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SCHOOL OF NURSING
DEPARTMENT OF
MEDICAL AND SURGICAL NURSING AND HUMAN HEALTH SCIENCES
BACHELOR OF SCIENCE IN NURSING
END OF JANUARY 2022 SEMESTER EXAMINATIONS
NUP 221: HEALTH ASSESSMENT

INSTRUCTIONS Time allowed 2 HOURS TOTAL SCORE 70 MARKS

Answer All questions on the Booklet provided

SECTION A: MULTIPLE CHOICE QUESTIONS (31 MARKS)

1. Nurse Mwende is teaching a female client to perform breast self-examination (BSE). A scientific rationale that Mwende should remember when conducting teaching sessions on BSE for female clients is:
    a. One half of all the breast cancer deaths occur in women of age 25 to 35 years.
    b. The tail of spence area must be included in self-examination
    c. The position of choice for the breast examination is supine.
    d. A pad should be placed under the opposite scapula of the breast being palpated.
2. A patient experiencing shortness of breath is due for a physical assessment. The nurse should proceed as follows:
    a. Have the patient lie down for the accurate cardiac, respiratory and abdominal assessment.
    b. Obtain a thorough history and physical assessment, information from the family member
    c. Perform a complete history and physical assessment immediately.
    d. Examine body areas appropriate to the problem and then complete the assessment after the problem has resolved.

3. Indicate whether the following statements are **true or false.**

i) Rinne test uses a tuning folk to test for air conduction and bone conduction for a patient's hearing Indicate.

ii) The Whisper test is used to test cranial nerve VIII.

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4. You are unable to palpate the right radial pulse of the patient. The right action for you to perform is:

a. call the team leader to come and identify it.
b. uses a goniometer to measure the pulsations.
c. uses a Doppler devise to confirm pulsations over the area.
d. check for presence of pulsations using a stethoscope.

5. In the examination of the external eye structures, abnormal findings include all the following with possible differential diagnosis except:

a. jaundiced sclera, liver disease
b. opaque surface of the cornea, diabetes
c. redness of the eye, infection
d. cloudiness of cornea,

6. . You are interviewing a client who does not understand your language but has minimal Kiswahili. During the discussion, the client continually smiles and nods the head. You should interpret this nonverbal behaviour as:

a. An acceptance of the treatment by the client.
b. Client understanding of the preoperative procedures
c. A reflection of a cultural value.
d. Client agreement to the required procedures.

7. The client states that she gets breathless while in Jogoo road traffic. The nurse documents this information under the following factor

a. Cultural
b. External environment
c. Emotional
d. Internal environment

8. After the health History from Mr. K Son, the nurse proceeds to take the patients vital signs. The data collected is grouped under:-

a. Subjective
b. Secondary
c. Objective
d. continuous

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9. During the Health history, Ms. N complains of nausea, fever diarhea vomiting. The nurses priority focused assessment should be on the following:

a. Vomiting
b. Nausea
c. Fever
d. Diarhea

10. The Nurse is documenting the patient's data. The following represents the subjective data.

a. Pulses present in the lower extremities.
b. " it hurts when I step out of bed in the mornings"
c. Blood pressure 120/78mmHG
d. Abdomen soft and non-tender to palpation.

11. The Nurse completes the health History taking and the physical assessment and gets a visitor from management. She returns to document after 3 hours. The likely scenario is:

a. It is likely to omit details of the process due to time lapse.
b. This is very accurate as the nurse has continued to care for the patient.
c. It will be thorough and complete.
d. It will be short and provide continuity of care.

12. Following the physical assessment of the patient, the nurse reviews the laboratory findings. The findings are an example of :

a. subjective data
b. primary source of information
c. secondary source of information
d. constant data

13. Following the health assessment and physical examination, the nurse compiles all the data. In the Nursing process this is the phase of:

a. planning
b. evaluation
c. diagnosis
d. assessment

14. You examine Ms. K and arrive at a Nursing diagnosis of fluid volume deficit. This is represented by:

a. abdominal tenderness
b. nausea

c. warm skin
d. dryness of lips and mucous membrane

15. The tympanic membrane is examined using an otoscope for maximum vision of the entire canal.An abnormal finding on inspection includes:
a. a grey color which is semi transparent.
b. Cerumen
c. Dull surface
d. All of the above

16. When testing the ear using Weber's Test, normal findings include
a. Normal sound is heard in both ears
b. Normal sound is heard in the dominant ear
c. Sound is heard at the point of contact on the forehead.
d. Sound is heard better by the impaired ear due to bone conduction

17. To ensure the patients safety when performing the Romberg's test, the nurse should:
a. Allow the client to keep his eyes open
b. Have the client hold on to her hand
c. Let the client spread his feet apart
d. Stand close to provide support

18. The nurse auscultates the carotid artery. The diaphragm and bell of the stethoscope are placed at all the following points **except:**

a. The base of the neck
b. Angle of the thyroid gland
c. The carotid bifurcation
d. The angle of the jaw

19. The nurse auscultates the abdomen for bowel sounds and documents- hyperactive/ increased bowel sounds that occur every 3 seconds. She enquires from the patient on all the following **except:**
a. Frequency of loose motions
b. Type of fluids consumed in the last 6 hours.
c. Last bowel movements as there may be intestinal obstruction.
d. Date when they last used laxatives

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20. A second-year nurse begins to explain to the patient the purpose of a complete physical assessment. The statement that makes the Clinical Instructor to intervene is when the student states that:

a. "I will use the information of the assessment to figure out if the antihypertensive medication is working"
b. "The data is only used to provide information about the effectiveness of the medical care".
c. " Nurses use data from their patient's physical assessment to determine a patients education need"
d. "Information from the physical assessment helps nurses better understand their patients emotional needs".

21. The nurse palpates the patient's urinary bladder and find that it is distended palpable as smooth round tense mass. The nurse should consider that this is possibly:

e. A tumor
f. A cyst
g. Urinary retention
h. Fecal implantation

22. In the table below, indicate what assessment you will carry out for the patient presenting with the indicated situation. An example of each section is provided for your guidance.

SITUATION	**PHYSICAL ASSESSMENT /10**
A. Client complains of abdominal pain	a…Inspect b……….. c………....... d………………. e………………...
B. Ms. M admitted with head injury	a…………. b………… c…………. d. Vital signs
C. You are preparing to administer a cardiogenic medication.	a………………. b. compares with baseline data.
D. The client's fluid chart indicates minimal fluid intake.	a………... b……... c…………. d. Vital signs

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SECTION B (SHORT ANSWER QUESTIONS) 39 MARKS

1. State five purposes of the physical examination. **(5 marks)**

3 Explain three (3) deviations from normal identified on the physical assessment of the (i) thorax and (ii) abdomen. **(9 marks**)

4. Compare and contrast the assessment findings of peripheral vascular

system in the older adult and child. **(10 marks)**

5. Explain the specific differences in the review of systems for the child and older adult identifying one abnormality for each.
   a. Integumentary system **(5 marks)**
   b. Ophthalmic system **(5 marks)**
   c. Urinary system **(5 marks)**

THE END

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