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MULTIPLE CHOICE

1. The nurse interviews a patient during admission. Which observation by the nurse identifies consistency between the patient's verbal and nonverbal communication?
   a. Asserts she is eager to answer questions while reading a magazine.
   b. States that he wants information while frequently changing the subject.
   c. Asks the nurse to explain a surgical procedure while she listens intently.
   d. Explains that he is relaxed while continuously shifting in his chair.

   ANS: C
   The patient demonstrates congruency, or consistency, between her verbal statement asking for an explanation and her nonverbal cue of listening intently. The verbal and nonverbal messages match; each indicates that the nurse's response is important to her. If she is eager to answer questions, the patient should focus on the nurse's questions or note taking; reading a magazine is a distraction and indicates a lack of interest. Changing the subject may indicate discomfort or reluctance to address the issue. Continually shifting position may be an indication of anxiety.

   DIF: Cognitive Level: Applying OBJ: NCLEX: Safe and Effective Care Environment
   TOP: Nursing Process: Assessment

2. The nurse is interviewing a newly admitted patient. Which statement by the nurse is most likely to result in effective patient communication?
   a. "I'm not sure why you're here. Can you explain it to me?"
   b. "Tell me about things and people that are important to you."
   c. "Tell me more about your pain. Where does it start?"
   d. "If you think it's important, I'll try to notify the provider."

   ANS: C
   The nurse communicates effectively by using focused questions. This encourages the patient to give more information about the specific topic of concern. The remaining options are ineffective communication techniques because each potentially impairs the exchange of information between the nurse and the patient regarding care needs. The patient may be unwilling to express concerns openly after the nurse expresses lack of understanding and empathy. The patient will also likely lose confidence in the nurse if the nurse expresses confusion about suitability of the patient's presence. By asking what is important to the patient, the nurse loses focus of the objective of the communication and is likely to confuse the patient.

   DIF: Cognitive Level: Applying OBJ: NCLEX: Safe and Effective Care Environment
   TOP: Integrated Process: Communication and Documentation

3. After receiving a diagnosis of a fatal disease, the patient expresses sadness and states "I don't know what to do next". Which action by the nurse best facilitates communication at this time?
   a. Sit quietly with the patient and observe nonverbal communication.
   b. Reassure the patient that his family will take care of him.
   c. Refer the patient to a church for spiritual counseling.

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d. Tell the patient that hospice care is available immediately.

ANS: A
Because of the grim diagnosis, the patient expresses confusion and lacks a clear direction. The patient is not able to process information at this time and is overwhelmed. Sitting quietly with the patient shows acceptance, empathy, and allows the nurse to observe nonverbal communication. The patient can benefit from a calming atmosphere and time to process the new information. Assuring the patient of family involvement requires consultation with the family first. Spiritual counseling may not be indicated for this patient if the patient does not wish to participate. Discussing hospice at this early stage is premature; the patient needs time to process the news and gather information but is not able to do so right now.

DIF: Cognitive Level: Applying OBJ: NCLEX: Safe and Effective Care Environment
TOP: Integrated Process: Communication and Documentation

4. The nurse is preparing to begin the patient hand-off procedure for five patients. Who should the nurse include in this process?
   a. Only the licensed nurses
   b. The nursing personnel caring for the patients
   c. The entire interdisciplinary team
   d. The nurses and health care provider

   ANS: B
   All the nursing personnel on the unit who will be interacting with this group of patients should actively participate in the patient hand-off. This would include nursing assistive personnel (NAP) and the nurses. An interdisciplinary team usually meets when there is a problem with a patient and all the team members need to discuss approaches and plans with and for a patient or as a routine meeting. The health care provider does not participate in the patient hand-off procedure.

   DIF: Cognitive Level: Remembering OBJ: NCLEX: Safe and Effective Care Environment
   TOP: Integrated Process: Communication and Documentation

5. The nurse brings the patient's medications into the room, and the patient shouts, "You don't care if I take these, so get out of my room!" Which response by the nurse is most appropriate?
   a. "Who misinformed you about my feelings?"
   b. "You seem very angry about the medications."
   c. "We know each other; why are you saying this?"
   d. "I cannot leave until you take these medications."

   ANS: B
   Stating observations encourages the patient to be aware of his or her behavior. This neutral response would allow the patient time to explain the meaning behind the anger. Asking who misinformed the patient is confrontational. "Why" questions tend to put people on the defensive. Stating that the nurse cannot leave until the medications are taken is also confrontational and would set up a possible power struggle between the two.

   DIF: Cognitive Level: Applying OBJ: NCLEX: Safe and Effective Care Environment
   TOP: Integrated Process: Communication and Documentation

6. The patient shouts at the nurse, "No one answered my nurse call system all night!" Which response would the nurse use with this patient to restore therapeutic communication?

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a. "Shouting is going to disturb other patients."
b. "I see how that would make you very angry."
c. "Are you sure the nurses were avoiding you?"
d. "The unit has many very sick patients right now."

ANS: B
Regardless of whether the nurses answered the patient's nurse call system during the night, the patient felt ignored. By empathizing with the patient's distress and reflecting feelings, the nurse displays respect and understanding of his or her experience. Reprimanding the patient is humiliating and conveys the nurse's lack of regard for the patient's feelings. Quieting the patient is achievable by displaying empathy, caring, respect, and willingness to hear his or her complaints. Questioning the patient's perception is demeaning and forces the patient to justify feelings, similar to asking a "why" question. Stating that the unit has very sick patients implies that the patient is not as important as the others are.

DIF: Cognitive Level: Applying OBJ: NCLEX: Safe and Effective Care Environment
TOP: Integrated Process: Communication and Documentation

7. A patient with a history of violence directed toward others becomes very excited and agitated during the nurse's interview. Which intervention does the nurse implement to foster therapeutic communication?
a. Call the security staff for assistance.
b. Ask the patient to use self-control.
c. Lean forward and touch the patient's arm.
d. Assume an open, nonthreatening posture.

ANS: D
The nurse should use neutralizing skills and assume an open, nonthreatening posture that conveys respect and acceptance, creating an atmosphere in which the patient can communicate without feeling threatened or defensive. Calling security in the patient's presence is likely to aggravate the patient and escalate the potential for violence because it is humiliating, conveys the nurse's rejection of the patient, and threatens to take all control away. Asking the patient to use self-control is reprimanding, humiliating, and conveys rejection and lack of respect by the nurse. The patient can perceive leaning in and touching as threatening.

DIF: Cognitive Level: Applying OBJ: NCLEX: Safe and Effective Care Environment
TOP: Integrated Process: Communication and Documentation

8. The nurse admits a patient who is nonverbal and agitated. What can the nurse do to communicate effectively with the patient?
a. Use a communication aid.
b. Wait for family to arrive.
c. Call interpreter services.
d. Treat the patient for pain.

ANS: A

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Patients with sensory losses require communication techniques that maximize existing sensory and motor functions. Some patients are unable to speak because of physical or neurological alterations such as paralysis; a tube in the trachea to facilitate breathing; or a stroke resulting in aphasia, difficulty understanding, or verbalizing. Many types of communication aids are available for use, including writing boards, flash cards, and picture boards. The nurse needs to determine what will work for the patient. Waiting for family is unacceptable because the patient needs care and the family may be delayed or not come at all. Interpreter services are for patients who do not speak the language. The nurse should not assume the patient has pain before completing an assessment.

DIF: Cognitive Level: Applying OBJ: NCLEX: Safe and Effective Care Environment
TOP: Nursing Process: Assessment

9. A patient's mother died several days ago. The patient begins to cry and states, "The pain of her death is impossible to bear." Which statement by the nurse is the most effective response?
   a. "I was depressed last year when my mother died, too."
   b. "I know things seem bleak, but you are doing so well."
   c. "I can see this is a very difficult time for you right now."
   d. "Should I cancel your appointment with the cardiologist?"

   ANS: C
   The nurse conveys empathy and respect by acknowledging the patient's grief. This is an effective response and is likely to enhance the nurse–patient relationship because it is patient centered, displays caring and respect, and helps to make the patient feel accepted. Relating personal details about the nurse's life redirects the focus of the communication to the nurse and fails to support the objectives of the nurse–patient relationship. Responding with a comment about the patient's progress and asking about the cardiologist's appointment ignores the patient's grief and conveys a lack of respect and consideration.

   DIF: Cognitive Level: Applying OBJ: NCLEX: Safe and Effective Care Environment
   TOP: Integrated Process: Communication and Documentation

10. A patient who says that both parents died of heart disease early in life is waiting for diagnostic testing results. The patient is biting fingernails and pacing around the room. Which statement should the nurse use to clarify patient information?
    a. "I can see that you are anxious about dying."
    b. "Tell me more about your family's history."
    c. "Do you have your parents' medical records?"
    d. "I'm not sure that I understand what you mean."

    ANS: B
    Asking for more information about the family's history directs the patient to expand on a specific, pertinent topic and relate key details before moving to another topic. "Early in life" and "heart disease" need to be defined by the patient; "early in life" can indicate a wide range of ages, depending on the definition of "early," and "heart disease" can mean conditions such as heart failure, coronary artery disease, valve disease, and arrhythmias. Until the patient discusses his particular concerns, the nurse cannot be sure about the source of his anxiety. Asking for the records can display a lack of respect by implying that the patient is an unreliable source for information. Stating that the nurse is not sure what the patient means is vague, leaving the patient to guess what the nurse wants to know.

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DIF: Cognitive Level: Applying OBJ: NCLEX: Safe and Effective Care Environment
TOP: Integrated Process: Communication and Documentation

11. The patient tells the nurse, "I must be very sick because so many tests are being performed." Which statement does the nurse use to clarify the patient's message?
    a. "I sense that you are very worried."
    b. "Why do you mention this so frequently?"
    c. "We should talk about this more."
    d. "Are you saying you think you are seriously ill?"

    ANS: D
    The nurse clarifies the patient's message. This encourages the patient to expand on a thought or feeling that seems vague to the nurse. Pointing out that the patient has stated this before can be misinterpreted to mean that the patient is forgetful or annoying, and "why" questions tend to put people on the defensive. Stating that the nurse feels that the patient is worried is a suitable response but does not clarify what the patient actually said. Telling the patient he or she "should" talk about this topic is confrontational.

    DIF: Cognitive Level: Applying OBJ: NCLEX: Safe and Effective Care Environment
    TOP: Integrated Process: Communication and Documentation

12. The patient tells the nurse, "I want to die." Which is the best response by the nurse to facilitate therapeutic communication?
    a. "Now why would you say a thing like that?"
    b. "Tell me more about how you're feeling."
    c. "We need to tell the provider how you feel."
    d. "You have too much to live for to say that."

    ANS: B
    The patient's statement warrants further investigation to determine how serious the patient is about dying and whether he or she has a plan. To elicit more information from the patient in a respectful and caring manner, the nurse allows the patient to expand on the statement, "I want to die" by stating, "Tell me more." The statement displays concern for and value of the patient by acknowledging the patient's message and encouraging him or her to continue. Safety is a major concern when a patient wants to die, and the remaining options are likely to be perceived as patronizing and/or dismissive.

    DIF: Cognitive Level: Applying OBJ: NCLEX: Safe and Effective Care Environment
    TOP: Integrated Process: Communication and Documentation

13. The nurse is explaining a procedure to a 3-year-old patient. Which strategy would the nurse use for patient teaching?
    a. Ask the patient to draw her feelings.
    b. Show needles, syringes, and bandages.
    c. Tell the patient about postoperative pain.
    d. Use dolls and stories to explain surgery.

    ANS: D

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Using dolls, stuffed animals, or puppets with stories is a suitable way to explain surgery to the 3-year-old patient because storytelling is a familiar communication method for the toddler's developmental stage. A 3-year-old child is unlikely to understand an explanation about the surgery suited for an adult, and the discussion can frighten the child and upset the family or guardian. A 3-year-old child lacks the fine motor and cognitive skills to draw an abstract concept. A toddler is unlikely to understand and probably would be frightened by a discussion about postoperative pain.

DIF: Cognitive Level: Applying OBJ: NCLEX: Safe and Effective Care Environment
TOP: Integrated Process: Communication and Documentation

14. The nurse is caring for a patient who states, "I don't feel well today." Which is the best response by the nurse?
    a. Ask the patient to continue to describe the feeling.
    b. Measure the blood pressure and temperature.
    c. State that the patient's diagnostic testing had normal results.
    d. Compare recent laboratory results with the prior results.

    ANS: A
    Because the patient's statement is too vague, the nurse asks him or her to continue describing, "I don't feel well today," because many disorders begin with nonspecific complaints. Depending on the details the patient shares, the nurse plans and implements nursing care individualized to his or her description. This may include taking vital signs, and reviewing lab data, but before taking action the nurse needs more information. Telling the patient that test results are normal is dismissive of the concern.

    DIF: Cognitive Level: Applying OBJ: NCLEX: Safe and Effective Care Environment
    TOP: Integrated Process: Communication and Documentation

15. The nurse is caring for a patient who refuses to participate in physical therapy (PT) and states, "I really don't like to exercise." Which response by the nurse is most likely to help engage the patient in PT?
    a. "It makes the pain worse, doesn't it?"
    b. "What don't you like about exercise?"
    c. "You really should do these exercises."
    d. "Do you like to do any other activities?"

    ANS: B
    The nurse asks an open-ended question using the patient's words to uncover information about the patient's refusal to participate in PT by asking what the patient dislikes about exercise. Using the patient's words conveys acceptance and value because the nurse listened closely enough to repeat what the patient said. Asking the patient a yes-or-no question such as, "It makes the pain worse, doesn't it?" is unlikely to promote further discussion because it is a closed, yes/no question. Telling the patient to do the exercises is giving advice; rather the nurse can tell the patient the reason for the therapy and the benefits of doing it or the risks of not doing it. Asking about other activities moves the focus away from the patient's need for physical therapy. This is also a yes/no question.

    DIF: Cognitive Level: Applying OBJ: NCLEX: Safe and Effective Care Environment
    TOP: Integrated Process: Communication and Documentation

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16. The nursing staff are using the SBAR communication technique during patient hand-off communication. The circumstances leading up to the current status would be explained by the nurses during which step of the technique?
    a. Situation
    b. Background
    c. Assessment
    d. Recommendations

    ANS: B
    The background explains circumstances leading up to the situation. The situation explains what is happening at the present time. The assessment phase identifies what the problem is thought to be. The recommendations explain how to correct the problem.

    DIF: Cognitive Level: Remembering OBJ: NCLEX: Safe and Effective Care Environment
    TOP: Integrated Process: Communication and Documentation

17. The nursing staff are working with a postoperative patient from another culture who does not understand or speak the English language well. Which approach by the nurse would be best?
    a. Act out what the patient needs to do.
    b. Obtain a medical interpreter.
    c. Assess if the patient can read or write.
    d. Talk slowly when instructions are given.

    ANS: B
    A medical interpreter would be most helpful for effective communication. Acting out what the patient needs to do is ineffective and may be embarrassing to both the patient and the nurse. Since the patient and nurse do not speak a common language, defining the patient's ability to read or write in his native language does not solve the communication problem. Talking slowly will not improve the patient's ability to understand an unfamiliar language.

    DIF: Cognitive Level: Applying OBJ: NCLEX: Safe and Effective Care Environment
    TOP: Integrated Process: Communication and Documentation

18. The nurse is working toward discharging a patient. Which of following demonstrates patient engagement during the discharge process?
    a. Teaching the patient how to use his equipment
    b. Having the patient establish daily goals
    c. Reviewing the discharge instructions with the patient
    d. Including the family in the discharge planning

    ANS: B
    All of the answers are important to the discharge process but having the patient set his or her own daily goals establishes true patient engagement. The other interventions are performed by the nurse and do not really engage the patient. Patient engagement requires that the patient's preferences be incorporated.

    DIF: Cognitive Level: Applying OBJ: NCLEX: Safe and Effective Care Environment
    TOP: Integrated Process: Communication and Documentation

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19. The registered nurse is orienting a new nurse to the unit. They are completing paperwork on a newly admitted patient. When the experienced nurse asks what the new nurse thinks the patient will need to learn for self-care at home, the new nurse expresses surprise. What statement by the registered nurse is most appropriate?
    a. "You should always at least start thinking about discharge planning."
    b. "We don't want to wait too long because unexpected things happen."
    c. "The admitting nurse has to fill in all sections of this document."
    d. "Best practice is to begin discharge planning on admission."

    ANS: D
    Discharge planning should begin on admission to be accurate, thorough, and to allow the patient and/or family enough time to learn information or to master skills they will need at home. The other options may be at least partially true, but the only comprehensive answer is that it is best practice.

    DIF: Cognitive Level: Understanding OBJ: NCLEX: Safe and Effective Care Environment
    TOP: Integrated Process: Communication and Documentation

20. A student is watching a nurse perform a medication reconciliation prior to transferring the patient to a skilled nursing facility. What explanation of this process to the student is best?
    a. "It is required by the Joint Commission before discharge or transfer."
    b. "It creates an accurate list of medications so errors do not occur later."
    c. "It helps us recognize lapses in patients' ability to remember their medications."
    d. "Receiving facilities won't accept patients without a reconciliation."

    ANS: B
    Medication reconciliation is the process of creating the most accurate list of medications a patient is taking and comparing it to provider admission, transfer, and discharge orders. This is done in order to prevent medication errors at each transition.

    DIF: Cognitive Level: Understanding OBJ: NCLEX: Safe and Effective Care Environment
    TOP: Integrated Process: Communication and Documentation

21. A nurse is reviewing medications and treatments one final time before the patient goes home. The patient becomes agitated and says "I just can't do this! I'm too upset to ever be able to learn this!" What action by the nurse is best?
    a. Provide immediate remediation on the knowledge and skills.
    b. Ask the patient if home health care might be acceptable.
    c. Request the provider re-examine all the discharge orders.
    d. Tell the patient you would like to understand what is most difficult.

    ANS: D
    Just prior to discharge, the nurse reviews the discharge orders and plans with the patient. When the patient cannot recall information or perform needed skills, the nurse can provide immediate re-teaching and skills practice. However, this patient is upset, so the nurse must first determine the most bothersome aspect of the situation, which may or may not include the instructions. The nurse must first assess this before deciding if home health care is acceptable or before asking the provider to review the orders to see if they are all necessary.

    DIF: Cognitive Level: Applying OBJ: NCLEX: Safe and Effective Care Environment
    TOP: Integrated Process: Communication and Documentation

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MULTIPLE RESPONSE

1. During a home care visit, the patient experiences an angry outburst and hits the nurse on the thigh and yells at her. The patient continues to be threatening. What are the most appropriate initial actions by the nurse? (*Select all that apply.*)
   a. Increase the personal space between the nurse and patient.
   b. Call law enforcement to take the patient to the hospital.
   c. Restrain the patient's hands to the chair.
   d. Be empathetic to the patient's feelings and concerns.
   e. Call the nursing agency to ask for advice in working with this patient.
   f. Use a calm, quiet voice when talking with the patient.

   ANS: A, D, F
   The priority in this situation is the safety of both nurse and patient. The nurse should ensure there is adequate personal space between the two of them so the patient cannot strike the nurse. Being empathetic displays respect; even if the nurse disagrees with the patient's perception, it is real to that person. Using a calm, quiet voice is a de-escalation technique. The patient may or may not need hospitalization, but calling the police would not be the first action. The patient's hands should not be restrained as this could cause the patient to escalate and perhaps feel assaulted. The nursing agency should be consulted, but not as an initial action. The nurse needs to create an environment that is safe for both parties.

   DIF: Cognitive Level: Applying OBJ: NCLEX: Safe and Effective Care Environment
   TOP: Integrated Process: Communication and Documentation

2. Which of the following pieces of information should be included in a hand-off to ensure patient safety? (*Select all that apply.*)
   a. Code status
   b. Recent changes in condition
   c. Age
   d. Family visitation
   e. Use of oxygen

   ANS: A, B, E
   It is important to include information on a patient's background, assessment, nursing diagnosis, interventions (including the patient's response), family information, discharge plans, and current priorities when handing off your patient to another unit or area. However, only code status, recent changes in patient's condition, and use of oxygen directly impact patient safety.

   DIF: Cognitive Level: Applying OBJ: NCLEX: Safe and Effective Care Environment
   TOP: Integrated Process: Communication and Documentation

3. A faculty member is explaining personal factors that influence communication. What factors does the faculty member include? (*Select all that apply.*)
   a. Perceptions
   b. Values
   c. Emotions
   d. Relationships

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e. Pain

ANS: A, B, C, D
Although a patient's pain may affect communication, it is not a personal factor as are perceptions, values, emotions, and relationships.

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TOP: Integrated Process: Communication and Documentation

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