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NURSING

Solved Question Papers for BSc Nursing

2025–2021

Semester II

As Per Revised INC Syllabus

I Clement

JAYPEE

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NURSING FOUNDATION I AND II

2024

LONG ESSAYS

1. Explain the physiological and behavioral responses to pain. List the factors affecting the pain experience. Distinguish the various pain assessment tools to assess the severity of pain.
2. What is critical thinking? Mention the component of critical thinking and nursing Judgement. Explain the steps of Nursing process. Describe the process of Planning and illustrate with examples.

SHORT ESSAYS

3. Explain nursing care of a client with dyspnea.
4. Explain the first aid measures for clients with shock.
5. Describe the steps in the assessment of thorax.
6. Explain briefly the urinary diversion.
7. Explain the purpose and principles of oral medication.

SHORT ANSWERS

8. Expand "INC" and "TNAI".
9. Enlist any two nursing actions to prevent Nosocomial infection.
10. List any four food items rich in high protein.
11. Mention any four causes of pressure sores.

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LONG ESSAYS

1. Explain the physiological and behavioral responses to pain. List the factors affecting the pain experience. Distinguish the various pain assessment tools to assess the severity of pain.

Ⓐ Pain is a complex phenomenon that involves many of the chemicals found naturally in the spinal cord and brain. All pain signals travel to the brain. The brain sends back signals to protect the body. The brain also makes its own painkillers (endorphins).

Physiological Responses to Pain

The body responds to pain through numerous and interconnected physiological processes via the sympathetic nervous system (SNS), neuro-endocrine system and immune system, but also via emotions **(Table 1)**.

TABLE 1: Effects of acute pain and nursing interventions.

Body system	*Change*	*Nursing intervention*
Cardiovascular	• Increased heart rate and blood pressure • Increased need for oxygen • Water retention, potential fluid overload	• Monitor and interpret vital signs • Administer oxygen as prescribed • Monitor fluid balance
Respiratory	• Increased respiratory rate • Shallow breathing • Increased risk of infection	• Encourage DB&C so lungs fully inflate and secretions are evacuated • Provide pad and/or pillow to support abdominal or thoracic wounds
Immune	• Increased susceptibility to infection • Increased or decreased sensitivity to pain • Activation of HPA axis	• Monitor temperature • Use infection prevention and control measures
Endocrine	• Increased blood glucose • Increased cortisol production	• Monitor blood glucose in patients with diabetes
Gastrointestinal	• Reduced gastric emptying and intestinal motility • Nausea and vomiting • Constipation	• Use anti-emetic medication as prescribed • Use laxatives as prescribed • Ensure adequate hydration
Urinary	• Urge to urinate/incontinence	• Monitor urine output and color
Musculoskeletal	• Tense muscles local to injury • Shaking or shivering • Pilo-erection (goose bumps)	• Encourage relaxation • Provide more comfortable bedding • Support movement using analgesia, splinting and/or weight reduction strategies
Nervous	• Changes in pain processing • Risk of pain becoming chronic	• Provide effective analgesia, closely monitor response and side-effects • Raise concerns if pain not well managed
Brain	• Anxiety/fear • Depression • Poor concentration • Inhibition or promotion of pain	• Communicate and inform effectively • Assess anxiety, depression and catastrophization • Teach effective coping strategies • Provide reassurance • Be visible and responsive to patient's needs

Behavior Response to Pain

Pain behaviors can be adaptive or pathogenic, as when the pain behavior is excessive in comparison to the objective pathology. It has been found that when pain behavior exists in pain patients, a psychiatric disease may aggravate pain. Chronic pain behavior seems to be composed of at least 9 components: anxiety, attention seeking, verbal pain complaints, medication use, general verbal complaints, distorted posture and mobility, fatigue, insomnia, and depressive mood **(Table 2)**.

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TABLE 2: Pain behavior.

Physiological	*Facial*	*Verbal*	*Body movement*
• Increased blood pressure • Increased heart rate • Increased respiratory rate • Dilated pupils • Perspiration • Flushing/pallor	• Grimace • Frowning • Wincing • Teeth clenching	• Moaning • Screaming • Whimpering • Crying	• Rigidity, splinting, tension • Slow, cautious movement • Arching • Clenched fists • Restlessness • Repetitive movements • Guarding

- There are different types of behaviors that can be exhibited with the feeling of pain. These can include phantom limb pain or pain catastrophizing.
- Pain behaviors can be verbal (e.g., verbal descriptions of the intensity, location, and quality of pain; vocalizations of distress; moaning, or complaining) or nonverbal (e.g., withdrawing from activities, taking pain medication, or pain related body postures or facial expressions).
- Pain behaviors can be adaptive or pathogenic, as when the pain behavior is excessive in comparison to the objective pathology. It has been found that when pain behavior exists in pain patients, a psychiatric disease may aggravate pain. Pain types differ.

Factors Affecting the Pain Experience

Pain is a multifaceted sensory and emotional experience that can vary greatly from person to person. While pain is often associated with physical injury or illness, it is influenced by a multitude of factors that extend beyond the mere presence of tissue damage **(Fig. 1)**.

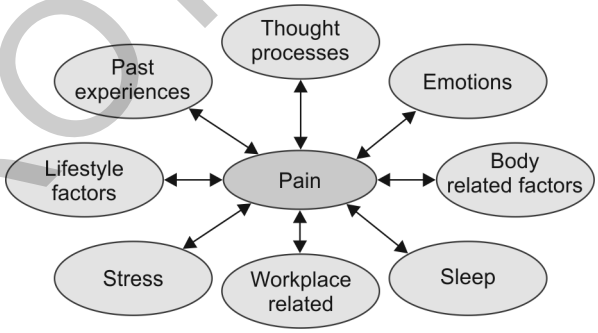

Fig. 1: Factors influencing pain.

Biological Factors

- **Genetics:** Genetic variations can influence an individual's pain sensitivity and response.
- **Age and gender:** Age-related changes in the nervous system can impact pain perception, with older adults often experiencing altered pain thresholds.
- **Health conditions:** Underlying health conditions, such as inflammation, nerve damage, or chronic diseases, can heighten pain sensitivity.

Psychological Factors

- **Attention and expectations:** The focus of attention on pain can influence its intensity and perception.
- **Emotional state:** Emotional factors, such as anxiety, depression, and stress, can influence pain perception.
- **Cognitive factors:** An individual's beliefs, thoughts, and cognitive appraisals about pain can shape their pain experience.

Social and Cultural Factors

- **Social support:** The presence of supportive relationships and social interactions can have a significant impact on pain perception.
- **Cultural beliefs and expectations:** Cultural factors shape the understanding and expression of pain. Cultural norms, beliefs, and attitudes towards pain can influence pain perception, pain expression, and help-seeking behaviors.

Environmental and Contextual Factors

- **Context of pain:** The circumstances surrounding pain, such as the setting, familiarity, and perceived threat, can influence pain perception.

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- **Learning and conditioning:** Previous experiences with pain can influence subsequent pain perception. Learned associations between certain cues or activities and pain can elicit anticipatory responses, altering the experience of pain.

Pain assessment Tools to Assess the Severity of Pain

The three most commonly utilized tools to quantify pain intensity include verbal rating scales, numeric rating scales, and visual analogue scales **(Fig. 2)**.

Verbal rating scales (verbal descriptor scales) utilize common words (eg, mild, severe) to grade pain intensity

Numeric Pain Rating Scale

- The patient is asked to make three pain ratings, corresponding to current, best and worst pain experienced over the past 24 hours.
- The average of the 3 ratings was used to represent the patient's level of pain over the previous 24 hours.

Visual Analogue Scale (VAS)

A visual analogue scale (VAS) is a measurement instrument that tries to measure a characteristic or attitude that is believed to range across a continuum of values and cannot easily be directly measured. For example, the amount of pain that a patient feels ranges across a continuum from none to an extreme amount of pain.

Categorical Scales

These pain scales give people a simple way to rate their pain intensity using a verbal or visual descriptor of their pain. Some examples would be the words "mild," "discomforting," "distressing," "horrible," and "excruciating."

FLACC Pain Scale

The FLACC Pain Scale is based on observations made by a healthcare provider. Originally created to evaluate young children, it can be used for anyone who cannot communicate.

FLACC stands for:

- Facial expression
- Leg tension or relaxation

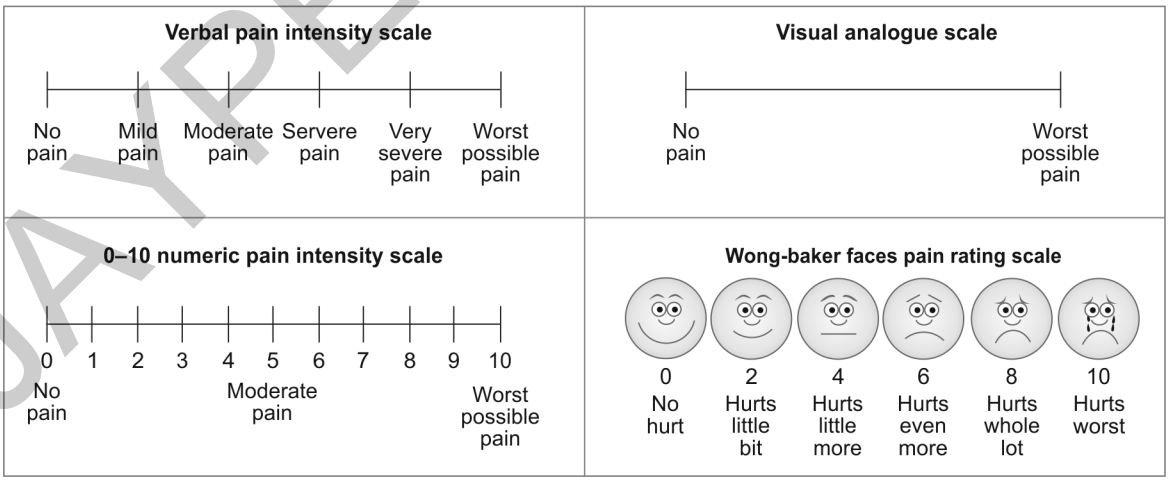

Fig. 2: Pain assessment scale.

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- Activity (still or squirming with pain)
- Crying
- Consolability (whether you can be comforted)

Zero to two points are assigned for each of the five categories. Then the overall score is tallied. Scores are interpreted as follows:

- **0:** Relaxed and comfortable
- **1–3:** Mild discomfort
- **4–6:** Moderate pain
- **7–10:** Severe discomfort/pain

2. What is critical thinking? Mention the component of critical thinking and nursing Judgement. Explain the steps of nursing process. Describe the process of planning and illustrate with examples.

A Critical thinking is the intellectually disciplined process of actively and skillfully conceptualizing, applying, analyzing, synthesizing, and/or evaluating information gathered from, or generated by, observation, experience, reflection, reasoning, or communication, as a guide to belief and action **(Fig. 3)**.

Critical thinking in nursing involves identifying a problem, determining the best solution, and implementing an effective method to resolve the issue using clinical decision-making skills.

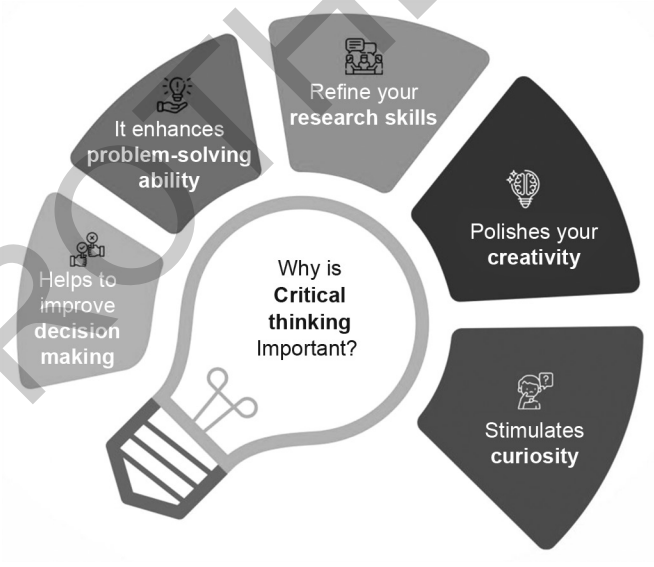

Fig. 3: Critical thinking.

Component of Critical Thinking

The major component in critical thinking includes: perception, assumptions, emotion, language, argument, fallacy, logic, and problem solving.

- **Perception:** Perception is considered to be the manner in which individuals receive, interpret and translate experiences.
- **Assumptions:** Assumptions are central to critical thinking. They tend to be implied, where individuals are not always conscious of them.
- **Emotion:** Trying to leave emotion out of almost anything is impossible as it is part of everything people do and think.
- **Language:** Thinking can't be separated from language since both tend to have three primary purposes: to inform, persuade and explain.
- **Argument:** An argument is a claim, which is used to persuade that something is (or is not) true, or should (or should not) be done. The goal of critical thinking is to implement a sound argument, which has both a valid or proper structure and contains true premises. This is where using logic makes all the difference.
- **Fallacy:** Reasoning that doesn't meet the criteria for being a sound argument is considered erroneous, or fallacious. A fallacy comes from incorrect patterns of reasoning.
- **Logic:** Logic incorporates two methods or types of reasoning: deductive and inductive. Deductive reasoning relies on facts, certainty, syllogisms, validity, truth of premises sound arguments and supported conclusions. Inductive reasoning relies on diverse facts, probability, generalizations, hypotheses, analogies and inductive strength.

Nursing Judgment

Nursing judgment is the culmination of education, experience, and insight that allows nurses to execute the best action possible on behalf of patients. Judgment skills are the abilities and mental tools that enable you to make effective decisions in critical situations or dilemmas. Use of these skills can include evaluation and prioritization of factors, making a weighed decision, arriving at a conclusion and forming subjective opinions.

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Steps of Nursing Process

The nursing process is a systematic method we use to provide individualized care to patients. It involves a series of steps designed to assess, diagnose, plan, implement, and evaluate patient care **(Figs. 4 and 5)**. The five steps of the nursing process are:

Step 1: Assessment: This step involves gathering information about the patient's health status, including physical, emotional, social, and environmental factors.

Step 2: Diagnosis: Based on the assessment data in step number one, you'll identify the patient's health problems and formulate nursing diagnoses. Nursing diagnoses are clinical judgments about the patient's response to actual or potential health problems. These diagnoses guide the development of the patient's care plan.

Step 3: Planning: In this step, you develop a plan of care that addresses the patient's identified health problems and goals. The plan includes interventions aimed at promoting the patient's health, preventing complications, and achieving optimal outcomes. Nurses collaborate with patients, their families, and other healthcare professionals to develop a comprehensive care plan.

Step 4: Implementation: Now for the action! You put the plan into motion, bring brilliant ideas to life, and carry out interventions outlined in the care plan. These interventions may include administering medications, providing treatments, teaching the patient and their family about self-care techniques, and advocating for the patient's needs. Nurses must also regularly reassess the patient's condition and adjust the care plan as needed.

Step 5: Evaluation: In the final step of the nursing process, you evaluate the effectiveness of the care plan in achieving the desired outcomes. You'll compare the patient's actual responses to the expected outcomes and determine whether the interventions were successful.

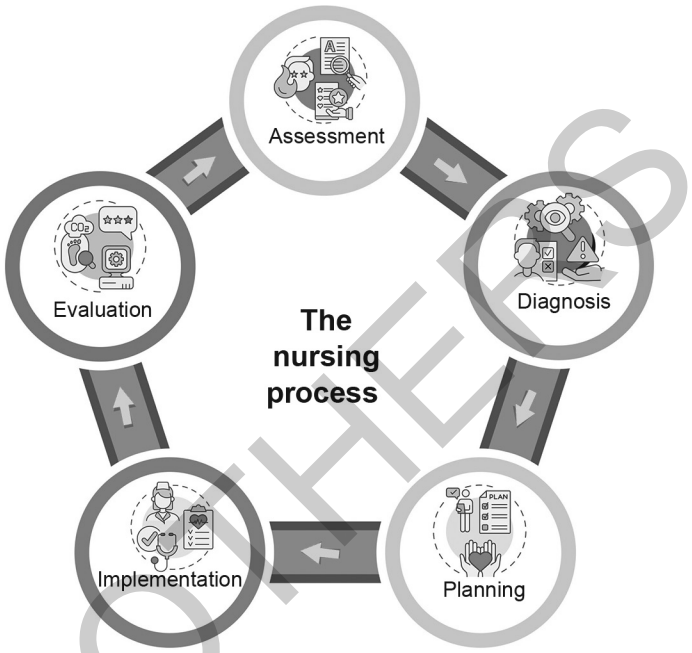

Fig. 4: Nursing process.

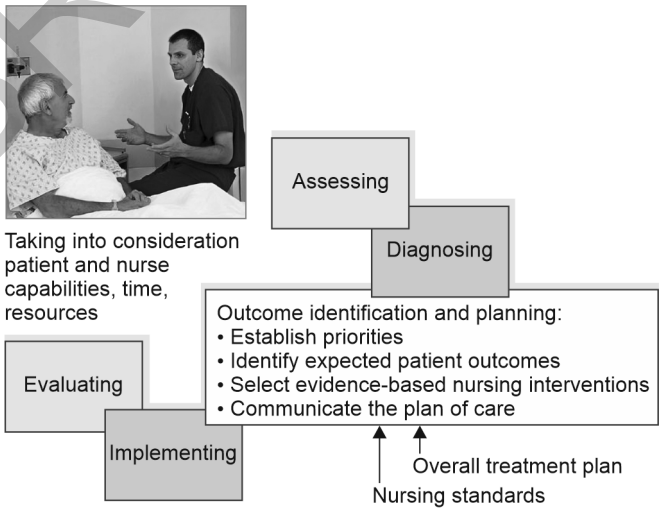

Fig. 5: Steps of nursing process.

Describe the Process of Planning and Illustrate with Examples

The planning stage is where goals and outcomes are formulated that directly impact patient care based on EDP guidelines. These patient-specific goals and the attainment of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting.

Goals should be

- Specific
- Measurable or meaningful
- Attainable or action-oriented
- Realistic or results-oriented
- Timely or time-oriented

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Types of Planning

Planning starts with the first client contact and resumes until the nurse-client relationship ends, preferably when the client is discharged from the health care facility.

- **Initial planning:** Initial planning is done by the nurse who conducts the admission assessment. Usually, the same nurse would be the one to create the initial comprehensive plan of care.
- **Ongoing planning:** Ongoing planning is done by all the nurses who work with the client. As a nurse obtains new information and evaluate the client's responses to care, they can individualize the initial care plan further.
- **Discharge Planning:** Discharge planning is the process of anticipating and planning for needs after discharge.

SHORT ESSAYS

3. Explain nursing care of a client with dyspnea.

A Dyspnea is a subjective experience. Treat the patient based on complaints or appearance, rather than relying on numerical values. Similar signs and symptoms across conditions make diagnosis difficult. The most common causes originate from the heart or lungs; although neuromuscular or psychologic origins should be considered **(Fig. 6)**.

Provide Respiratory Support

- Assess and monitor airway, breathing and circulation; maintain close surveillance for deterioration.
- Maintain open and patent airway with use of positioning, airway adjuncts and secretion clearance.
- Position to minimize the risk of aspiration, ventilation-perfusion mismatch and breathlessness.
- Minimize oxygen consumption and demand; limit activity, reduce fever and utilize breathing techniques.
- Provide oxygen therapy judiciously; titrate to prevent hyperoxemia.
- Consider inhaled beta-1 or beta-2 agonist, such as racemic epinephrine or albuterol, especially in the presence of stridor or wheezing.
- Implement noninvasive or invasive positive pressure ventilation to support oxygenation and ventilation, as well as relieve respiratory distress.

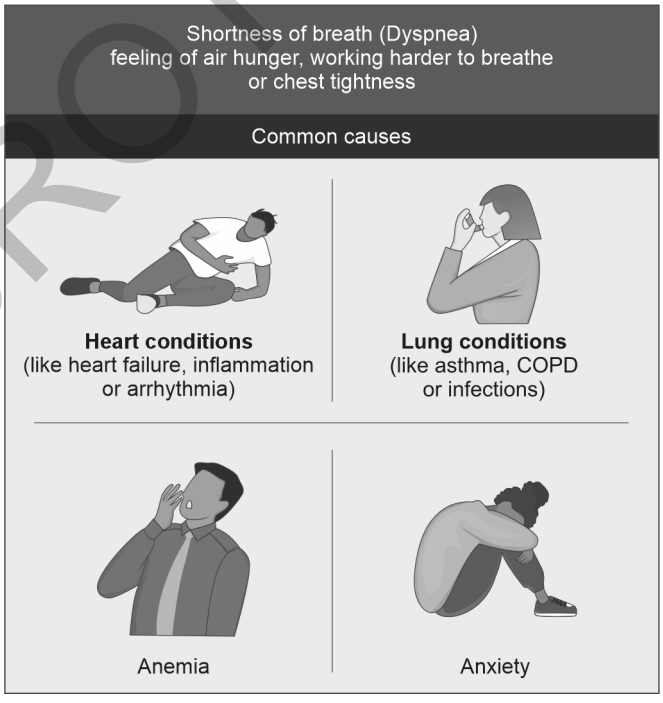

Fig. 6: Causes of dyspnea.

Provide Hemodynamic Support

- Monitor cardiovascular status.
- Observe for, and address, cardiac dysrhythmia.
- Position to support perfusion.
- Evaluate fluid status; provide fluid therapy to improve blood flow, perfusion and tissue oxygenation.
- Monitor and manage electrolyte levels; anticipate the need to correct imbalance; evaluate patient response.
- If cardiac origin identified, consider the need for pharmacologic measures, such as a diuretic or vasoactive agent.
- Anticipate urgent intervention in the presence of hemodynamic instability.

Promote Comfort and Manage Pain

- Use a consistent pain assessment tool; evaluate pain and treatment response at regular intervals.
- Involve patient and family in the management plan.
- Provide nonpharmacologic strategies, such as breathing techniques, positioning, distraction and diversion.

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- Consider pharmacologic measures, such as an opioid or benzodiazepine agent, especially for palliation or breathlessness associated with anxiety or panic attack.
- Evaluate risk for opioid use and dependence.

Minimize and Manage Infection

- Assess for presence of infection and signs of early sepsis.
- Initiate precautions to prevent the spread of infection.
- Obtain cultures prior to initiation of antimicrobial therapy, when possible.
- Anticipate antimicrobial therapy administration; do not delay in the presence of high suspicion or clinical indicators.

Provide Psychosocial Support

- Proactively provide information; encourage questions and address concerns.
- Provide a calm, reassuring presence.
- Recognize, identify and allow expression of emotions.
- Promote family/caregiver presence at bedside.
- Offer choices to enhance a sense of control.
- Honor spiritual and cultural preferences.
- Recognize and utilize personal coping strategies.

4. Explain the first aid measures for client with shock.

Ⓐ Shock is a critical condition brought on by the sudden drop in blood flow through the body. Shock may result from trauma, heatstroke, blood loss or an allergic reaction. It also may result from severe infection, poisoning, severe burns or other causes. Different types of shock is given in **Fig. 7**.

Shock keeps organs from getting enough blood or oxygen. If shock is not treated, it can lead to permanent organ damage or even death.

Signs and Symptoms of Shock

Signs of shock can include:

- Weak, rapid pulse
- Cold, clammy skin
- Faintness/dizziness
- Nausea.

Immediately after an injury, people may show little evidence of experiencing shock. Signs and symptoms may gradually develop depending on:

- Severity of the injury
- Continuation of fluid loss
- Effectiveness of management.

Warning

- Shock can be life-threatening.
- Try not to leave a patient suffering from shock alone.

Managing Shock

Follow DRSABCD and manage injuries such as severe bleeding.

- Reassure the patient.
- Raise the patient's legs (unless they have fractures or a snake bite) above the level of the heart, with head flat on the floor.
- Treat any wound or burn and immobilize fractures.

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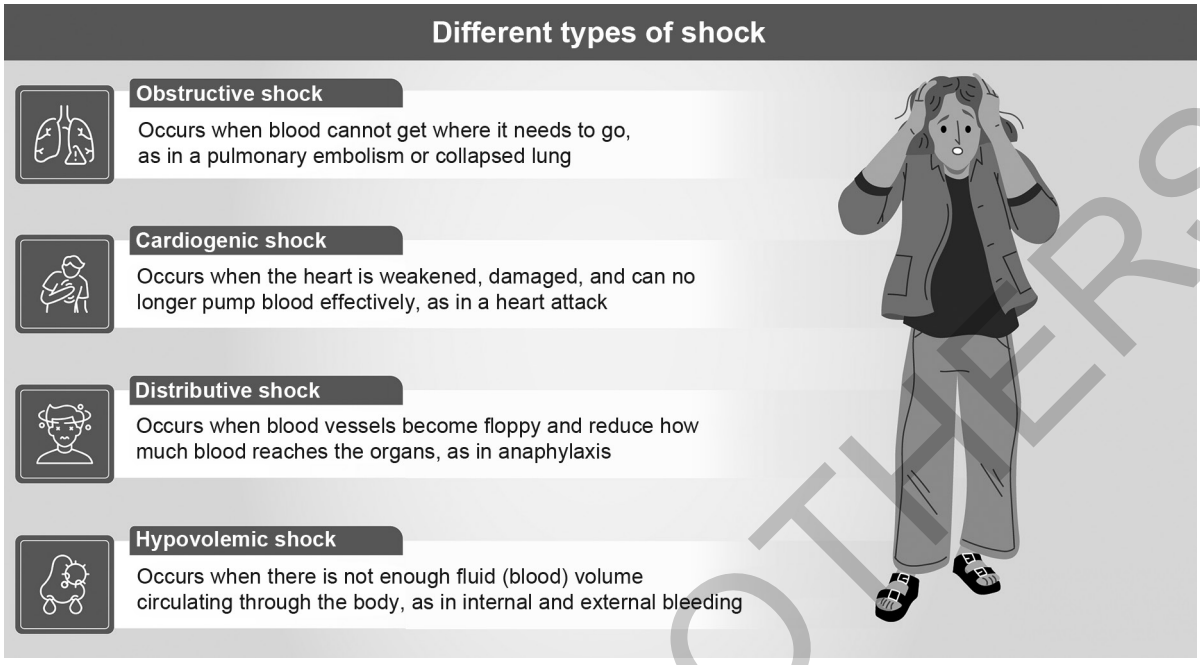

Fig. 7: Types of shock.

- Loosen tight clothing around neck, chest and waist.
- Maintain the patient's body warmth with a blanket or similar. Do not use any source of direct heat.
- Give small, frequent amounts of water to the conscious patient who does not have abdominal trauma and who is unlikely to require an operation in the immediate future.
- Monitor and record breathing, pulse and skin color at regular intervals.
- Place the patient in the recovery position if the person:
  - Has difficulty breathing.
  - Becomes unconscious.
  - Is likely to vomit.

5. Describe the steps in the assessment of thorax.

A Identifying thoracic landmarks is essential to the systematic examination of the respiratory system.

Equipment Needed

- Stethoscope with bell (for low pitched sounds) and diaphragm, (for high pitched sounds), with approximately 12-inch-long tubing.
- Pen and tape measure.

Safety Considerations

- Perform hand hygiene.
- Check room for contact precautions.
- Introduce yourself to patient.
- Confirm patient ID using two patient identifiers (e.g., name and date of birth).
- Explain process to patient.
- Be organized and systematic in your assessment.
- Use appropriate listening and questioning skills.

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- Listen and attend to patient cues.
- Ensure patient's privacy and dignity.
- Apply principles of asepsis and safety.
- Check vital signs.

Chest

- **Inspect:**
  - Expansion/retraction of chest wall/work of breathing and/or accessory muscle use.
  - Jugular distension
- **Auscultate (Fig. 8):**
  - For breath sounds anteriorly and posteriorly
  - Apices and bases for any adventitious sounds
  - Apical heart rate
- **Palpate:** For symmetrical lung expansion



Fig. 8: Auscultation of chest using stethoscope.

General Approach to the Thoracic Examination

- Thorough evaluation of the thorax and lungs is an essential component of a complete physical examination.
- The traditional systematic approach involves inspection, followed by palpation, percussion and then auscultation of both the anterior, lateral, and posterior thorax.
- The experienced clinician may vary the order or use advanced techniques to further characterize abnormal findings.
- The posterior thorax is best examined with the patient sitting upright, arms folded across the chest, and hands placed on opposite shoulders. This displaces the scapulae laterally and exposes more pulmonary parenchyma to the examiner's hands and ears.
- Patients unable to sit upright should be assisted to do so; alternatively, the examination may be conducted while the patient is lying on his side. The anterior thorax may be examined while the patient is either upright or supine.
- Always compare one side to the other (thus having the patient serve as his or her own control), and apices to bases. No portion of the exam should be conducted through clothing.

6. Explain briefly the urinary diversion.

A. A urinary diversion is a surgical procedure to reconstruct or re-route the urinary tract to allow urine to exit the body in a safe manner **(Fig. 9)**. The urinary tract consists of kidneys which filter blood and produce urine. This allows extra fluid and waste products to leave the body.

Indications

Indications someone needs a urostomy could include bladder cancer, radiation to the prostate or bladder, nerve damage to the bladder, neurologic disorders (such as multiple sclerosis, stroke or cerebral palsy), spinal cord injuries, pelvic trauma, urinary fistula (abnormal communication with the urinary tract), pelvic cancers, chronic infection or inflammation of the bladder, or severe urinary incontinence.

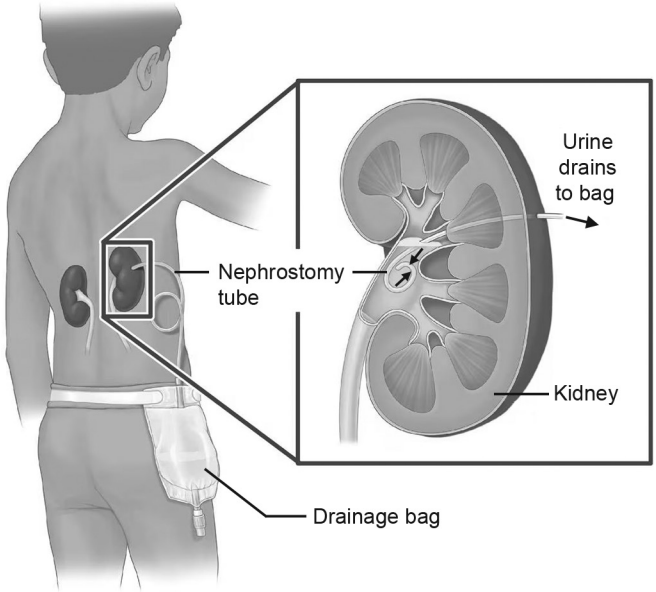

Fig. 9: Nephrostomy.

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Procedure

- A urostomy is the creation of a new passage route for urine to exit the body.
- A short section of small bowel, generally 12–14 centimeters, is used to form the conduit.
- The remaining bowel is reconnected to allow for normal bowel function after surgery.
- The ureters are disconnected from the bladder and sewn into one end of the conduit. The bladder may then be removed.
- The opposite end of the conduit is brought to the surface of the abdominal wall.
- The site is usually in the lower right side of the belly. The stoma or opening of the conduit is then created at the skin as is generally the size of a quarter once healed.
- This surgery is permanent and patients in the future will need to wear a collection pouch/ostomy appliance over the stoma to control the urine.
- The short section of the conduit made out of bowel will continue to produce mucus naturally.
- Individuals with a urostomy will notice mucus collecting in their pouch/appliance at times. This is normal and expected.

Complications

Potential complications of this surgery include urinary tract blockage or obstruction, bleeding, infections, stoma-related problems, kidney stones, bowel leak or obstruction, kidney deterioration or blood clots.

Urostomy Care

- After the diversion surgery, wound-ostomy nurses meet with patients in the hospital to help orient and familiarize the patient with the care of urinary diversion.
- Most pouch systems consist of two pieces: a wax wafer which sticks to the skin and provides a water-tight seal to prevent leakage and accidents and a pouch which attaches to the barrier.

7. Explain the purpose and principles of oral medication.

Ⓐ Oral administration of medication is a convenient, cost-effective, and most commonly used medication administration route **(Fig. 10)**. The primary site of drug absorption is usually the small intestine, and the bioavailability of the medication is influenced by the amount of drug absorbed across the intestinal epithelium.

Purpose

- Oral administration of medication is a convenient, cost-effective, and most commonly used medication administration route.
- The primary site of drug absorption is usually the small intestine, and the bioavailability of the medication is influenced by the amount of drug absorbed across the intestinal epithelium.

Principles

Most health care professionals, especially nurses, know the "five rights" of medication use: the right patient, the right drug, the right time, the right dose, and the right route—all of which are generally regarded as a standard for safe medication practices.



Fig. 10: Oral administration of medication.

General Preparation Steps

These are the basic preparatory procedures for administering oral medications:

- Wash hands thoroughly before handling medication. Prevents the spread of infections and contamination of medication.
- Verify medication order. Check the patient's medication administration record (MAR) for the correct medication, dose, and time.
- Confirm the patient's identity using at least two identifiers (e.g., name and date of birth). Ensures the correct patient receives the medication.

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- Explain the purpose of the medication and any potential side effects. Increases patient understanding and compliance.
- Check for any contraindications or allergies and assess the patient's ability to swallow. Ensures safe administration and prevents adverse reaction.

Advantages

- Ease of administration
- Widespread acceptance by the patients.

Disadvantages

- Slow onset of action
- Gastric irritation and stability
- Interaction with food and enzymes

SHORT ANSWERS

8. Expand "INC" and "TNAI".

A 1. **INC:** The Indian Nursing Council (INC) is constituted under the Indian Nursing Council Act 1947. INC is a statutory Autonomous body under Union Ministry of Health and Family Welfare.
2. **TNAI:** The Trained Nurses' Association of India (TNAI) is a national organization of nurse professionals at different levels. It was established in 1908 and was initially known as Association of Nursing Superintendents. The Government of India has recognized TNAI as a service organization in 1950.

9. Enlist any two nursing actions to prevent nosocomial infection.

A **PPE:** Proper use of personal protective equipment (e.g., gloves, masks, gowns), aseptic technique, hand hygiene, and environmental infection control measures are primary methods to protect the patient from transmission of microorganisms from another patient and from the health care worker.

Hand hygiene: Proper hand hygiene is the most important, simplest, and least expensive means of reducing the prevalence of HAIs and the spread of antimicrobial resistance (AMR). Cleaning hands healthcare workers can prevent the spread of microorganisms, including those that are resistant to antibiotics and are becoming difficult, if not impossible, to treat.

10. List any four food items rich in high protein.

A Food items rich in high protein includes:

- Meat and fish
- Eggs
- Dairy products
- Seeds and nuts
- Legumes like beans and lentils

11. Mention any four causes of pressure sores.

A **Causes of pressure sores are:**

- **Pressure:** Constant pressure on any part of the body can lessen the blood flow to tissues. Blood flow is essential to deliver oxygen and other nutrients to tissues. Without these key nutrients, skin and nearby tissues are damaged and might die over time.
- **Friction:** Friction occurs when the skin rubs against clothing or bedding. It can make fragile skin more vulnerable to injury, especially if the skin also is moist.
- **Shear:** Shear occurs when two surfaces move in the opposite direction. For example, when a bed is raised at the head, a person can slide down in bed. As the tailbone moves down, the skin over the bone might stay in place, pulling in the opposite direction.
- **Incontinence:** Skin becomes more vulnerable with extended exposure to urine and stool.

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- **Lack of sensory perception:** Spinal cord injuries, neurological disorders and other conditions can make you lose sensation.
- **Poor nutrition and hydration:** People need enough fluids, calories, protein, vitamins and minerals every day to maintain healthy skin and stop the breakdown of tissues.

MULTIPLE CHOICE QUESTIONS

1. A disease that has an unknown cause or source is called:
a. Iatrogenic disease
b. Idiopathic disease
c. Genetic disease
d. Terminal disease

2. Clove hitch restraint is used to immobilize:
a. Abdomen
b. Hands
c. Head
d. Neck

3. Channels of communication are all, *except*:
a. Email
b. Mind
c. Mobile
d. Television

4. A report that maintains the daily count of the number of patients admitted in the hospital is called:
a. Accidental report
b. Census report
c. Incident report
d. Transfer report

5. Example of coordination tests in the lower limb is all, *except*:
a. Foot close to foot test
b. Food tapping test
c. Romberg's test
d. Weber's test

6. The presence of bile pigments in the urine results in color change to:
a. Bright red
b. Greenish yellow
c. Milky white
d. Smoky brown

7. Fluid overload is otherwise called:
a. Dehydration
b. Fluid deficit
c. Hypervolemia
d. Hypovolemia

8. Tactioception refers to:
a. The sense of hearing
b. The sense of vision
c. The sense of smell
d. The sense of touch

9. Discoloration of the body after death is called:
a. Algor mortis
b. Decomposition
c. Livor mortis
d. Rigor mortis

10. The idea one has of one's abilities, appearance, and personality is known as:
a. Self-image
b. Self-distrust
c. Self-centered
d. Self-doubt

11. The condition of experiencing recurring and intense sexual arousal in response to enduring moderate or extreme pain, suffering, or humiliation is known as:
a. Pedophilia
b. Sexual masochism
c. Sexual sadism
d. Voyeurism

12. A stage in a person's life where adjustment and adaptation to new responsibilities and life patterns are necessary is called:
a. Dispositional crisis
b. Maturational crisis
c. Social crisis
d. Situational crisis

ANSWERS

1. b	**2. b**	**3. b**	**4. b**
5. d	**6. b**	**7. c**	**8. d**
9. c	**10. a**	**11. b**	**12. b**

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