Balzer Riley: Communication in Nursing, 8th Edition

Chapter 2: The Client-Nurse Relationship: A Helping Relationship

Test Bank

Multiple Choice

1. The nurse cares for a patient who has just been diagnosed with lung cancer. Which statement by the nurse is therapeutic?

    a. "You sound really frightened about your diagnosis of cancer."
    b. "You will get better because the treatment will be started this week."
    c. "I think you should take a vacation and try to forget about the cancer."
    d. "An apple a day will keep the doctor away."

ANS: A
Reflecting helps the patient to clarify feelings and is a therapeutic communication technique. Reassuring (i.e., "you will be okay") negates fears and feelings of the patient. Getting advice (i.e., declaration to the patient of what the nurse thinks) negates the worth of the patient as a mutual partner in decision making. Making stereotyped responses (i.e., trite, meaningless verbal expressions) negates the significance of the patient's communication.DIF: Analysis REF: p.25 TOP: Integrated Process: Communication and Documentation MSC: Psychosocial Integrity

2. The home health nurse cares for a patient who is diagnosed with chronic obstructive pulmonary disease. Which response(s) and behavior(s) by the nurse would indicate that bonding between nurse and patient has occurred? (Select all that apply)

    a. Expects the patient to meet the goals for exercise as determined by the nurse.
    b. Listens to the patient describe the feelings of anxiety related to severe dyspnea.
    c. Develops teaching plan based on the learning preferences of the patient.
    d. Refrains from touching the patient unless performing physical assessment techniques.
    e. Requests that the patient wait to ask questions until the end of the home visit.
    f. Learns the names of the patient's family members and close friends and neighbors.

ANS: B, C, F
Responses and behaviors of the nurse that indicate bonding between the nurse and the patient include listening to verbalization of the patient's feelings, asking for the patient's input on learning styles and needs, and listening to the patient talk about support persons. Other indicators (responses and behaviors by the nurse) of bonding include touching a patient for reassurance when appropriate, including the patient in the plan of care (and

developing goals), and encouraging inquiries from the patient.DIF: Application REF: p. 27 TOP: Integrated Process: CaringMSC: Psychosocial Integrity

3. The nurse cares for a client who is scheduled for a breast biopsy. Which is the main purpose of the client–nurse relationship?

    a. To develop a mutually satisfying experience for the client and nurse.
    b. To assist the client in achieving and maintaining optimal health.
    c. To provide excellent client service and improve quality of care.
    d. To allow the client to receive important health information.

ANS: B
The client–nurse relationship is established primarily to help the client achieve and maintain optimal health. The client–nurse relationship is entered for the benefit of the client but is more effective if the relationship is mutually satisfying. The ability to communicate clearly and with compassion is central to excellent customer (or client) service. The client is not just a passive receiver of health information; the client–nurse relationship refers to the interaction between the nurse and the client.DIF: Knowledge REF: pp. 19-20 TOP: Integrated Process: Communication and Documentation MSC: Psychosocial Integrity

4. While admitting a patient to the medical unit, the nurse should take which action?

    a. Demonstrate human caring by hugging the patient for brief intervals.
    b. Disclose shared intimate details with other healthcare providers.
    c. Maintain a physical distance of at least 3 to 4 feet at all times.
    d. Develop the plan of care and measurable objectives with the patient.

ANS: D
The patient and nurse should develop the plan of care together; attainment of objectives should be evaluated with the patient. Nurses may have strong feelings for their patients and express caring, but the nurse should maintain adequate objectivity and perspective to provide therapeutic assistance. Patients should have a sense of privacy, and confidentiality should be maintained. The nurse should not share intimate patient details with others.DIF: Application REF: p. 23 TOP: Integrated Process: CaringMSC: Psychosocial Integrity

5. The community health nurse is listening to a client talk about a personal problem. Which of these actions by the nurse is most appropriate?

    a. The nurse should increase the physical distance from the client.
    b. The nurse should lean toward the client and make eye contact.
    c. The nurse should periodically interrupt the client to ask questions.

d. The nurse should initiate the physical assessment to distract the client.

ANS: B
To actively listen to a client, the nurse should use open body language, arms open—not crossed; make eye contact without staring; echo words or paraphrase facts and feelings; lean toward the person speaking; do not interrupt; pay attention; and try to relax.DIF: Application REF: p. 25 TOP: Integrated Process: Communication and Documentation MSC: Psychosocial Integrity

6. As a part of the F.O.C.U.S. model, the "C" stands for

a. Communicate
b. Connect
c. Concern
d. Convince

ANS: B
According to the author, F.O.C.U.S. is a model she created to help nurses connect with the current moment in which they are serving. The model contains the following elements: Feel, Observe, Connect, Understand, and Share.DIF: Knowledge REF: p. 30 TOP: Integrated Process: Communication and Documentation MSC: Psychosocial Integrity

7. The nurse cares for a female patient who is trying to gain understanding of her life and her diagnosis of metastatic breast cancer. Which approach by the nurse would best meet this patient's needs?

a. Suggest the patient join a breast cancer support group.
b. Provide the patient with reading material on death and dying.
c. Contact the patient's spiritual leader to request daily visits.
d. Listen to the patient's stories about her past experiences.

ANS: D
Listening to the patient's story is an important assessment tool; the nurse can assess a patient's self-care knowledge and gain greater understanding of the patient. The nurse is able to learn what is important to the patient and create a personalized plan of care.DIF: Application REF: p. 27 TOP: Integrated Process: Communication and Documentation MSC: Psychosocial Integrity

8. The nurse cares for a patient who has type 2 diabetes mellitus and does not consistently follow the dietary restrictions and exercise recommendations. The patient takes a daily oral hypoglycemic agent as prescribed. Which statement by the nurse is most appropriate?

a. “It is great that you take your medicine as prescribed.”
b. “It wouldn’t be that hard to walk a few blocks every other day.”
c. “You are definitely not one of my good patients.”
d. “It is a waste of time to help you because you will never change.”

ANS: A
There are guidelines for nurse conduct in client–nurse helping relationships. The nurse should praise and encourage clients in their efforts to take better care of themselves. The nurse should not patronize clients, pigeonhole clients with labels (e.g., good, lazy, or uncooperative), or put down clients by making them feel inadequate or estranged.DIF: Application REF: p. 24 TOP: Integrated Process: Communication and Documentation MSC: Psychosocial Integrity

9. The home care nurse visits a mother and her newborn 2 days after discharge from the hospital. The mother states, “My baby cries all the time. I must not be a very good mother.” Which response by the nurse is nontherapeutic?

a. “It sounds as if you are concerned about your ability to care for your baby.”
b. "The nurse moves closer to the mother and places a hand on her shoulder."
c. “You just need to get away for a few hours. Find a babysitter and go to a movie.”
d. “I am not sure that I understand what you mean. Tell me more about how you feel.”

ANS: C
Giving advice (i.e., declaring to the patient what the nurse thinks) negates the worth of the patient as a mutual partner in decision making and is a nontherapeutic communication technique. Restating is repetition to the client of what the nurse believes is the main thought or idea expressed; restating asks for validation of the nurse’s interpretation of the message. Reducing distance between the nurse and the client nonverbally communicates that the nurse wants to be involved with the client. Seeking clarification demonstrates the nurse’s desire to understand the client’s communication.DIF: Analysis REF: p. 26 TOP: Integrated Process: Communication and Documentation MSC: Psychosocial Integrity

10. The nurse is performing a well-child assessment on a 15-month-old child. The child’s mother and father are present. Which action by the nurse will best determine the health beliefs and values of the parents?

a. Have the parents independently complete the Myers-Briggs Type Indicator survey.
b. Read the documented health histories of the child’s parents and grandparents.
c. Actively listen to the parents talk about their lives and health concerns.
d. Review the traditional health practices of the ethnic group identified by the parents.

ANS: C
Nurses should listen to their client's story to gain insight and knowledge into how a person defines "health." The Myers-Briggs Type Indicator identifies a person's preferences in regard to perception and judgment. Review of health histories or traditional health practices will not provide as much insight on health beliefs and values as allowing the client to tell his or her story.DIF: Application REF: p. 23 TOP: Integrated Process: Communication and Documentation MSC: Psychosocial Integrity

11. The nurse cares for a client with abdominal pain who is scheduled for exploratory surgery. Which statement(s), if made by the nurse, indicates that the client's rights in the helping relationship have been violated? (Select all that apply)

    a. "I do not have time right now to help you call your family."
    b. "I am available to answer questions that you may have about your surgery."
    c. "You seem frightened. I will stay with you until your family arrives."
    d. "Your neighbors called, and I told them that you will have surgery."
    e. "If you do not let me start your IV, I will not give you pain medication."

ANS: A, D, E
Client rights that were violated are: (1) to secure help conveniently, without hassles or roadblocks; (2) to trust that the confidentiality of any personal information will be respected; and (3) to refuse or consent to nursing treatments without jeopardizing their relationship with their nurses. Client rights that were respected are: (1) to be informed about their health status and have all their questions answered so that they clearly understand what nurses mean and (2) to feel confident that they will be treated courteously and that their nurses show genuine interest in them.DIF: Application REF: pp. 23-24 TOP: Integrated Process: CaringMSC: Safe and Effective Care Environment: Management of Care