ROYAL CIVIL SERVICE COMMISSION
BHUTAN CIVIL SERVICE EXAMINATION (BCSE) 2020
EXAMINATION CATEGORY: TECHNICAL

PAPER III: SUBJECT SPECIALISATION PAPER FOR NURSING

Date	: February 27, 2021
Total Marks	: 100
Writing Time	: 150 minutes (2.5 hours)
Reading Time	: 15 Minutes (prior to writing time)

GENERAL INSTRUCTIONS:

1. Write your Registration Number clearly and correctly on the Answer Booklet.
2. The first 15 minutes is being provided to check the number of pages of the Question Paper, printing errors, clarify doubts and to read the instructions. You are NOT permitted to write during this time.
3. This paper consists of **TWO SECTIONS**, namely SECTION A & SECTION B:
   - **SECTION A** has two parts: Part I - 30 Multiple Choice Questions
     Part II - 4 Short Answer Questions

     All questions under SECTION A are COMPULSORY.
   - **SECTION B** consists of two Case Studies. Choose only **ONE** case study and answer the questions of your choice.
4. All answers should be written on the Answer Booklet provided to you. Candidates are not allowed to write anything on the question paper. If required, ask for additional Answer Booklet.
5. All answers should be written with correct numbering of Section, Part and Question Number in the Answer Booklet provided to you. Note that any answer written without indicating the Section, Part and Question Number will NOT be evaluated and no marks will be awarded.
6. Begin each Section and Part on a fresh page of the Answer Booklet.
7. You are not permitted to tear off any sheet(s) of the Answer Booklet as well as the Question Paper.
8. Use of any other paper including paper for rough work is not permitted.
9. **You must hand over the Answer Booklet to the Invigilator before leaving the examination hall.**
10. This paper has **9 printed pages**, including this instruction page.

GOOD LUCK!

SECTION A

PART I: Multiple Choice Questions [30 marks]

Choose the correct answer and write down the letter of your chosen answer in the Answer Booklet against the question number e.g. 31 (d). Each question carries ONE mark. Any double writing, smudgy answers or writing more than one choice shall not be evaluated.

1. The primary treatment for Type I diabetes is
   a) Dietary modification
   b) Exercise and active life style
   c) Oral Diabetes Medication therapy
   d) Insulin replacement therapy

2. In hypothyroidism, there is a decrease in Parathyroid hormone (PTH) and this leads to
   a) Hypocalcemia
   b) Hyponatremia
   c) Hypercalcemia
   d) Hypernatremia

3. All are examples of primary prevention of diseases EXCEPT
   a) Nutritional counselling
   b) Hypertension screening
   c) Maintaining weight
   d) Regular exercise program

4. The most common symptoms of Covid-19 are
   a) fever, productive cough and chest pain.
   b) fever, dry cough and diarrhea.
   c) fever, shortness of breath and headache.
   d) fever, dry cough and tiredness.

5. A nurse who is taking care of infants undergoing phototherapy treatment needs to observe all EXCEPT
   a) Eye patches are in place
   b) Hyperthermia
   c) Dehydration
   d) Monitor serum bilirubin every half an hour

6. The neurovascular assessment a nurse must perform for the patient with a fracture injury to identify “compartment Syndrome” are
   a) colour, pain, temperature, pulses and sensation.
   b) pain, pulses, drowsiness, lethargy and disorientation.
   c) drowsiness, disorientation, pulses and headache.
   d) colour, temperature, pulses and disorientation

7. BCG vaccine which is primarily used against tuberculosis is
   a) killed vaccine
   b) live attenuated vaccine
   c) toxoid
   d) immunoglobulin

8. The nursing diagnosis which is the second step of nursing process is very important during patient care because it
   a) helps in documentation of nursing process.
   b) is required by Law.
   c) draws conclusion regarding patient's specific needs.
   d) is a tool to communicate with the patient and the family.

9. A male baby was delivered spontaneously following a term pregnancy. Apgar scores are 8 and 9 respectively. When is the APGAR score taken?
   a) Immediately after birth and at 30 minutes after birth.
   b) At 1 minute after birth and at 5 minutes after birth.
   c) At 5 minutes after birth and at 30 minutes after birth.
   d) Immediately after birth and at 5 minutes after birth.

10. In nursing process, the purpose of planning is to
    a) formulate nursing diagnoses.
    b) carry out selected nursing interventions.
    c) formulate goals/objectives.
    d) determine if interventions was effective and efficient.

11. All are nursing interventions for assessing intolerance to tube feeding EXCEPT
    a) Assess the abdomen for distention
    b) Auscultate bowel sounds
    c) Palpate the abdomen to assess for tenderness
    d) Aspirate with syringe and check the contents

12. The "Glasgow Coma Scale" which is used to assess the level of consciousness of the patient evaluate which of the following three areas?
    a) Eye opening, orientation to time and place, and best motor response.
    b) Verbal response, best motor response, and orientation to time and place.
    c) Eye opening, verbal response, and best motor response.
    d) None of the above.

13. The only IV fluid that can be administered with blood is
    a) Normal Saline
    b) Dextrose Solutions
    c) Lactated Ringer's Solutions
    d) None of the above

14. The most important nursing rationale for measuring and recording of accurate intake and output is to
    a) estimate fluid balance.
    b) monitor cardiac load.
    c) monitor nutritional balance.
    d) restrict fluid intake.

15. Which of the following action should a nurse implement for a patient scheduled for magnetic resonance imaging (MRI)?
    a) Shave the groin for insertion of a femoral catheter.
    b) Remove all metal-containing objects from the patient.
    c) Keep the patient NPO (nothing by mouth) for 6 hours before the test.
    d) Instruct the patient in inhalation techniques for the administration of the radioisotope.

16. The laboratory test that will be ordered for a patient with hypoxia is
    a) Hematocrit
    b) Sputum analysis
    c) Arterial blood gas analysis (ABG)
    d) Hormone analysis

17. The most common contributing factor for pressure ulcer formation is
    a) Intracranial pressure
    b) Chronic wound
    c) High loading pressure
    d) Malnutrition

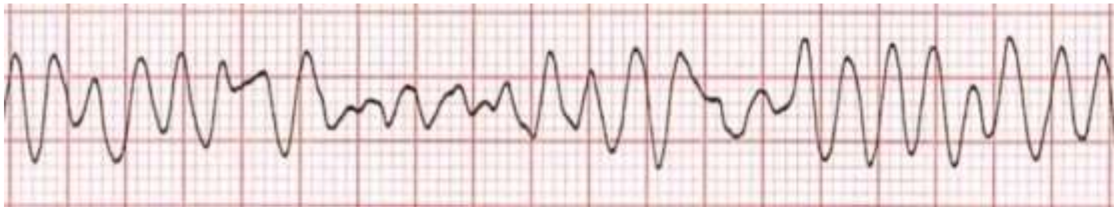
18. A patient is having a generalized tonic clonic seizure. Which of the following should a nurse do FIRST?
    a) Check patient's breathing.
    b) Remove objects from patient's surrounding.
    c) Place a tongue blade in patient's mouth.
    d) Restrain the patient.

19. The nurse is caring for a patient who just returned from the recovery room after undergoing abdominal surgery. The nurse should monitor for which early sign of hypovolemic shock?
    a) Sleepiness
    b) Increased pulse rate
    c) Increased depth of respiration
    d) Increased orientation to surroundings

20. The nurse is performing an assessment of a pregnant mother who is at 28 weeks of gestation. The nurse measures the fundal height in centimeters and notes that the fundal height is 30 cm. How should the nurse interpret this finding?
    a) The patient is measuring large for gestational age.
    b) The patient is measuring small for gestational age.
    c) The patient is measuring normal for gestational age.
    d) More evidence is needed to determine size for gestational age.

21. The nurse working in emergency department is assigned to triage patients. The nurse should assign priority to which patient?
    a) A patient complaining of muscle aches, a headache, and history of seizures.
    b) A patient who twisted his ankle when playing football and requesting medication for pain.
    c) A patient with a minor laceration on the index finger sustained while cutting vegetables.
    d) A patient with chest pain.

22. A patient who experienced a myocardial infarction is being monitored via cardiac monitor. The nurse noted a sudden onset of this cardiac rhythm on the monitor (refer to figure). Which is the immediate nursing implementation that must be undertaken?



    a) Takes the patient's blood pressure.
    b) Initiates cardiopulmonary resuscitation (CPR).
    c) Places a nitroglycerin tablet under the patient's tongue.
    d) Continues to monitor the patient and then contact the doctor.

23. A patient with hypokalemia is prescribed intravenous Potassium chloride (KCL) administration. All of the statement regarding administration of IV KCL is correct EXCEPT
    a) Prepare for a bolus administration.
    b) Ensure the preparation is labeled.
    c) Monitor IV site for infiltration or phlebitis.
    d) Monitor urine output.

24. What is the immediate action a nurse must perform when there is a presence of umbilical cord protruding from the vagina during delivery process?
    a) Gently push the cord into the vagina.
    b) Place the patient in Trendelenburg position.
    c) Inform the doctor on call.
    d) Call the delivery room to notify the staff that the patient will be transported immediately.

25. Which of the following statement is INCORRECT about heart rate?
    a) Pain increases heart rate
    b) Hemorrhages increase heart rate
    c) Heart rate increases with old age
    d) When blood pressure is low, heart rate is usually increased

26. The nurse is caring for a patient with liver cirrhosis. To minimize the effects of the disorder, the nurse recommended the patient about the diet that is high in Thiamine. Which food from the list should the nurse encourage the patient to take?
    a) Milk
    b) Chicken
    c) Broccoli
    d) Legumes

27. The process of tapping the patient's skin to assess underlying structures and to determine the presence of vibration is
    a) Auscultation
    b) Inspection
    c) Percussion
    d) Palpation

28. A doctor orders 1000 mL of normal saline (NS) to be infused over 12 hours. The drop factor is 15 drops/mL. At what drop per minute should the nurse set the flow rate? Record your answer to the nearest whole number
    a) 21
    b) 26
    c) 29
    d) 15

29. The nurse admits a child with pyloric stenosis in the ward. On assessment, which symptom would the nurse expect to ask the parent about the child's condition?
    a) Watery diarrhea
    b) Projectile vomiting
    c) Increased urine output
    d) Vomiting large amounts of bile

30. Which sign is the indicative of infection when the nurse is assessing the casted extremity of a patient?
    a) Dependent edema
    b) Diminished distal pulse
    c) Presence of a "hot spot" on the cast
    d) Coolness and pallor of the extremity

PART II – Short Answer Questions [20 marks]

This part has 4 Short Answer Questions. Answer ALL the questions. Each question carries 5 marks. Mark for each sub-question is indicated in the brackets.

1. Consent is the voluntary authorization by a patient or the patient's family who is a legally recognized representative to do something to the patient. It is based on the mutual consent of all patients involved, and the key to true and valid consent is patient comprehension. Consent may be given orally or in writing.

    a) Why is obtaining consent from patient or family important before starting any medical procedures? (2 marks)

    b) To ensure that a patient or family has given an informed consent, what are some of the points that the nurse should be very clear of before the party signs the consent Form? (3 marks)

2. What are the common causes of nursing negligence? What are the nursing interventions that will prevent nurses from legal implications? (5 marks)

3. Mr Dorji, a diabetic patient on treatment complains of dizziness, profuse sweating, tremors and palpitation. His random blood glucose is 58mg/dL.

    a) What is this acute complication of diabetes mellitus called? (1 mark)

    b) What are the simple, non-pharmacological management of this patient (4 marks)

4. Given below are pictures of various supplemental oxygen delivery devices.

Device A **Device B** **Device C**

   a) What is the name of **Device A**? (1 mark)
   b) What is the name of **Device B**? (1 mark)
   c) What is the name of **Device C**? (1 mark)
   d) How many litres of oxygen can be delivered with **Device A**? (1 mark)
   e) What is the maximum litre of oxygen that can be delivered with **Device C**? (1 mark)

SECTION B: CASE STUDY [50 marks]

Choose either CASE I or CASE II from this section. Each case study carries 50 marks. Mark for each sub-question is indicated in the brackets.

CASE I

After passing civil service examination you are placed in inpatient department of a hospital. You observe things are very different from what you have expected. The nurses in the ward are only doing what the doctors instructed or ordered them to do. There are hardly any interaction between the nurses and patients.

In the last two years, there were an increase number of nurses in the wards with proportion to increase number of patient admission. The ward is managed by a senior staff nurse who is approachable and liked by all the nurses working with her.

Once you are settled in the new environment, you understood you just need to do the routine nursing functions like your colleagues at work. You knew that there are no opportunities for the nurses in the ward for professional development such as participating in workshops or attending continuous medical education. Life went on quietly for the nurses and changes in the nursing intervention for improvement of patient care were never thought of.

1. Why is it important for nurses to be effective leaders? What are the qualities of an effective leader? (10 marks)

2. If you are appointed as the chief nurse of this hospital, what transformation will you make for the ward and patient care? (10 marks)

3. According to “Behavioural Theories” what are the three styles of leadership? Explain each leadership style with examples related to nursing? (10 marks)

4. Why is communicating with patient important? What are the barriers to effective communication with patient and family? (10 marks)

5. What is patient satisfaction? How can patient satisfaction be measured? (10 marks)

CASE II

Miss Yangchen, a 32-year-old who tested positive for Covid-19 is admitted in Covid Ward during your duty shift. You notice that she often wakes up in the middle of the night, crying and repeatedly stating that she is going to die. She complains of choking sensation, pounding heart, dizziness, chest pain and insomnia. Her vital signs are as follows:

Bp- 136/92 mmhg, R-20/min, HR- 116/min, Spo2- 94% on room air, T-98 F

The doctor on call thinks she is having an anxiety attack and orders Tablet Diazepam, 5 mg Hs. You use therapeutic communication to approach her.

1. State different levels of anxiety and relate which level of anxiety is this patient experiencing. (5 marks)
2. List down two signs and symptoms of each level of anxiety. (8 marks)
3. What are the nursing considerations while administering Diazepam? (2 marks)
4. Write down two non-pharmacological management of anxiety. (5 marks)
5. List five nursing diagnosis relevant for this patient. (10 marks)
6. Prepare a care plan for this patient with a nursing diagnosis. (10 marks)
7. List five types of therapeutic communication technique. (5 marks)
8. What protective measure will you take while taking care of this patient? (5 marks)

TASHI DELEK