UNIVERSITY OF SWAZILAND

FACULTY OF HEALTH SCIENCES

FINAL EXAMINATIONS

MAY 2009

COURSE TITLE: **FUNDAMENTALS OF NURSING**

COURSE CODE: **NUR 101**

TIME ALLOWED: **2 HOURS**

TOTAL MARKS: **75**

INSTRUCTIONS:

1. **PLEASE READ QUESTIONS CAREFULLY**
2. **ANSWER ALL QUESTIONS**
3. **HAND IN THE SCRIPT AND QUESTION PAPER**

MARK ALLOCATION: 1 MARK per FACT/CORRECT PHRASE.

PLEASE DO NOT OPEN QUESTION PAPER UNTIL PERMISSION IS GRANTED BY THE INVIGILATOR.

QUESTION 1

MULTIPLE CHOICE QUESTIONS

INSTRUCTION: CHOOSE THE MOST APPROPRIATE ANSWER

1.1 The purpose of assessment it to:

a) establish a database concerning the client.

b) teach the patient about his/her health.

c) implement nursing care.

d) delegate nursing responsibility.

1.2. A nursing diagnosis is a:

a) a clinical judgment about individual, family, or community responses to actual and potential health problems or life processes.

b) the identification of a disease condition based on a specific evaluation of physical signs, symptoms, the client's medical history, and the results of diagnostic tests and procedures.

c) the diagnosis and treatment of human responses to health and illness.

d) the advancement of the development, testing, and refinement of a common nursing language.

1. 3. This organization is the leader in nursing diagnosis classification:

a) ANA (American Nurse Association).

b) AMA (American Medical Association).

c) NANDA (North American Nursing Diagnosis Association).

d) American Nurses Diagnostic Society.

1.4. Once a nurse assesses a client's condition and identifies appropriate nursing diagnoses

a) Plan is developed for nursing care

b) Physical assessment begins.

c) List of priorities is determined.

d) Review of the assessment is conducted with other team members.

1. 5. Planning is a category of nursing behaviours in which:

a) The nurse determines the health care needed for the client.

b) The physician determines the plan of care for the client.

c) Client – centered goals and expected outcomes are established.

d) The client determines the care needed.

1.6. For clients to participate in goal – setting, they should be:

a) Alert and have some degree of independence.

b) Ambulatory and mobile.

c) Able to speak and write.

d) Able to read and write.

1.7. Collaborative interventions are therapies that require:

a) Physician and nurse intervention.

b) Nurse and client intervention.

c) Client and physician intervention.

d) Multiple health care professionals.

1.8 When does implementation begin in the nursing process?

a) During the assessment phase.

b) Immediately, in some critical situations.

c) After there is mutual goal – setting between nurse and client.

d) After a care plan has been developed.

e)

1.9. Environmental factors heavily affect a client's care. The first environmental client concern is always:

a) Safety

b) Food and fluids

c) Adequate pain relief

d) Location of fire exits.

1.10. Evaluation is an important part of nursing care. During this process you determine the effectiveness of a specific nursing action by:

a) Reassessing the client for new problems.

b) Determining that the specific nursing action was completed.

c) Comparing the client's response to the nursing actions with other clients receiving the same nursing actions.

d) Comparing the client's response with expected outcomes established during the planning phase.

1.11 Nursing interventions such as removing excess blankets from the client and applying cool cloths to the axilla act to decrease body temperature through:

a) Conduction.

b) Convection.

c) Evaporation.

d) Radiation.

1.12. Poor oxygenation of the blood ordinarily will affect the pulse rate and cause it to become:

a) Bounding.

b) Irregular.

c) Faster than normal.

d) Slower than normal.

1.13. The basic techniques of which of these are used to determine vital signs:

a) Inspection, palpation, and auscultation.

b) Inspection, blood work, and x-rays.

c) Rhythm, rate, and open communication.

d) Psychology, physiology, and nursing skills.

1.14. Hygienic care requires close contact with the client; the nurse initially uses which of the following to promote a caring therapeutic relationship?

a) Communication skills.
b) Therapeutic touch.
c) Assessment skills.
d) Fundamental skills.

1.15. Clients most in need of perineal care are those at greatest risk of:

a) Acquiring infection.
b) Death.
c) Needing to be institutionalized.
d) Falling.

FILL IN THE BLANKS.

1.16. The bulb of a thermometer should be lubricated in order to

.....

1.17, 1.18, 1.19. The oral mercury thermometer should be held in place .....minutes, the rectal thermometer,.....minutes; the axillary thermometer.....minutes

1.20. The normal rate of respiration for the adult is.....to.....

TRUE/FALSE QUESTIONS

1.21. A patient's face should be washed with soap and water.

1.22. When washing the arms, long, firm strokes toward the center of the body are used to decrease venous return.

1.23. The back of the neck is washed separately from the front of the neck.

1.24. The unconscious patient does not need oral care.

1.25 A patient should be offered the opportunity for oral care before breakfast, after all meals, and at bedtime.

(25 Marks)

DISCUSSION QUESTIONS

QUESTION 2

2.1 Explain the different roles and functions of the nurse (15 Marks)

2.2 Discuss the levels of preventive care. (10 Marks)

(TOTAL =25)

QUESTION 3

3.1 Describe the basic principles of infection control. (15 Marks)

3.2 Describe the following positions that can be used for a patient:

- Supine position
- Prone position
- Fowlers position
- Trendelenburg position
- Lithotomy position (10 Marks)

(TOTAL = 25)

TOTAL EXAM. MARKS = 75