occipital) with markedly elevated blood pressure requiring immediate intervention.

mometrix.net

**QUESTION 3** SINGLE CHOICE

A client diagnosed with major depressive disorder states, 'I don't think anyone would care if I disappeared.' Which response by the nurse is most therapeutic?

A "Don't talk like that—things will get better."

**B "Are you having thoughts of harming yourself?"**

C "Why would you say something like that?"

D "Let's talk about something more positive."

**ANSWER B**

**WHY** Directly asking about suicidal ideation is the appropriate therapeutic response to a statement suggesting hopelessness or self-harm. Dismissals, 'why' questions, and topic changes are non-therapeutic and can cut off communication.

**QUESTION 4** SINGLE CHOICE

A client in alcohol withdrawal develops tremor, diaphoresis, and tachycardia six hours after his last drink. Which medication is most appropriate for symptom management at this stage?

A Naltrexone

B Disulfiram

**C Chlordiazepoxide**

D Acamprosate

**ANSWER C**

**WHY** Chlordiazepoxide, a long-acting benzodiazepine, is used to manage the autonomic hyperactivity and seizure risk associated with acute alcohol withdrawal. Naltrexone and acamprosate are used for maintenance after withdrawal, and disulfiram creates an aversive reaction to alcohol use.

mometrix.net

**QUESTION 5** SINGLE CHOICE

An adolescent client with anorexia nervosa is admitted to an inpatient unit. Which nursing intervention is most important to include in the initial plan of care?

A Encourage the client to select all of their own meals

B **Supervise meals and observe for 1 hour after eating**

C Allow unlimited phone access to maintain social support

D Place the client on bed rest until a target weight is reached

**ANSWER** **B**

**WHY** Supervised meals with post-meal observation (typically 30 minutes to 1 hour) are essential to prevent purging behaviors and monitor for refeeding-related complications. Client food selection must be balanced against the treatment plan, and bed rest is not a standard intervention for this population.

**QUESTION 6** SINGLE CHOICE

On an inpatient psychiatric unit, a client becomes increasingly agitated, pacing and raising his voice. Which initial nursing intervention reflects appropriate milieu management?

A Call for security to initiate restraint

B **Move the client to a quiet area and offer time to talk**

C Administer a sedative medication immediately

D Place the client in seclusion until calm

**ANSWER** **B**

**WHY** The least restrictive intervention is appropriate for early escalation. Moving the client to a calmer environment and using verbal de-escalation can prevent further agitation. Restraints, seclusion, and PRN medications should be reserved for situations where less restrictive measures have failed.

mometrix.net

**QUESTION 7** SINGLE CHOICE

A client with schizophrenia is started on clozapine. Which laboratory finding requires the nurse to withhold the medication and notify the provider immediately?

**A** **WBC of 2,800/mm$^3$**

B Hemoglobin of 12 g/dL

C Platelet count of 200,000/mm$^3$

D Serum sodium of 140 mEq/L

**ANSWER A**

**WHY** Clozapine carries a black box warning for agranulocytosis. Treatment is generally held if the WBC drops below 3,500/mm$^3$ or ANC below 1,500/mm$^3$, and discontinued in more severe drops. A WBC of 2,800/mm$^3$ requires immediate notification and intervention.

**QUESTION 8** SINGLE CHOICE

A client with bipolar disorder, currently in a manic episode, is refusing prescribed psychotropic medications. The client is competent and does not appear to be a danger to self or others. Which action by the nurse is most appropriate?

A Administer the medication based on the provider's standing order

**B** **Document the refusal and continue to engage the client to identify concerns**

C Obtain a court order to force medication administration

D Tell the client the medications are optional and there are no consequences

**ANSWER B**

**WHY** Competent clients have the right to refuse treatment. The nurse must respect the client's autonomy by documenting the refusal and working therapeutically to explore concerns and revisit education. Forcing medication without a documented risk of harm violates ethical and legal standards.

mometrix.net

**QUESTION 9** MULTIPLE CHOICE

A nurse is caring for an older adult client newly diagnosed with major depressive disorder. Which findings would the nurse expect to assess? (Choose two.)

**A** **Somatic complaints such as vague pain or GI upset**

B Increased interest in hobbies and social activities

**C** **Loss of appetite and unintentional weight loss**

D Pressured speech and decreased sleep need

E Memory deficits that reverse with treatment of the depression

**ANSWER** **A** · **C**

**WHY** Older adults with depression often present with somatic complaints (aches, constipation, GI symptoms) and decreased appetite or weight loss rather than the classic affective complaints seen in younger adults. Increased interest in activities is the opposite of expected findings, pressured speech suggests mania, and pseudodementia (cognitive deficits that reverse with treatment) is characteristic but the better answer for this clinical presentation is somatic complaints combined with appetite changes.

mometrix.net