Question 3. (a) To allow re-expansion of the lung and drainage of blood/ooze from the pleural cavity without air and infection entering the chest. -(2 marks)

(b) Upright position. -(1 mark)

VICTORIAN NURSING COUNCIL

Nurses Act 1958

NURSES' FINAL EXAMINATION - GENERAL NURSE TRAINING

31ST MAY, 1978

EXAMINERS' GUIDE TO SURGICAL NURSING PAPER

The following is forwarded as a general indication to examiners of the essential information expected in answers to the various questions. The suggestions are not intended to be either complete or inflexible, but it is hoped they may be of some guidance to examiners and to that extent lead to uniformity of marking.

Question 1. (a) Abdominal wound:- Observe dressing - reinforce if necessary. Adequately covered. Avoid contamination from colostomy. When dressing changed - aseptic technique.
Sutures out.
If tissue drain - mention care.
Perineal wound:- If drain tube - suitable explanation explanation re care. See that not kinked.
Patient in position of comfort. ?Use of suction - care of this if so. Gentle technique when dressing - prevent tension. Sutures - 10-12 days. Or other appropriate care, e.g., lifting.
Colostomy:- Explanation of any acceptable technique using either "long bags" or other colostomy equipment, for covering colostomy.
Explanation re irrigation, or changing bag when colostomy opens. Observation of surrounding skin and appropriate treatment if necessary. Observation of stoma, discharge. -(10 marks)

(b) Answer should include:- Education of patient re appliance; how to deal with problems such as soiling, odour, skin care, diet; how to deal with complications as they arise, e.g., constipation, diarrhoea etc. Adequate emotional support. Help to adjust to situation. Follow up care. Colostomy Association re purchasing equipment etc.
Nurse's own attitude. Family involvement.
Ref. to employment. -(10 marks)

-(20 marks)

Question 2. Observations:
Conscious state - responding to painful/verbal stimuli; deterioration in conscious state. Colour/state of skin - peripheral cyanosis. Blood pressure - increases if compression. Pulse - rate; volume - gradually slows. Respirations - rate - depth - become slow - stertorous; rhythm. Ear discharge - amount, type of ooze. Pupils - size, equality - unequal pupil - affected side; reaction - later dilated and fixed. Muscle tone - any paralysis, weakness - assess by hand grip. As pressure rises - increase in muscle tone, exaggerated movements - later reflexes disappear to paralysis.

Other signs

Headache - may be severe. Vomiting. Restlessness - cerebral irritation. Retention of urine. Temperature - sudden rise.

-(10 marks)

Question 6.(Contd.)

(b) Decreased drainage - cessation.
Increased blood/small clots.
Restlessness increasing. General signs.
Abdominal pain and distension.
General signs for internal bleeding. -(3 marks)

(c) Gentle irrigation/repeat p.r.n. until flow established.
Report if not successful - patient treated for shock.
Re-catheterisation

Question 3. (a) To allow re-expansion of the lung and drainage of blood/ooze from the pleural cavity without air and infection entering the chest. -(2 marks)

(b) Upright position. -(1 mark)

(c) Self-explanatory. -(2 marks)

(d) Keep tubes patent and prevent tension on them.
Milking. Regime for changing bottles.
Aseptic technique.
Keep below chest level.
Secure connections - airtight system.
Enough tube to move but no dependant loops - respiratory distress.
Observations - drainage - fluid swing etc.
Acceptable emergency routine if disconnected for whatever reason. -(6 marks)

(e) Support the patient and wound while coughing.
Instruct patient to breathe deeply and then cough, 2 hourly. Abdominal breathing exercises.
Analgesic prior as indicated. Physiotherapist. -(4 marks)
-(15 marks)

Question 4. (a) Restlessness. ?Pyrexia. Tachycardia. Fall in blood pressure. Headache. Sub-sternal pain.
Loin pain. Haemoglobinuria. -(4 marks)

(b) Slow drip right down. Ring doctor. If severe reaction, stop drip.
Observe patient. Give emotional support.
Save the blood bag. -(2 marks)

(c) Adequate explanation of checking:-
re order; blood; patient.
By one trained nurse at least, + one other person.-(4 marks)
-(10 marks)

Question 5. (a) (i) To replace and maintain normal blood volume, and to treat and prevent oligaemic shock.
Answer should include reason for these particular infusion products. -(2 marks)

(ii) For accurate measurement urinary output as a guide to fluid replacement and kidney function. -(1 mark)

(iii) Haematocrit to determine ratio plasma cells for possible cell concentration. -(1 mark)

(iv) Electrolytes to correct balance. -(1 mark)

(v) To assist healing - tissue repair.
Prevent infection by increasing body resistance. Replace loss. -(1 mark)

(b) Infection - Aseptic technique. Reverse barrier nursing. Filtered air. Sterile equipment.
Restrict visitors. -(4 marks)
-(10 marks)

Question 6. (a) Irrigation. Milking tubing.
Free drainage - uniform connections; - no kinks.
Encourage movement of patient. Sterile tubes/bag - change daily; - penile dressing q.q.h.
Copious fluids - ensure I.V. correct rate initially; oral route as soon as possible.
Care with bladder washouts - maintain asepsis. -(5 marks)

Question 6.(Contd.)

(b) Decreased drainage - cessation.
Increased blood/small clots.
Restlessness increasing. General signs.
Abdominal pain and distension.
General signs for internal bleeding. -(3 marks)

(c) Gentle irrigation/repeat p.r.n. until flow established.
Report if not successful - patient treated for shock.
Re-catheterization. - prepared for return to theatre. -(2 marks)

-(10 marks)

Question 7. (a) Temperature. Pulse. Colour. Respirations.
Excess swallowing. Child's attitude.
Vomiting. Obvious bleeding. Restlessness.
Recognition of onset of complications. -(5 marks)

(b) Keep fairly quiet, not to get dressed for a couple of days. Give plenty of fluids. Diet as desired. Avoid coughing or forceful blowing of the nose.
Watch for any signs of bleeding/infection.
Give ordered analgesia before meals. Appointment with Doctor or at Outpatients' Department about 10 days. Not to go to school until seen by Doctor. To include reasons. -(5 marks)

-(10 marks)

Question 8. (a) Investigations - chest X-ray; full blood examination; biopsy; mammography. -(2 marks)

(b) Minimum area - shoulder - pubis;
- axilla;
- bedline - opposite nipple line. -(2 marks)

(c) (i) Promotion of drainage.
Limit movement.
Observations.
Diet.
No tension on suture line.
Asepsis.

(ii) Position.
Exercises & movement.
Analgesia.

(iii) Initially movement of wrist and fingers.
Later gradual shoulder movement and increase range.
Encouragement.
Position arm to help reduce oedema. -(6 marks)

-(10 marks)

Question 9. Self-explanatory.

-(6 marks)
