

**UNIVERSITY OF SWAZILAND  
FACULTY OF HEALTH SCIENCES  
SEMESTER TWO FINAL EXAMINATION PAPER  
MAY 2008**

**COURSE CODE: NUR 431**  
**TITLE OF THE COURSE: ADVANCED MED-SURG NURSING**  
**TIME ALLOCATED: 2 HOURS**  
**MARKS ALLOCATED: 75**

**INSTRUCTIONS**

- 1. ANSWER ALL QUESTIONS**
- 2. EACH QUESTION CONSISTS OF 25 MARKS**
- 3. WRITE CLEARLY**
- 4. ONE MARK FOR A FACT**

**NUR 431      MAIN EXAMINATION**

**Question 1      Multiple Choice**

Select the most appropriate answer for the following questions.

1. In assessing a patient with pneumococcal pneumonia, the nurse recognises that clinical manifestations of this condition include
  - a. fever, chills, and a productive cough with rust-colour sputum
  - b. a non-productive cough and night sweats that are usually self-limiting
  - c. a gradual onset of nasal stuffiness, sore throat, and purulent productive cough
  - d. an abrupt onset of fever, non-productive cough, and formation of lung abscesses
  
2. An appropriate nursing intervention for a patient with pneumonia with the nursing diagnosis of ineffective airway clearance related to thick secretions and fatigue would be to
  - a. perform postural drainage every hour
  - b. provide analgesics as ordered to promote patient comfort
  - c. administer oxygen as prescribed to maintain optimal oxygen levels
  - d. teach the patient how to cough effectively to bring secretions to the mouth
  
3. A patient with TB has a nursing diagnosis of non-compliance. The nurse recognises that the most common etiologic factor for this diagnosis in patients with TB is
  - a. fatigue and lack of energy to manage self-care
  - b. lack of knowledge about how the disease is transmitted
  - c. little or no motivation to adhere to a long-term drug regimen
  - d. feelings of shame and the response to the social stigma associated with TB

4. A patient has been receiving high-dose corticosteroids and broad-spectrum antibiotics for treatment of serious trauma and infection. The nurse plans care for the patient knowing that the patient is most susceptible to
  - a. candidiasis
  - b. aspergillosis
  - c. histoplasmosis
  - d. coccidioigomycosis
  
5. A primary goal for the patient with bronchiectasis is that the patient will
  - a. have no recurrence of disease
  - b. have normal pulmonary function
  - c. maintain removal of bronchial secretions
  - d. avoid environmental agents that precipitate inflammation
  
6. During assessment of a patient with obstructive jaundice the nurse would expect to find
  - a. clay-coloured stools
  - b. dark urine and stools
  - c. pyrexia and severe pruritus
  - d. elevated urinary urobilinogen
  
7. A patient with hepatitis A is in the prodromal (preicteric) phase. The nurse plans the care for the patient base on the knowledge that
  - a. pruritus is a common problem with jaundice in this phase
  - b. the patient is most likely to transmit the disease during this phase
  - c. gastrointestinal symptoms are not severe in hepatitis A as they are in hepatitis B
  - d. extrahepatic manifestations of glomerulonephritis and polyarteritis are common in this phase

8. A patient with hepatitis B is being discharged in 2 days. The nurse includes in the discharge teaching plan instructions to:
- avoid alcohol for 3 weeks
  - use a condom during sexual intercourse
  - have family members get an injection of immunoglobulin
  - follow a low-protein, moderate-carbohydrate, moderate-fat diet
9. The patient with advanced cirrhosis asks the nurse why his abdomen is so swollen. The nurse's response to the patient is based on the knowledge that
- a lack of clotting factors promotes the collection of blood in the abdominal cavity
  - portal hypertension and hypoalbuminemia cause a fluid shift into the peritoneal space
  - decreased peristalsis in the GI tract contributes to gas formation and distention of the bowel
  - bile salts in the blood irritate the peritoneal membranes, causing edema and pocketing of fluid
10. When caring for a patient with hepatic encephalopathy, the nurse may give enemas, provide a low-protein diet, and limit physical activity. These measures are done to
- promote fluid loss
  - decrease portal pressure
  - eliminate potassium ions
  - decrease the production of ammonia

11. The polydipsia and polyuria related to diabetes mellitus and primarily caused by
  - a. the release of ketons from cells during fact metabolism
  - b. fluid shifts resulting from the osmotic effect of hyperglycemia
  - c. damage to the kidneys from exposure to high levels of glucose
  - d. changes in RBCs resulting from attachment of excessive glucose to hemoglobin
  
12. When a patient with type 2 diabetes mellitus is admitted to the hospital with pneumonia, the nurse recognises that the patient
  - a. must receive insulin therapy to prevent the development of ketoacidosis
  - b. has islet cell antibodies that have destroyed the ability of the pancreas to produce insulin
  - c. has minimal or absent endogenous insulin secretion and requires daily insulin injections
  - d. may have sufficient endogenous insulin to prevent ketosis but is at risk for development of hyperosmolar hyperglycaemic nonketotic syndrome
  
13. Effective collaborative management of diabetes includes
  - a. using insulin with all patients to achieve glycemic goals
  - b. relying on the health care provider as the central figure in the program for good control
  - c. relying solely on nutritional therapy as the initial treatment modality for all patients with diabetes
  - d. aiming for a balance of diet, activity, and medications together with appropriate monitoring and patient and family teaching

14. The nurse assists the patient with nutritional therapy of diabetes with the knowledge that a “diabetic diet” is designed
- to be used only for type 1 diabetes
  - for use during periods of high stress
  - to normalize blood glucose by elimination of sugar
  - to help normalize blood glucose through a balanced diet
15. In teaching a newly diagnosed type 1 diabetic “survival skills”, the nurse includes information about
- weight loss measures
  - elimination of sugar from diet
  - need to reduce physical activity
  - self monitoring of blood glucose
16. An appropriate teaching measure for the patient with diabetes mellitus related to care of the feet is to
- use heat to increase blood supply
  - avoid softening lotions and creams
  - inspect all surfaces of the feet daily
  - use iodine to disinfect cuts and abrasions
17. A diabetic patient has a serum glucose level of 824 mg/dl (45.7 mmol/L) and is unresponsive. Following assessment of the patient, the nurse suspects diabetic ketoacidosis rather than hyperosmolar hyperglycaemic nonketotic syndrome based on the finding of
- polyuria
  - severe dehydration
  - rapid, deep respirations
  - decreased serum potassium

18. Which of the following is not an appropriate therapy for patients with diabetes mellitus?
- a. use of diuretics to treat renal problems
  - b. use of ACE inhibitors to treat renal problems
  - c. use of laser photocoagulation to treat retinopathy
  - d. use of regular insulin for a patient with type 2 diabetes during the intraoperative period
19. Of the following patients, the nurse recognizes that the one with the highest risk for a stroke is
- a. an obese 45 year old Native American
  - b. a 35 year old Asian American woman who smokes
  - c. a 32 year old white woman taking oral contraceptives
  - d. a 65 year old African American man with hypertension
20. The factor related to cerebral blood flow that most often determines the extent of cerebral damage from a stroke is the
- a. amount of cardiac output
  - b. oxygen content of the blood
  - c. degree of collateral circulation
  - d. level of carbon dioxide in the blood
21. Information provided by the patient that would help differentiate a hemorrhagic stroke from a thrombotic stroke includes
- a. sensory disturbance
  - b. a history of hypertension
  - c. presence of motor weakness
  - d. sudden onset of severe headache

22. A patient with right-sided hemiplegia and aphasia resulting from a stroke most likely has involvement of the
- brainstem
  - vertebral artery
  - left middle cerebral artery
  - right middle cerebral artery
23. The nurse explains to the patient with a stroke who is scheduled for angiography that this test is used to determine the
- presence of increased ICP
  - site and size of the infarction
  - presence of blood in the cerebrospinal fluid
  - patency of the cerebral blood vessels
24. A patient experiencing TIAs is scheduled for a carotid endarterectomy. The nurse explains that this procedure is done to
- decrease cerebral edema
  - reduce the brain damage that occurs during a stroke in evolution
  - prevent a stroke by removing atherosclerotic plaques blocking cerebral blood flow
  - provide a circulatory bypass around thrombotic plaques obstructing cranial circulation.
25. Nursing management of the patient with hemiplegia during the acute phase of a stroke includes
- restricting active movement
  - positioning each joint higher than the proximal joint
  - performing passive range of motion on all limbs every 4 hours
  - maintaining the patient in a recumbent, side-lying position

TOTAL 25 MARKS



**Question 2**

- a. An unconscious patient is admitted in your unit. How would you differentiate if he is hypoglycaemic or hyperglycaemic? (10)
- b. Manage a patient diagnosed with liver cirrhosis utilizing the following nurses' diagnoses.
- i. Imbalanced nutrition; less than body requirements. (4)
  - ii. Impaired skin integrity. (8)
  - iii. Risk for infection. (3)

TOTAL 25 MARKS

**Question 3**

- a. What areas are assessed when using a Glasgow Coma Scale? (6)
- b. Discuss the nursing interventions and rationale for the following nursing diagnoses for a client with increase intracranial pressure (unconscious).
- i. ineffective airway clearance. (3)
  - ii. ineffective tissue perfusion (cerebral) (6)
  - iii. self-care deficit (total) (5)
  - iv. interrupted family processes (5)

TOTAL 25 MARKS