UNIVERSITY OF SWAZILAND

FACULTY OF HEALTH SCIENCES

GENERAL NURSING SCIENCE DEPARTMENT

FINAL EXAMINATION – DECEMBER 2008

COURSE CODE :NUR 420

COURSE TITLE :HEALTH ASSESSMENT,DIAGNOSIS AND TREATMENT I

TIME ALLOCATED : 2 HOURS

MARKS ALLOCATED: 75

TOTAL NO. OF PAGES: 07

EXAMINER : DR. M.D MATHUNJWA

INSTRUCTIONS:

1. ANSWER ALL QUESTIONS IN THE ANSWER BOOK PROVIDED
2. EACH QUESTION CONSISTS OF 25 MARKS.
3. ANSWER CLEARLY.
4. ONE MARK FOR AN EXPLAINED FACT UNLESS INDICATED OTHERWISE

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SECTION ONE: MULTIPLE CHOICE QUESTIONS

QUESTION 1

Answer the following multiple choice questions by indicating the most appropriate answer(s) e.g. 1. b.

1.1 During active data collection reflection can be used to obtain data. Reflection is when:

a) The patient is encouraged to continue with the account and indicate that he is being listened to.
b) The patient is given an opportunity to think.
c) The patient is allowed to give view of the subject
d) A word, sentence or phrase is repeated to the patient in precisely the same way as it was said.

1.2 Mrs. Swazi, a 45 year old mother of two is 50 pounds overweight. She has a smoking history of two packs a day for 20 years. She is to have hysterectomy tomorrow. Which nursing diagnosis should appear on Mrs. Swazi's nursing care plan?

a) Social isolation
b) Potential uterine cancer
c) Risk for ineffective airway clearance related to obesity and smoking
d) Uterine fibroids

1.3 All of the following are the purposes of the introductory phase in the interviewing process **except:**

a) Defining expectations
b) Ensuring comfort
c) Verifying the client's perceptions
d) D) Establishing rapport

1.4 Data analysis in health assessment leads to the following conclusions except:

a) Establishment of good client rapport
b) Identification of the client's strengths
c) Affirmation of the client's wellness state
d) Formulation of a nursing diagnosis

1.5 Percussion of the abdomen for shifting dullness is performed to detect:

a) Splenomegally
b) Pancreatitis
c) Uterine fibroids
d) Ascites

1.6 The scope of health assessment is influenced by:

a) The health assessor's ability to do health assessment
b) The client's ability to communicate
c) The client's health status
d) All of the above

1.7 The following are barriers to therapeutic communication:

a) Seeking clarification
b) Offering advice
c) Changing the subject abruptly
d) Acting defensively
e) Minimizing feelings

1.8 One of the following is a principle of documentation:

a) Being alert to potential risk factors
b) Writing concisely and efficiently
c) Organizing cues in such a way that they become meaningful
d) Consider a broad range of assessment
e) None of the above

1.9 When palpating the spleen the client should lie:

a) Flat on his/her back
b) On right side
c) In a semi fowlers position
d) On his/her left side

1.10 When auscultating the heart, the most appropriate technique is:

a) To press the bell firmly against the skin
b) To listen first with the diaphragm then the bell
c) To place the diaphragm lightly on the skin
d) Listen first with the diaphragm only if abnormalities are suspected

1.11 Assessing the individual's nutritional status involves:

a) Weight and height checking

b) Oral mucosa inspection

c) Colour and distribution of hair

d) All of the above

1.12 The following percussion sound is heard when fluid is present in the lungs

a) Hyper resonance

b) Flatness

c) Tympany

d) Dullness

1.13 The following are objective characteristic behaviours of a client experiencing pain **except:**

a) Jumping when palpated

b) Groaning when palpated

c) Verbalizing pain

d) Guarding the painful area

1.14 Functional assessment data are recorded in which section of the history:

a) Present problem

b) Past medical history

c) Family history

d) Review of systems

1.15 What is the usual sequence of examination procedure?

a) Auscultation, inspection, palpation, percussion

b) Inspection, palpation, percussion, auscultation

c) Inspection, percussion, auscultation, palpation

d) Palpation, percussion, auscultation, inspection

1.16 A brief description of perceived problem is for:

a) Medical history

b) Chief complaint

c) Chronological course of events

d) Past medical history

1.17 A damage to the olfactory nerve leads to problems affecting :

a) The sense of sight

b) The sense of hearing

c) The sense of smell

d) The sense of taste

1.18 All of the findings below are subjective data **EXCEPT:**

a) Chest pain

b) Fruity breath odour

c) Gas

d) Vision

1.19 The data provided by the patient when describing his illness are called:

a) Signs

b) Objective data

c) Symptoms

d) Data base

1.20 The nursing history provides information to assist primarily in:

a) Diagnosing a medical problem

b) Investigating patient symptoms

c) Classifying subjective and objective data

d) Supporting identification of nursing diagnoses

1.21 To examine the skin of a patient who has full thickness burn the nurse burn, the nurse primarily uses the technique of:

a) Inspection

b) Palpation

c) Percussion

d) Auscultation

1.21 Auscultation of the abdomen precedes percussion:

a. Only when one is examining an infant

b. When the examiner suspects a pulsatile mass is present

c. Because the latter maneuvers mat distort bowel sounds

d. Because palpitation may displace organs and blood vessels

1.22. Extension of the elbow is the normal response of:

a. Triceps muscle

b. Biceps muscle

c. Both Triceps and Biceps

d. None of the above

1.23. When evaluating the blood pressure of an older adult, the nurse needs to know that:

a. systolic blood pressure decreases when diastolic pressure increases with age

b. blood pressure should decrease with age because of decreased heart rate and cardiac output

c. the systolic pressure tends to rise with aging because of loss of elasticity of the arteries

d. dilation of the aorta and rigid arterial pulses make the blood pressure more difficult to measure accurately

1.24. You are auscultating Mrs. T's arterial blood pressure and hear a tapping sound at 210 mmHg that continues until the mercury reaches 195. Then there is silence until the mercury reaches 185, at which time the tapping resumes and gradually intensifies. At 140, the loud, sharp sounds become muffled. At 110, the sounds disappear. How would you record this pressure?

a. 210/140

b. 210/110

c. 210/185/140

d. 195/185/110

e. 210/140/110

1.25. The systolic pressure in an older individual:

a. May the slightly higher because elderly people are often more excitable

b. May be slightly higher than the young adult because of elasticity changes in the large arteries

c. May be slightly lower than the young adult because of loss of subcutaneous fat

d. It only involves the nurse and the client

TOTAL {25 MARKS}

QUESTION 2

a) Describe the guidelines used for recording the chief/main complaint or reason for coming to health facility. **5 marks**

b) A relationship of trust was established during the taking and recording of health history. Describe the activities and conditions the nurse must do to maintain the patient's confidence and put him at ease during a physical examination. **10 marks**

c) Describe the questions a nurse would ask from a client who has symptomatic complaints of the breast as pain, tenderness, lump, nipple discharge, skin rashes or changes in shape or size of breasts. **10 marks**

TOTAL { 25 MARKS }

QUESTION 3

a) Describe the data to be collected (questions to ask) during analysis of a symptom of the current illness. **5 marks**

b) Describe physical examination of the abdomen using the four techniques of inspection, palpation, percussion and auscultation. **20 marks**

TOTAL { 25 MARKS }