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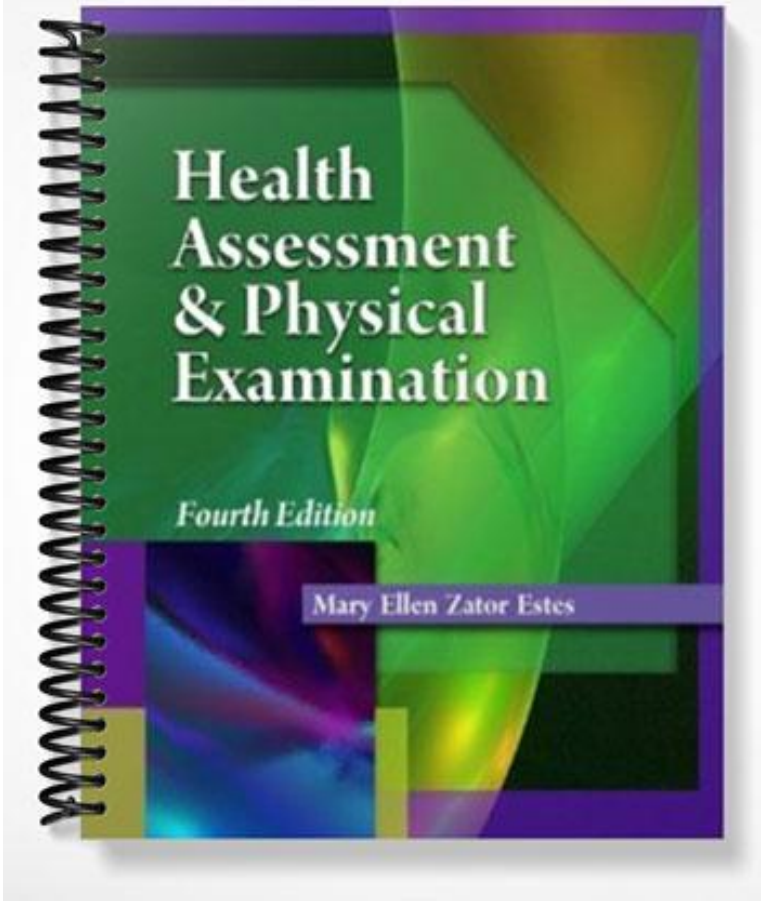
Health
Assessment
& Physical
Examination
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Mary Ellen Zator Estes

CHAPTER 2: THE PATIENT INTERVIEW

MULTIPLE CHOICE

1. The nurse's role during the nursing assessment interview includes all of the following, except:
   a. embracing a nonjudgmental attitude.
   b. assisting the patient in effectively using the health care system.
   c. establishing a mutually respectful dialogue in a safe environment.
   d. outlining appropriate plans for the patient.

   ANS: D
   The nurse frequently assumes the role of intermediary for the patient in the larger health care system. A critical role of the nurse is to assist the patient in effectively utilizing the system. The nurse is the facilitator of the interview and thus collaborates with the patient in establishing a mutually respectful dialogue. Because the primary purpose of the interview is to collect accurate data, the patient must feel comfortable and safe enough to provide information, ask questions, and express concerns. The nurse can foster an atmosphere of comfort by approaching the patient with an accepting, respectful, nonjudgmental attitude.

   PTS: 1 DIF: Comprehension REF: The Role of the Nurse

2. Which of the following can interfere with establishing the patient's trust during the initial interview?
   a. greeting the patient by first name
   b. conducting the interview in a private room
   c. stating the purpose of the interview
   d. establishing a time frame for the interview

   ANS: A
   Begin the interview with an introduction that includes your name and title. Initially call the patient by his formal name and ask how the patient prefers to be addressed. Simple communication using appropriate names is respectful and helps identify patients as unique individuals. Giving recognition helps lower patient anxiety and increase patient comfort level.

   PTS: 1 DIF: Comprehension
   REF: Factors Influencing the Interview: Approach

3. Ms. M asks you if the information she has shared with you will be kept confidential. Your best response is to assure her that you will:
   a. not share any information she has told you under any circumstances.
   b. share only critical medical information with physicians.
   c. share information with members of her care team for her benefit.
   d. share the information only with her primary nurse.

   ANS: C
   Confidentiality is essential in developing trust between nurse and patient. Your verbal assurance of confidentiality often eases the patient's concerns and fosters trust in the relationship. In practice, there are exceptions to absolute confidentiality. One example is a teaching institution where a team approach is used and information must be shared. Another reason for sharing confidential information is when a patient is a danger to self or others.

   PTS: 1 DIF: Application REF: Confidentiality

4. Which of the following occurs during the working stage of the interview process?

a. Goals are established.
b. The bulk of the patient data is collected.
c. Information is summarized and validated.
d. Progress toward goals is evaluated.

ANS: B
During this stage of the interview process the bulk of the patient data is collected. It is a nursing responsibility to keep the interview goal-directed, including refocusing the patient and redefining the goals established in the joining stage. Information is summarized and validated in the termination stage. Progress toward goals is evaluated in the evaluation stage.

PTS: 1 DIF: Knowledge REF: Stage II

5. A nurse engaged in active listening is paying close attention to:
a. verbal communication only.
b. all sensory data resulting from the patient's messages.
c. selecting an appropriate listening response.
d. preparing responses to the patient's comments.

ANS: B
Active listening, or the act of perceiving what is said both verbally and nonverbally, is a critical factor in conducting a successful health assessment interview. The primary goal of active listening is to decode patient messages in order to understand the situation or problem as the other person sees it. The nurse needs to pay careful attention to all sensory data to make sense of the patient's message and formulate an appropriate response.

PTS: 1 DIF: Comprehension REF: Listening

6. Which of the following is an open-ended question?
a. Is your breathing better than the last time you were here?
b. Have you had this type of wheezing and coughing episode before?
c. How do you typically deal with an asthma attack?
d. Did you take medication for your asthma?

ANS: C
Open-ended questions encourage the patient to provide general rather than more focused information. Open-ended questions that begin with the words *how, what, where, when,* and *who* are usually more effective in eliciting the maximum amount of information. These questions indicate respect for the patient's ability to articulate important or pressing health concerns, and therefore to help set priorities.

PTS: 1 DIF: Application REF: Using Open-Ended Questions

7. Patients often respond to questions that begin with the word *why* by:
a. sharing important and useful information.
b. trying to explain or defend themselves.
c. establishing a closer relationship with the nurse.
d. becoming confused.

ANS: B
Open-ended questions that begin with the words *how, what, where, when,* and *who* are usually more effective in eliciting the maximum amount of information than those that begin with the word *why. Why* questions can cause patients to become defensive and feel the need to somehow explain or defend their ideas and behaviors, which sets up an adversarial relationship between the nurse and patient.

PTS: 1 DIF: Application REF: Using Open-Ended Questions

8. Which action taken by an interviewer is most likely to encourage a patient to continue talking?
   a. sitting quietly and patiently in silence
   b. saying “uh-huh” or “go on”
   c. avoiding eye contact while straightening your clothes
   d. talking on the phone

   ANS: B
   A variety of both verbal and nonverbal means can be used to encourage patients to continue talking. Phrases such as “go on” or “uh-huh,” the simple repetition of key words the patient has spoken, or even head nods or a touch on the hand prompt the patient to resume speaking and also indicate the nurse’s continued interest and attention.

   PTS: 1 DIF: Application REF: Facilitating

9. Mr. C has been readily answering your interview questions and now has become silent. This onset of silence most likely indicates that he is:
   a. anxious or embarrassed.
   b. tired and wants to end the interview.
   c. uncooperative.
   d. waiting for you to talk.

   ANS: A
   Silence on the part of a patient may indicate feelings of anxiety, confusion, embarrassment, a lack of understanding about the question asked, or a lack of proficiency in English.

   PTS: 1 DIF: Knowledge REF: Silence

10. Listening responses are communication techniques that enable the nurse to do all of the following, except:
    a. communicate empathy, concern, and attentiveness.
    b. accurately receive, process, and respond to patient messages.
    c. understand the context of the patient’s experiences.
    d. offer judgment about the appropriateness of the patient’s responses.

    ANS: D
    Communication techniques can be divided into two groups: listening responses and action responses. Listening responses are attempts made by the nurse to accurately receive, process, and then respond to patient messages. They provide one way for the nurse to communicate empathy, concern, and attentiveness. In order to “listen” to what the patient says, the nurse must not only process the words spoken by the patient, but also understand the context of the patient’s experience.

    PTS: 1 DIF: Knowledge REF: Listening Responses

11. Which statement is an example of the use of reflection?
    a. “Tell me more about it.”
    b. “It sounds as if you’re angry that the pain has returned.”
    c. “Did this pain occur after you ate lunch?”
    d. “Is this pain similar to, or different from, the pain you experienced before surgery?”

    ANS: B

Reflection focuses on the content of the patient's message as well as the patient's feelings. In reflecting, the nurse directs the patient's own questions, feelings, and ideas back to the patient and provides an opportunity for the patient to reconsider or expand on what was just said. Option "A" is an example of facilitating. Option "C" is an example of sequencing in which a patient places a symptom, problem, or an event in its proper sequence. Option "D" is an example of encouraging comparisons.

PTS: 1 DIF: Comprehension REF: Reflecting

12. An example of an action response that stimulates the patient to make some change in thinking and behaving is:
    a. clarifying.
    b. sequencing.
    c. focusing.
    d. restating.

    ANS: C
    Action responses are the second group of effective interviewing or communication techniques. These responses stimulate patients to make some change in their thinking and behavior. Action responses include techniques such as focusing, exploring, presenting reality, confronting, informing, collaborating, limit setting, and normalizing. Focusing is the only option that is an action response. It allows the nurse to concentrate on or "track" a specific point the patient made. All the other options are listening responses.

    PTS: 1 DIF: Comprehension REF: Action Responses

13. The statement, "Perhaps you and I can talk further about your diabetes and identify your specific concerns," is an example of a communication technique that conveys the message that the:
    a. nurse has the primary responsibility in problem solving.
    b. patient should take the lead in the planning process.
    c. nurse and patient will work together in addressing the patient's health concerns.
    d. nurse will supply the necessary information and instructions for the patient.

    ANS: C
    This statement is an example of an action response called collaborating. In collaboration, the patient is offered a relationship in which both nurse and patient work together, rather than one in which the nurse is in total control of the interaction. This technique provides a respectful way for the nurse to encourage the patient's active involvement in his own health care, in setting goals, in gathering information, and in problem solving.

    PTS: 1 DIF: Analysis REF: Collaborating

14. Ms. W comments that she feels "like a baby" when she starts crying during a discussion of her cancer surgery scheduled for the next day. Which communication technique is most likely to reassure her that her response is common given her situation?
    a. informing
    b. presenting reality
    c. normalizing
    d. clarifying

    ANS: C
    Often individuals faced with unexpected or life-threatening illnesses, or possible surgeries, respond in ways that seem extreme or out of the ordinary (e.g., becoming depressed or overly tearful). The technique called normalizing allows the nurse to reassure the patient that the response is quite common given the situation. This helps to decrease patient anxiety and encourages the patient to share thoughts and feelings that might otherwise be kept private for fear of being judged or misunderstood.

PTS: 1 DIF: Application REF: Normalizing

15. The use of probing questions can increase the patient's anxiety or cause her to withdraw. When this happens, the nurse most often experiences feelings of:
    a. being pursued or attacked.
    b. participating in a tug-of-war.
    c. being overwhelmed.
    d. being confused.

    ANS: B
    Probing is an example of a nontherapeutic interviewing technique. Repeated or persistent questioning of the patient about a statement or a behavior increases patient anxiety and can cause confusion, hostility, and a tendency to withdraw from the interaction. A helpful rule of thumb for nurses to use in identifying probing is to pay attention to their own behavior and feelings. If, in attempting to gather information, nurses feel frustrated or irritated, feel that they are pursuing the patient, or have become involved in a verbal tug-of-war with the patient, they are most likely probing.

    PTS: 1 DIF: Comprehension REF: Probing

16. The statement "Everything will be fine," made by a nurse to parents of an infant being prepared for surgery will most likely:
    a. decrease the parents' anxiety.
    b. reassure the parents.
    c. communicate the nurse's understanding and concern.
    d. relieve the nurse's anxiety.

    ANS: D
    The impulse to provide false reassurance typically originates in the nurse's own feeling of helplessness. Giving false reassurance is an attempt by the nurse to relieve personal feelings of anxiety. This behavior often increases the patient's anxiety. A more valuable response would be to first acknowledge personal feelings of anxiety and then to acknowledge the patient's feelings.

    PTS: 1 DIF: Application REF: Offering False Reassurances

17. Mr. R informs you that he would like to stop his two-pack-a-day cigarette habit but has heard complaints about the clinic's antismoking program. Which of the following would be an appropriate response?
    a. "Why do you smoke that much?"
    b. "What a good idea, I'm sure that the clinic's program will help you."
    c. "Tell me more about your concerns about stopping smoking."
    d. "Try the support group for smokers instead; it has had great success in helping people stop smoking."

    ANS: C
    Patients who have had previous stressful or unpleasant experiences with physicians, hospitals, or other agents of the health care system often engage in criticism or verbal attack. It is not helpful for the nurse to defend the object of the attack. Defending implies that the patient has neither the right to hold such opinions or feelings, nor the right to express them. Defending is not therapeutic because it requires the nurse to speak not just for herself but for others, something that nurses are realistically not able to do. It is more useful to accept patients' right to feel as they do without agreeing with the expressed feelings. This empathic behavior defuses any antagonism and minimizes patient resistance to continued interaction.

    PTS: 1 DIF: Application REF: Defending

18. A patient is most likely to perceive that a nurse is unwilling to share information or that the nurse feels superior to the patient when the nurse:
    a. interrupts the patient.
    b. uses medical jargon.
    c. is talkative.
    d. asks multiple questions.

    ANS: B
    The use of medical jargon can be seen by the patient as unwillingness to share or an attempt to hide information, or it can give the impression that the nurse feels superior to the patient and is unwilling to engage in collaboration or mutual problem solving.

    PTS: 1 DIF: Application REF: Using Medical Jargon

19. When interviewing a patient who is hearing impaired, the nurse should implement which approach?
    a. Use clock hours to indicate the position of items in relation to the patient.
    b. Face the patient, and use nonverbal cues to supplement and reinforce messages.
    c. Ask simple questions that require yes or no answers.
    d. Speak loudly and slowly to facilitate lip reading.

    ANS: B
    Patients with a hearing impairment often read lips, so it is important for the nurse to remain within sight of the patient and face the patient when talking. Tone and inflection of voice are lost to the patient with a hearing impairment. However, other nonverbal cues such as facial expression and body movements can be used to convey the meaning of what is said. Speaking loudly or slowly detracts from the patient's ability to read lips.

    PTS: 1 DIF: Comprehension
    REF: The Patient Who is Hearing Impaired

20. In an interview with a patient who is visually impaired, it is important for the nurse to:
    a. speak loudly and distinctly.
    b. touch the patient frequently to emphasize the nurse's presence.
    c. use a tone of voice, volume, and inflection appropriate to the message.
    d. use simple phrases and closed questions.

    ANS: C
    When interviewing patients who are visually impaired, always look directly at them as you would with a person who is not visually impaired. Because they cannot rely on visual cues, voice intonation, volume, and inflection are important. Speaking loudly can hinder communication and can be insulting. Touch is especially important to a patient who has a visual impairment; however, the nurse should ask permission before touching.

    PTS: 1 DIF: Comprehension
    REF: The Patient Who Is Visually Impaired

21. Mr. B, a patient who is aphasic, has asked his wife to serve as an intermediary for the interview with his nurse. The nurse should conduct the interview by directing:
    a. all questions to the patient.
    b. questions requiring yes or no answers to the patient and all others to the wife.
    c. questions related to the health history to the wife and current health issues to the patient.
    d. all questions to the wife.

    ANS: A

When interviewing a patient who is speech impaired or aphasic, all questions should be directed to the patient even if someone else is speaking for the patient. It is important to ask simple questions that require yes and no answers and allow additional time for patient responses. Even when all questions in the interview are asked and answered using closed questions, allow the patient the opportunity to contribute to the information gathering.

PTS: 1 DIF: Application REF: The Patient Who Is Speech Impaired or Aphasic

22. During your interview with the parents of a critically injured 9-year-old boy, the mother begins to cry. Your best response is to say:
    a. "I'll leave you alone for a few minutes while you get a hold of yourself."
    b. "I'm sure that your son is receiving the best of care; our trauma team is highly trained."
    c. "I can see that you are upset; your husband can provide the rest of the information."
    d. "It's OK to cry; let's sit here together for a few minutes."

    ANS: D
    It is very important to show empathy and to allow the patient to cry. Offering tissues indicates to the patient that it is okay to cry and conveys a message of thoughtfulness. When the patient has regained composure, proceed with the interview.

    PTS: 1 DIF: Application REF: The Patient Who Is Crying

23. You should minimize the risk of aggression from a patient with a history of violence by doing all of the following, except:
    a. positioning your chair between the patient's chair and the door.
    b. using limit setting and refocusing.
    c. leaving the door to the interview room open.
    d. confronting the patient.

    ANS: D
    The nurse can minimize the risk of aggression through nonthreatening interventions such as limit setting and refocusing. Position yourself near an easily accessible exit. Do not turn your back on the patient, and never allow the patient to walk behind you or come between you and the exit. Consider leaving the door to the room open and letting a colleague know where you are.

    PTS: 1 DIF: Application REF: The Patient Who Is Hostile

24. When interviewing an elderly patient, all of the following techniques will be helpful, except:
    a. allowing extra time for the interview.
    b. scheduling more than one interview.
    c. speaking loudly and slowly.
    d. interviewing a family member or caregiver as well as the patient.

    ANS: C
    Interviewing the older patient may require additional time for question interpretation and patient responses. It may be necessary to schedule more than one interview because the patient may have multisystem changes or complaints, a weakened physical condition, or a cognitive impairment. It may be necessary to interview an older patient's family member or caregiver to assess the patient's past and present health or illness status. Speaking loudly and slowly is not helpful.

    PTS: 1 DIF: Analysis REF: The Older Adult

25. The purpose of rephrasing what a patient has said is to:
    a. reach a nursing diagnosis.
    b. promote further dialogue.

c. end the interview.
d. correct patient errors.

ANS: B
Restating involves repeating or rephrasing the main idea expressed by the patient and lets the patient know that you are paying attention. It promotes further dialogue and provides the patient with an opportunity to explain or elaborate on an issue or concern.

PTS: 1 DIF: Comprehension REF: Restating

COMPLETION

1. If a patient is excessively talkative during the patient interview, the nurse may find it necessary to provide some direction as to how to behave. This communication technique is called _____.

   ANS:
   limit setting
   Rationale: During the interview with a seductive, hostile, or talkative patient, the nurse may find it necessary to set specific limits on the patient's behavior. Patients may require some direction as to how to behave; provide guidance by calmly, clearly, and respectfully telling the patient what behavior is expected. Limit only the behavior that is problematic or detrimental to the purpose of the interview. When limit setting, do not argue or use empty threats or promises. Do offer the patient alternatives.

   PTS: 1 DIF: Knowledge REF: Limit Setting

2. During the interview, it is best to place your chair approximately _____ feet from the patient.

   ANS:
   6
   six
   Rationale: The amount of space a person considers appropriate for interaction is a significant factor in the interview process and is determined in part by cultural influences. Social distance is approximately 4 to 12 feet and is considered appropriate for the interview process. It allows for good eye contact and for ease in hearing and in seeing the patient's nonverbal cues.

   PTS: 1 DIF: Knowledge REF: Distance