NND 3215: Health Assessment **Main exam** **Time: 2 hours**

Instructions: Answer all questions
SECTION A : 20 MARKS (MCQ).

1. When a client first enters the hospital for an elective surgical procedure, the nurse should perform an assessment termed as?
    a) Entry.
    b) Exploratory.
    c) Focused.
    d) Comprehensive.
2. The nurse is interviewing an adult client for the first time. The nurse should first?
    a) Assess the client's hearing acuity.
    b) Establish rapport with the client.
    c) Obtain biographic data.
    d) Use medical terminology appropriately
3. During palpation of a client's organs, the nurse palpates the spleen by applying pressure between 2.5 and 5 cm. The nurse is performing?
    a) Light palpation.
    b) Moderate palpation.
    c) Deep palpation.
    d) Very deep palpation.
4. Based only on anthropometric measurements, which set of clients listed below are at the greatest risk for diabetes and cardiovascular disease?
    a) Clients with a BMI of 23.
    b) Females with 88 cm or greater waist circumference.
    c) Males with 88 cm or greater waist circumference.
    d) Clients with a BMI of 20.
5. A client has tested 20/40 on the distant visual acuity test using a Snellen chart. The nurse should?
    a) Document the results in the client's record.
    b) Ask the client to read a handheld vision chart.
    c) Ask the client to return in 2 weeks for another examination.
    d) Refer the client to an optometrist.
6. After the test, the client reports that her bone conduction sound was heard longer than the air conduction sound. The nurse determines that the client is most likely experiencing?
    a) Normal hearing.
    b) Sensorineural hearing loss.
    c) Conductive hearing loss.
    d) Central hearing loss.
7. While assessing an older adult client's neck, the nurse observes that the client's trachea is pulled to the left side. The nurse should?
    a) Ask the client to flex his neck to the left side.
    b) Observe whether the client has difficulty swallowing water.

c) Refer the client to a physician for further evaluation.
d) Palpate the cricoid cartilage for smoothness

8. The nurse assesses an adult client's breath sounds and hears sonorous wheezes, primarily during the client's expiration. The client may have?
   a) Asthma.
   b) Chronic emphysema.
   c) Pleuritis.
   d) Bronchitis
9. While assessing the peripheral vascular system of an adult client, the nurse detects cold clammy skin and loss of hair on the client's legs. The client may be experiencing?
   a) Venous stasis.
   b) Varicose veins.
   c) Thrombophlebitis.
   d) Arterial insufficiency
10. To assess an adult client for possible appendicitis and a positive Rovsing's sign, the nurse should?
    a) Rotate the client's knee internally.
    b) Palpate at the lower left quadrant.
    c) Raise the client's right leg from the hip.
    d) Support the client's right knee and ankle.
11. The client is unable to shrug her shoulders against resistance. The nurse suspects that the client has a lesion of cranial nerve?
    a) VIII.
    b) IX.
    c) X.
    d) XI.
12. Which of the following indicators are used to determine the Glasgow coma scale score?
    a) Eye opening, and appropriateness of verbal and motor responses.
    b) Ability to recall recent and remote memories, and to use abstract reasoning.
    c) Assessment of the 12 cranial nerves.
    d) Naming of objects, recall of three words, and ability to redraw a design.

13. When the nurse asks the client to explain similarities and differences between objects, what abilities are being tested?
    a) Judgment.
    b) Concentration.
    c) Memory to learn new information.
    d) Abstract reasoning.
14. Skin lesions found on a client diagnosed with measles are?
    a) Plaques.
    b) Macules.
    c) Papules.
    d) Patch.
15. A male client has gynecomastia. The nurse should ask the client if he is taking any medications for?
    a) Inflammation.

b) Depression.
c) Infection.
d) Ulcers.

16. The nurse is caring for a female client during her first postoperative day after a temporary colostomy. The client refuses to look at the colostomy bag or the area. A priority nursing diagnosis for this client is?
    a) Denial related to temporary colostomy.
    b) Fear related to potential outcome of surgery.
    c) Disturbed body image related to temporary colostomy.
    d) Altered role functioning related to frequent colostomy bag changes
17. The nurse has assessed a male client and determines that one of the testes is absent. This condition is termed?
    a) Hypospadias.
    b) Hematocele.
    c) Cryptorchidism.
    d) Orchitis.
18. While assessing muscle strength in an adult client, the nurse determined that the client's knee joint has a rating of 3 and exhibits active motion against gravity. The client's muscle strength is documented as being?
    a) Normal.
    b) Slight weakness.
    c) Average weakness.
    d) Poor range of motion.
19. To test the client's recent memory the nurse should ask the client:
    a) "What did you have for breakfast?"
    b) "How old were you when you began working?"
    c) "Can you repeat *rose*, *hose*, *nose*, *clothes*?"
    d) "Can you tell me your name?".
20. A male patient's complete blood count results are back from the laboratory. Select all the NORMAL results:
    i. RBC 4.8 million
    ii. WBC 12,000
    iii. Platelets 350,000
    iv. Hbg 12 g/dL
    v. Hematocrit 37%

SECTION B: SHORT ANSWER QUESTIONS 30 MARKS

1. Outline five importance of biographic data during a health history (5 marks)
2. Describe how you would prepare the following for a physical assessment
    a) Patient (3 marks)
    b) Environment (3 marks)
3. Describe the components of a general survey (4 marks)
4. Describe five gross motor and balance tests (5 marks)

5. The nurse finds a mass during examination of a female patient's breast. State five characteristics that the nurse would record regarding the mass 5 marks
6. State five post procedure nursing interventions following a thoracocentesis 5 marks

SECTION C: LONG ANSWER QUESTIONS 20 MARKS

Mrs Vena is a 75 years old lady who is admitted to the medical ward with complaints of shortness of breath , pain in her chest when she breathes and a cough which began four days ago. Her vital signs are: Pulse: 100, respiratory rate is 28, BP 144/85, temperature 39°C & SaO_2 is 89. She is coughing up yellow sputum and has diminished bilateral lung sounds. The laboratory results show white blood cell count elevation and the sputum result is pending. A provisional diagnosis of pneumonia is made. Mrs Vena is married and lives with her 90 year old husband who is sickly and states that lately she has no energy to care for her husband. She has a 5-year history of adult-onset asthma with attacks which often awakens her at night. She uses laxatives twice a week and has no urinary problems. She does not eat any fried foods because it gives her "heart burn". She has been menopausal for the last 25 years and is not sexually active. She is currently on antihypertensives and asthma medications.

a) Identify five functional health patterns and for each, describe its accompanying data from the case study 10 marks
b) Identify one priority actual nursing diagnosis and develop a 24 hour care plan for Mrs Vena with two priority independent nursing interventions. 10 marks