THEORY 1st - IN-SEM EXAMINATION			
SESSION: 2022-23(SUMMER SEMESTER)			
B.Voc/M.Voc	**Semester**	5TH	
Course name / Module	Sexual health (Open elective)		
Course code	SHP 1111		
Date			
Name of the Student		**Reg. No.**	

INSTRUCTIONS

- Maximum Marks: **20**
- Duration of Examination: **01 Hour**
- Attempt all questions.
- Any other instruction may be included, If required.

1. Section A (05 objective type questions, each question carries 01 mark) **05×1 = 05**

1. In a healthy relationship your partner will?

a. Trust you
b. Abuse you
c. Will not accept you
d. Ignore you

2. Have you ever been hit, kicked, shoved, or had things thrown at you, this helps you to identify that you are in which type of relationship.

a. Healthy relationship
b. Abusive relationship
c. Loving relationship
d. None of the above

3. In which type of communication does the person uses threats or force?

a. Aggressive
b. Passive
c. Assertive
d. Both a and b

4. Assertive is a type of communication in which a person

a. Dominates others
b. Think of themselves first , at the expense of others
c. Use threats
d. Stand up for their rights without denying other people

5. Which among these is not a safety tip while you are in or leaving an abusive relationship?

a. Stay in touch with friends and be involved in activities
b. Keep important phone numbers with you at all times
c. Consider telling your parents, teachers, or other trusted adults
d. Never share your feelings with your loved ones

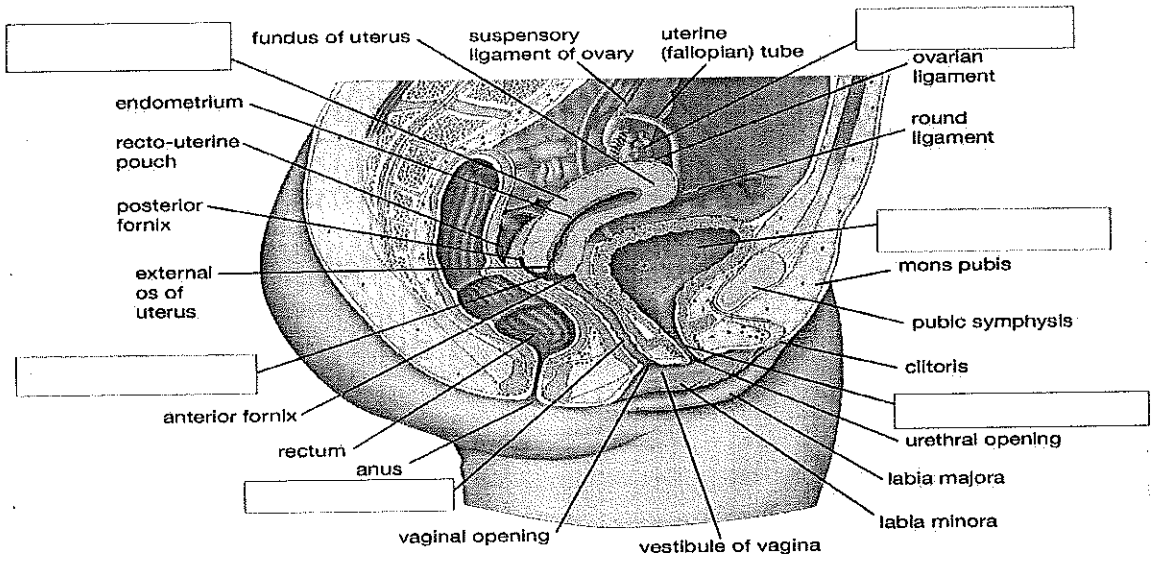
2. Section B (03 short answer type questions, each question carries 02 marks) **03×02 = 06**

1) Mention the periods of human development.
2) Write a short note on adolescence.
3) Fill in the blank with the existential questions.

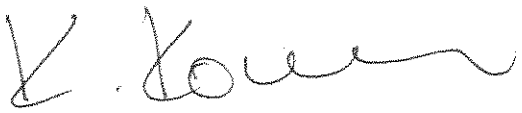
Approximate Age in years	Virtues	Psycho Social Crisis	Significant Relationship	Existential Question
0 – 2	Hopes	Basic Trust vs. Mistrust	Mother	Can I trust the World?
2 – 4	Will	Autonomy vs. Shame and Doubt	Parents	Is it ok to be me?
4 – 5	Purpose	Initiative vs. Guilt	Family	
5 – 12	Competence	Industry vs. Inferiority	Neighbors, School	
13 – 19	Fidelity	Identity vs. Role of Confusion	Peers, Role Model	
20 – 24	Love	Intimacy vs. Isolation	Friends, Partners	Can I love?
25 – 64	Care	Generativity vs. Stagnation	Household, Workmates	Can I make my life count?
65 - death	Wisdom	Ego Integrity vs. Despair	Mankind, My Kind	Is it okay to have been me?

3. Section C (03 long type questions, each question carries 03 marks) **03×03 = 09**

1) Mention the missing labels from the picture shown below



2) **Describe the clitoris in your own words.**
3) **Explain the female reproductive organ vagina along with its functions.**



THEORY 1st - IN-SEM EXAMINATION			
SESSION: 2022-23(SUMMER SEMESTER)			
B.Voc	**Semester**	5th	
Course name / Module	Pregnancy & Birth		
Course code	SHP1502		
Date			
Name of the Student		**Reg. No.**	

INSTRUCTIONS

- Maximum Marks: **20**
- Duration of Examination: **01 Hour**
- Attempt all questions.

1. Section A (05 objective type questions, each question carries 01 mark)	**05×1 = 05**

1. Which gland is responsible for initiating the menstrual cycle?
a. Hypothalamus
b. Anterior Pituitary gland
c. Posterior pituitary gland
d. Ovaries

2. The commonest presentation of fetus at the onset of labour is:
a. Podalic presentation
b. Vertex presentation
c. Shoulder presentation
d. Face presentation

3. The most common site of implantation of fertilization ovum is:
a. Posterior wall of uterus
b. Fundus of uterus
c. Anterior wall of uterus
d. Fallopian tube

4. What is the normal colour of amniotic fluid when the bag of waters ruptures?
a. As like water
b. Bluish
c. Brownish
d. Yellowish

5. Mrs. Poonam was pregnant for the first time and delivered alive baby at 35 weeks. When the child becomes 3 years old, she was pregnant again but had a miscarriage at 12 weeks. Then a few months later, she become pregnant again and gave birth at 30 weeks. What is the obstetrical score of Mrs. Poonam using GTPAL system?
a. G3 T1 P1 A1 L2
b. G2 T1 P1 A1 L2
c. G3 T2 P0 A1 L2
d. G3 T0 P2 A1 L2

2. Section B (03 short answer type questions, each question carries 02 marks)	**03×02 = 06**

1) What do you mean by morula?
2) Write down the four functions of amniotic fluid.
3) Mention the landmark of female pelvis.

3. Section C (03 long type questions, each question carries 03 marks)	**03×03 = 09**

1) Describe the "**Leopold's Maneuvers**" with the help of diagram.
2) Describe the events of first stage of labour.
3) Explain the physiological changes of during pregnancy uterus and haemtological changes.

THEORY 1st - IN-SEM EXAMINATION			
SESSION: 2022-23(SUMMER SEMESTER)			
B.Voc	**Semester**	5th	
Course name / Module	Skin & Wound Management		
Course code	SHP1503		
Date			
Name of the Student		**Reg. No.**	

INSTRUCTIONS
• Maximum Marks: **20**
• Duration of Examination: **01 Hour**
• Attempt all questions.

1. Section A (05 objective type questions, each question carries 01 mark)	**05×1 = 05**

1. Full forms of MUST is:
   a. Malnutrition universal screening tool
   b. Metabolism universal screening tool
   c. Mechanical universal screening tool
   d. None of above

2. In pain assessment what does "S" stands for in SOCRATES:
   a. Score
   b. Severity
   c. Site
   d. Score

3. Gas gangrene is caused by:
   a. Clostridia
   b. Clostridium perfringes
   c. Clostridium tetani
   d. E.coli

4. Cellulitis is:
   a. Bacterial infection
   b. Parasite infection
   c. Mixed infection
   d. Both b and c

5. Full form of MRSA:
   a. Methicillin recovered staphylococcus aureus infection
   b. Mucosa resistant staphylococcus aureus infection
   c. Methyl resistant staphylococcus aureus infection
   d. Methicillin resistant staphylococcus aureus infection

2. Section B (03 short answer type questions, each question carries 02 marks)	**03×02 = 06**

1) Mention the four functions of skin.
2) Write a short note on phases of wound healing with the help of diagram.
3) What do you mean by BMR. Mention the formula for calculating BMR of men and women.

3. Section C (03 long type questions, each question carries 03 marks)	**03×03 = 09**

1) Describe the international classification system for pressure sore of NPUAP along with well labelled diagram.
2) Explain the four principles of **"TIME"** module for wound bed preparation along with the application to practice.
3) Describe along with a well labelled diagram the triangle of wound assessment.

THEORY 1st - IN-SEM EXAMINATION			
SESSION: 2022-23(SUMMER SEMESTER)			
B.Voc	**Semester**	5th	
Course name / Module	Pregnancy & Birth		
Course code	SHP1502		
Date			
Name of the Student		**Reg. No.**	

INSTRUCTIONS

- Maximum Marks: **20**
- Duration of Examination: **01 Hour**
- Attempt all questions.

1. Section A (05 objective type questions, each question carries 01 mark)	**05×1 = 05**

1. Which gland is responsible for initiating the menstrual cycle?

a. Hypothalamus
b. Anterior Pituitary gland
c. Posterior pituitary gland
d. Ovaries

2. The commonest presentation of fetus at the onset of labour is:

a. Podalic presentation
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a. G3 T1 P1 A1 L2
b. G2 T1 P1 A1 L2
c. G3 T2 P0 A1 L2
d. G3 T0 P2 A1 L2

2. **Section B** (03 short answer type questions, each question carries 02 marks)	**03×02 = 06**

1) What do you mean by morula?

After the zygote formation, typical mitotic division of the nucleus occurs producing two blastomeres. The two cell stage is reached approximately 30 hours after fertilization. Each contains equal cytoplasmic volume and chromosome numbers. The blastomeres continue to divide by binary division through 4,8,16 cell stage untill a cluster of cells is formed and is called morula. The morula after spending about 3 days in the uterine tube enters the uterine cavity through the narrow uterine ostium on the 4th day in the 16-24 cell stage.

2) Write down the four functions of amniotic fluid.

Function of amniotic fluid:

Its main function is to protect the fetus

During Pregnancy:

- It acts as a shock absorber, protecting the fetus from possible extraneous injury.
- Maintains an even temperature
- The amniotic sac and thereby allows for growth and free movement of the fetus.
- Its provide nutritive of small amount of protein and salt content and water supply to the fetus is quite adequate.

During Labour:

- The amnion and chorion are combined to form a hydrostatic wedge, which help in dilatation of the cervix.
- It flushes the birth canal at the end of first stage of labour and by its aseptic and bactericidal action protects the fetus and prevents ascending infection to the uterine cavity.

3) Mention the landmark of female pelvis.

- symphysis pubis
- Pubic crest
- Pubic tubercle
- Pectineal line
- Iliopubic eminence
- Iliopectineal line
- Sacro-iliac articulation
- Anterior border of the ala of sacrum
- sacral promontory

3. **Section C** (03 long type questions, each question carries 03 marks)	**03×03 = 09**

1) Describe the "Leopold's Maneuvers" with the help of diagram.

Leopold's Maneuvers

There are four maneuvers starting at the fundus and ending at the pelvis brim.

A. First Maneuver (Fundal Palpation): Situation

- Both hand place on whole fundal area and find which fetal part lying in fundus (Presentation).
- Examiner should face to mother face.
- Feeling of broad, irregular soft mass in fundus, suggest broad (Buttocks) presentation.

- Smooth, hard and globular mass, suggest head (Vertex) presentation.
- In transverse lie fundal area found empty.

B. Second Maneuver (Lateral Palpation): Position

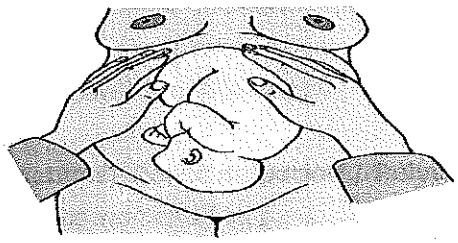
- Continue to face the women's head. place your hand on both sides of the uterus about midway between the symphysis pubis and the fundus.
- Apply firm gently pressure with one hand against the side of the uterus. There by pushing the fetus to the other side of the abdomen and with your examining hand stabilizing if there. Maintaining pressure on one side, palpate the other side of the uterus.
- Both hand place either side of umbilicus to palpate the position of back, limb and the anterior shoulder.
- With the examining hand, palpate the entire area from the abdominal midline to the lateral side and from the symphysis to the fundus. use firm, smooth pressure and rotary movement.

C. Third Maneuver/ Pawlik's Maneuwer / Second pelvic Grip: Presentation

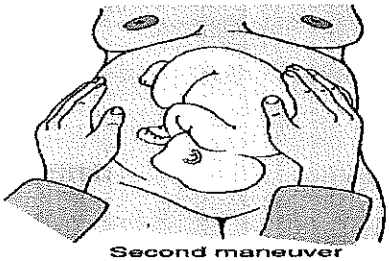
- Continue to face the women's head. have her knees bend in order to avoid discomfort during this maneuver.
- Grasp the portion of the lower abdomen immediately above the symphysis pubis between the thumb and middle finger of one of your out stretched hands. Press gently in to the abdomen in order to feel the presenting part below and between your thumb and finger.
- It gives information about engagement
- It transverse lie pawlik's grip is empty.

D. Fourth Maneuver/ Pelvic palpation / Pelvic Grip First:

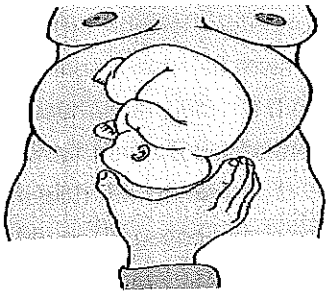
- Turn and face the women's feet
- Make sure that the women's knees are bent to avoid pain during the maneuver.
- Place your hand on the sides of the uterus with the palms of your hands just below the level of the umbilicus and your fingers directed towards the symphysis pubis.
- Press deeply with your finger tips into the lower abdomen and more them towards the pelvic inlet.
- Continue to move your hands towards the pelvic inlet.
- Share your finding with the woman.
- See divergent of finger (Engaged head) or Convergence of finger (Not engaged head)



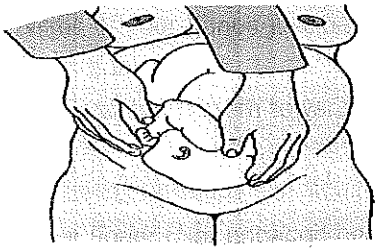
First maneuver



Second maneuver



Third maneuver

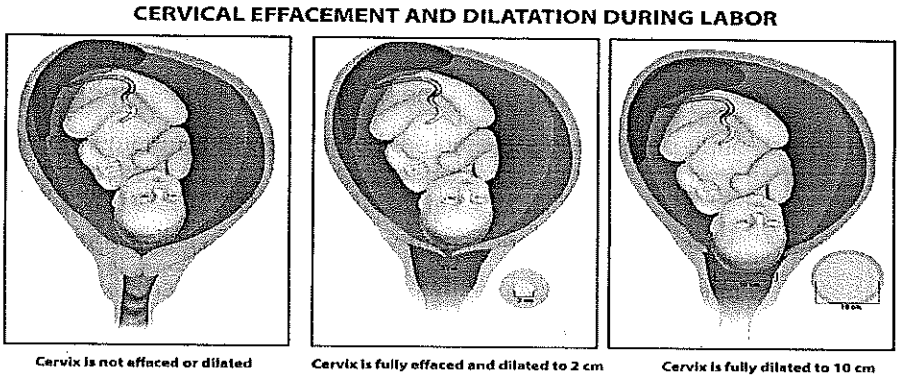


Fourth maneuver

2) Describe the events of first stage of labour.

Event in First Stage of Labor

1. Cervical Dilatation:



- Dilatation of the cervix is the process of enlargement of the external OS from on orifice of a few milimeters to an opening large enough for the baby to pass through.
- Dilatation is effected primarily by the action of contractions and facilitated by the hydrostatic action of the amniotic fluids under the influence of contraction, causing the membranes to severe as a dilating wedges in the area of least resistance in the uterus.
- If the membranes have ruptured the pressure of the presenting part on the cervix and the lower uterine segment has a dilating effect.
- Dilatation is clinically evaluated by measuring the diameter of the cervix opening in cm. with a cm being a close external cervical OS and 10 cm being complete dilatation.

Factors for Cervical Dilatation-

a) Mechanical Stretching:

Mechanical stretching of the cervix intensifies uterine activity. Release of endogenous progesterone/oxy-tocin may mediate this process.

b) Myometrial Contraction and Retraction:

Myometrial fibers of upper uterine segment contracts and retract helping in cervical dilatation. Once forceful contraction of the fundus and body of the uterus start, It exerts a hydrostatic pressure via the fetal membrane on the cervix and lower uterine segment helping in dilatation of cervix from above downward.

c) Formation of bag of membranes:

- As the lower uterine segment stretches and the cervix starts to efface some chorion becomes detached from the decidua and forms with the amnion a small bag containing amniotic fluid which protrudes in to the cervix.
- When the fetal head descends it separates the small bag in front from the rest of the amniotic fluid. The fore waters aid effacement and early dilatation of the cervix while the amniotic fluid equalize the pressure in the uterus during contraction and provide protection to the fetus and placenta.

- Myometrial contractions exert pressure on the intact membrane. This hydrostatic pressure of the amniotic sac causes cervical dilatation from above downwards similar to a wedge.

d) Role of fetus in cervical dilatation:

Contraction of circular myometrial fibers of the body of uterus and straightening of the fetus passing on the upper uterine segment contraction to the lower part of fetus which in turn dilates the cervix from above downward.

1. Cervical Effacement:

- Cervical effacement is define as the thinking of the cervix and shortening of the cervical canal from its usual length of 2-3 cm to one in which the cervical canal is obliterated leaving only the external OS as a circular orifice with thin edge.
- This shorting results from the lengthening of the muscular fibers around the internal OS as they are taken up in to the lower uterine segment.
- The process of effacement is also facilitated by the expulsion of the mucus plug.

2. Formation of upper and lower uterine segment:

By the end of pregnancy, the body of the uterus is divided into two anatomically distict segment upper and lower uterine segments. The upper uterine segment is mainly concened with contraction and is thick and muscular the lower segment is prepared for distension and dilatation and is thinner. The lower segment develops from the isthmus and is about 8-10 cm in length.

i. Retraction Ring-

- A ridge forms between the upper and lower uterine segments, which are known as the retracting ring.
- The physiological retraction ring gradually rises as the upper uterine segment contracts and retracts, and the lower uterine segment thins out to accommodate the descending ring rises no further.
- Once the cervical is fully dilated and the fetus can leave the uterus the retraction ring rises no further.
- The retraction ring is normally not visible over the abdomen. When the phenomenon is exaggerated in an obstructed labor the retraction ring become visible above the symphysis pubis it is term as "Bandls Ring".

ii. Ripening of the cervix-

- The term "Ripe" cervix is often used. It is belived that the "Braxton Hicks Contraction" help to prepare the cervix or ripen it for the job a head.
- The cervix moves from its posterior position during pregnancy to an anterior position and the normally firm tissue softness considerably.

3) Explain the physiological changes of during pregnancy uterus and haemtological changes.

Uterus:

There is enormous growth of the uterus during pregnancy. The uterus which is non-pregnant state weighs about 60gm and measures about 7.5 cm in length. At term, weight 900-1000 gm and measure 35 cm in length.

Body of the uterus: There is increase in growth and enlargement of the body of the uterus.

Enlargement of the uterus is affected by the following factors:

Changes in the muscles:

Hypertrophy and Hyperplasia
Stretching - The muscle fiber further elongate beyond 20weeks due to distension by the growing foetus.

Haematological Changes

Blood Volume: During pregnancy there is increased vascularity of the enlarging uterus with the interposition of utero-placental circulation. The activities of all the system are increased. Blood volume is markedly raised during pregnancy. The blood volume starts to increase from about 6th week, expands rapidly thereafter to maximum 40-50% above the non-pregnant level at 30-32 weeks.

Plasma Volume: It starts to increase by 6 weeks and it plateaus at 30 weeks gestation. total plasma volume increase to the extent of 1.25 lit.

RBC and Haemoglobin: The RBC mass is increased to the extent of 20-30%. This increase is regulated by the increased demand of oxygen transport during pregnancy. The disproportionate increase in plasma and RBC volume produces a state of haemodilution during pregnancy. The total haemoglobin mass increases during pregnancy to the extent of 18-20%.

Leucocytes and Immune System: Neutrophilic leucocytes occurs to the extent of 10-15000/cu.mm and even to 20000/cu.mm in labour. The increase may be due to rise in the levels of oestrogen and cortisol. The major changes in the immune system.

Total Protein: Total plasma protein increase from the normal 180gm (Non-pregnant) to 230gm at term.

Blood Coagulation Factors: Pregnancy is a hypercoagulable state. Fibrinogen level is raised. Level of coagulation factors normalise.

K. Kaur

THEORY 1st - IN-SEM EXAMINATION			
SESSION: 2022-23(SUMMER SEMESTER)			
B.Voc	**Semester**	5th	
Course name / Module	Skin & Wound Management		
Course code	SHP1503		
Date			
Name of the Student		**Reg. No.**	

INSTRUCTIONS
• Maximum Marks: **20**
• Duration of Examination: **01 Hour**
• Attempt all questions.

1. Section A (05 objective type questions, each question carries 01 mark)	**05×1 = 05**

1. **All forms of must is:**
   a. **Malnutrition universal screening tool**
   b. Metabolism universal screening tool
   c. Mechanical universal screening tool
   d. None of above

2. **In pain assessment what does "S" stands for in SOCRATES:**
   a. Score
   b. Severity
   c. Site
   d. Score

3. **Gas gangrene is caused by:**
   a. Clostridia
   b. Clostridium perfringes
   c. Clostridium tetani
   d. E.coli

4. **Cellulitis is:**
   a. Bacterial infection
   b. Parasite infection
   c. Mixed infection
   d. Both b and c

5. **Full form of MRSA:**
   a. Methicillin recovered staphylococcus infection
   b. Mucosa resistant staphylococcus infection
   c. Methyl resistant staphylococcus infection
   d. Methicillin resistant staphylococcus infection

aureus

2. **Section B** (03 short answer type questions, each question carries 02 marks)	**03×02 = 06**

1) **Mention the four functions of skin.**

Functions of human skin

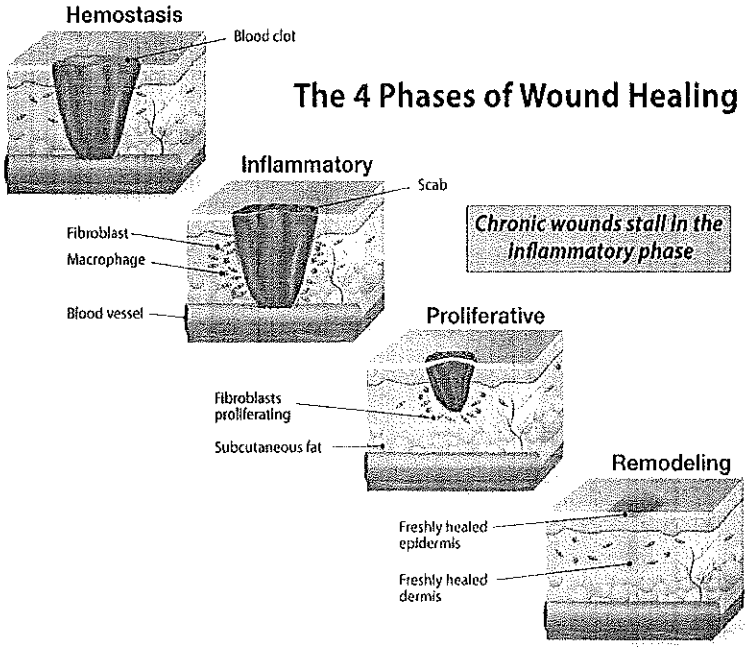
Summary:
Functions of the skin include:
- ✓ protection from:
  - fluid and electrolyte loss
  - mechanical injury
  - ultraviolet injury
  - ✓ pathogens
- ✓ **temperature regulation**
- ✓ **metabolism**
- ✓ **sensation**

With an area of 1.6 to 2 square meters for an adult and a weight of up to 1/6 of the body weight, the skin is thelargest human organ. It forms the outer boundary layer between humans and their environment and functionson the one hand as a barrier to the outside world and on the other hand as a connection between the outsideworld and the internal organs. Our skin has to fulfil a multitude of vital tasks, which is why its intactness is a high health good for humans.

- if the surface is intact, the skin **prevents** the loss of body fluids and offers protection against the penetration of microorganisms into the body
- the mechanical stress on the skin in case of pressure, impact or shock is extremely high, thus protecting the internal organs from damage
- to a certain extent, the skin can **ward off the harmful effects of chemicals and ultraviolet light**
- through the appropriate widening and narrowing of the blood vessels as well as through sweating, our skin is decisively **involved in heat regulation** and thus contributes to the maintenance of the vital body temperature of 37 degrees.
- As a sensory organ, the skin enables **the perception of mechanical** stimuli such as pressure, touch and vibration as well as temperature and pain. Many character-defining sensations could only be absorbed through the skin, so that the human development process would not take place without the skin
- Of particular importance is that the skin is capable of **regeneration and repair,** which means that in the event of a cut or injury, the skin can heal itself and restore continuity. The healing of skin woundsis based on the skin's ability to regenerate epithelia and repair skin connective tissue.
- **Regeneration means** that the injured skin heals without scarring and is possible if only the uppermost layer of the skin is damaged.
- **Reparation means** that replacement tissue must be built up to close the skin defect. This is always

the case if the injury affects deep skin layers.

2) Write a short note on phases of wound healing with the help of diagram.



First & second phase of wound healing: Haemostasis & inflammatory/exudation phase (1-5 days)

The first phase of wound healing is called **exudation phase**, also called **inflammatory phase**, or **cleansing phase.** During the exudation phase, cells and hormones of the immune system are significantly involved in killing invading bacteria and viruses and stimulating the healing process.

Initially, **haemostasis** (minutes)follows a very specific pattern:

- The vessels contract and thus lead to a reduced blood flow.
- Blood platelets (thrombocytes) attach themselves to collagen fibres.
- The thrombocytes activate themselves by releasing their storage substances and thus attract other thrombocytes.

Third phase of wound healing: granulation phase or proliferative/reconstructive phase (building up granula-tion tissue, 3-24 days)**.** The granulation phase begins approximately 24 hours after the wound has developedand reaches its maximum within 72 hours. In this phase new tissue is formed which fills the wound. It is char-acterised by the immigration of vascular cells into the wound edges. These cells can form vessels themselves(endothelial cells), to phagocytise bacteria (macrophages) and to form fibrin fibres (fibroblasts). The fibroblastsalso form mucopolysaccharides and other substances that are important for wound healing. The fibroblasts can feed mainly on amino acids, which are produced when macrophages break down blood clots. Normally the fibrin is broken down when collagen is incorporated. It is precisely at this point that chronic wounds often have a wound healing disorder: **fibrin persistence.** Fibrin is not degraded but is deposited on the wound surface.

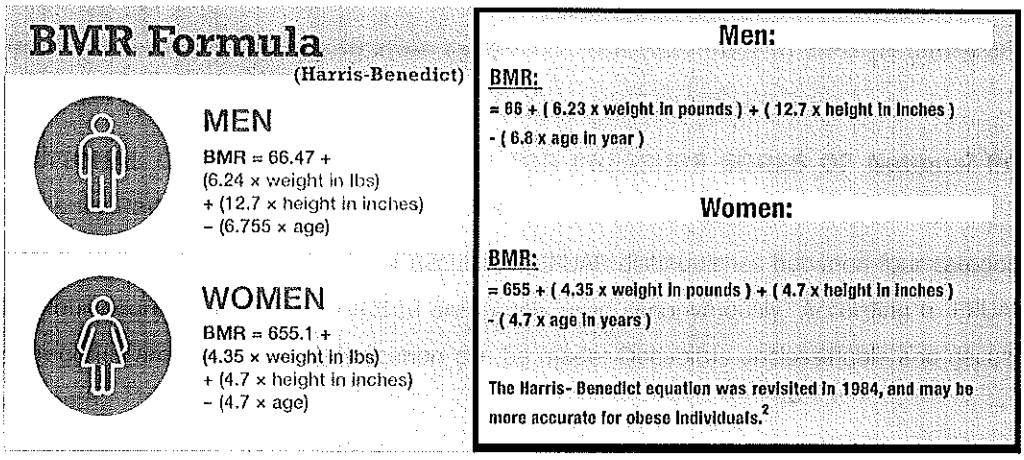
Fourth phase of wound healing: epithelisation or remodelling/maturation phase (scarring 21 days

onward)The epithelialisation phase begins with an acute wound after 3 to 4 days and can last several weeks. The wound is closing

- 1/3 solely by shrinkage
- 2/3 by new formation (scar tissue)

There is an increased formation of collagen fibres which cross-link in bundles (scarring). Epithelial cells closethe wound surface and migrate along a glide path of liquefied fibrin. The firmness of normal tissue is no longerachieved by scars. A decubitus develops on scarred skin about 5 to 10 times faster than on normal skin. Theepidermal cells usually begin to spread unevenly from the edge over the wound surface. However, epithelial islet cells can also settle in the middle of individual areas of the wound. This also allows migration, which ultimately serves to close the wound.

3) **What do you mean by BMR. Mention the formula for calculating BMR of men and women.**
Basal Metabolic Rate (BMR) is **the number of calories you burn as your body performs basic (basal) life-sustaining function**

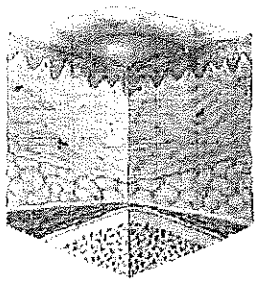
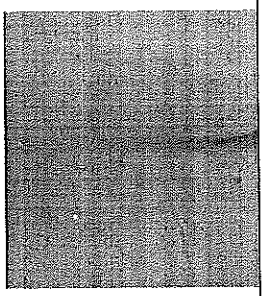
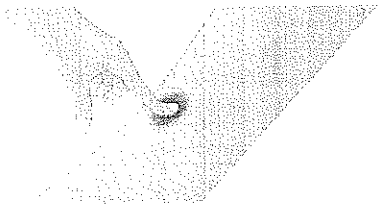
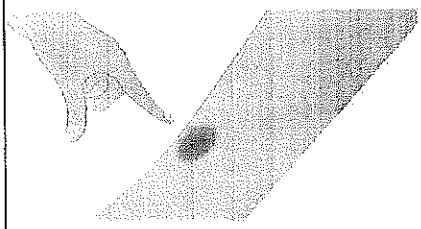
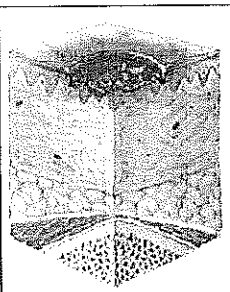
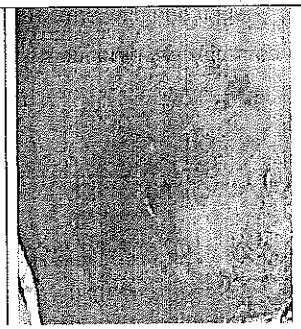


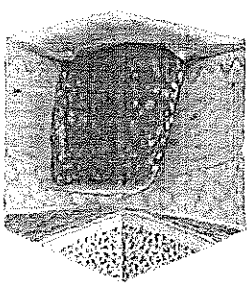
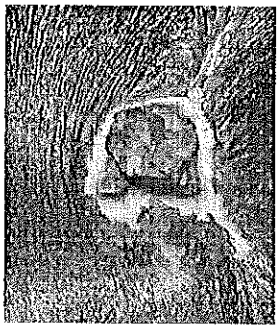
3. Section C (03 long type questions, each question carries 03 marks)	**03×03 = 09**

1) **Describe the international classification system for pressure sore of NPUAP along with well labelled diagram.**

INTERNATIONAL CLASSIFICATION SYSTEM FOR PRESSURE SORES OF National Pressure Ulcer Advisory Panel (NPUAP) **/ European Pressure Ulcer Advisory Panel (EPUAP)**

Instead of decubitus stages or degrees of decubitus, EPUAP distinguishes between four categories, to which the four degrees according to ICD10 are largely used synonymously. According to EPUAP, two further categories are used if no classification can be made: Decubitus unclassifiable and decubitus of unknown depth.

Decubitus Category 1- Non-removable erythema The area can be more sensitive to pain, harder orsofter, warmer or colder than the surrounding skin. Atfinger pressure ("finger test") non-decreasing, circum-scribed reddening of the skin with intact skin. Otherclinical signs may include oedema, hardening, localoverheating and discoloration of the skin. Darkly pig-mented skin may not show any visible fading, but thecolour may differ from the surrounding skin. It may therefore be difficult to detect category/stage I in peo-ple with dark skin. May indicate "at risk" persons (indi-cation of a pos-sible risk). With continuous pressure re-lief, the reddening of the skin disappears after a fewhours or days. If there is no pressure relief, there is increased fluid retention with subsequent blistering.	  
Note: **Pressure Ulcer Early Test** **A first-degree decubitus can be detected easily and without special aids. A watch glass or a transparent piece of plastic can be used as a support.**	Press on the reddened skin area with one finger for about one second. Then observe the skin area closely  Healthy skin first turns white and then returns to its original colour. An endangered skin area re- mains red and cannot be pushed away
Decubitus Category 2- Partial loss of skin **Partial loss of skin. Epidermis up to parts of the dermis are damaged. The pressure damage is superficial and presents clinically as a blister, skin abrasion or flat ul-cer - open ulcer with a red to pink wound bed, without coatings, can also appear as bruises. A weeping skin defect, very susceptible to infection, has developed.**	 

Decubitus Category 3- Complete loss of skin Deep damage to skin and tissue, loss of all skin layers, Damage or necrosis of the subcutaneous (subcutane- ous) tissue, no involvement of bones, tendons, mus- cles, possibly with wound coatings, **Decubitus clinically manifests itself as a deep, open ulcer with or without undermining.**	  The depth of a category/stage 3 decubitus can vary depending on its anatomical location. The bridge of the nose, ear, occiput and ankle have no subcutaneous tissue and category/stage III ulcers may be superficial. In contrast, particu- larly obese areas can develop an extremely deep category/stage III decubitus. Bones/tendons are not visible or directly palpable
Note: **Due to the pressure exerted on the tissue from the inside by the body's own weight from the bone and the resulting damage to the tissue, it is possible that stages I and II are not noticed and the decubitus ulcer is only detected in stage III. Healthy skin is under- mined by necrotic pockets. For this reason, always look for palpable clinical signs such as overheating and hardening when treating the patient.**	
Decubitus Category 4- Complete tissue loss **Total tissue loss with exposed bones, tendons and muscles, Loss of all skin layers, Undermining, tunnels, pockets, coverings and scabs may be present. The depth of a category/stage 4 decubitus varies accord- ing to its anatomical location. The bridge of the nose, ear, occiput and ankle have no subcutaneous tissue**	

2) Explain the four principles of "TIME" module for wound bed preparation along with the application to practice.

The Four Principles of TIME Wound Bed Preparation

The TIME mnemonic is composed of the following factors: **t**issue management, **i**nfection or inflammation, **m**oisture balance, and **e**dge of wound. Assessing and managing each of these elements is critical

to compre-hensive wound care.

PRINCIPLES = TIME

	Framework terms	Application to practice
T	Tissue management	Removal of nonviable tissue
I	Inflammation and infection control	Control of bacterial load / burden
M	Moisture balance	Management and control of exudates
E	Epithelial advancement / edge	Promotion of a healthy wound edge

T=Tissue Management and Debridement

The goal of debridement is to remove the necrotic tissue, such as eschar and slough. Invisible to the naked eye, senescent or aberrant cells may harbour bacteria, increase the risk of infection, delay the healing process and impair macrophage function. Additionally, any foreign material that inhibits healing such as toxins, microbes, biofilms, bacteria, yeast or viruses, as well as substances such as dressing residue, animal hair or dander, suture material or any other types of debris, should be removed. Until the wound bed is prepared anddebrided, the wound bed is not fully visible, and appropriate assessment is not possible. When debridement of a wound is contemplated, a number of considerations must be taken into: account, including the condition of the patient, the cost of the products, the therapeutic effectiveness, the efficiency of the procedure and re- sources available. There are also many ways to debride a wound, including sharp surgical and conservative sharp debridement, as well as mechanical, enzymatic, biological and autolytic debridement. Matching the ap-propriate method to the patient's overall needs is essential to achieving the best outcome. Non-viable tissue can impede healing and obstruct inspection of the underlying wound. This makes it important that all necrotictissue, devitalized tissue and bacteria be removed from the wound area. This helps ensure that the wound hasa healthy base for healing.

I = Inflammation and Infection Control

Inflammation is a component of the healing process, and it is important to remember that all wounds are contaminated with microorganisms. These low levels of bacteria can actually stimulate wounds to repair them-selves. It is when the organisms profusely increase in the wound bed that they extend the inflammatory phaseof wound healing and can severely retard or prevent wound repair. Understanding the difference in inflamma-tion and infection is important because they can manifest very similarly with erythema, warmth, pain and oe- dema. To this point, it is also very helpful to differentiate among contamination, colonization and infection.

Wound contamination is the presence of **non-replicating/ multiplying bacteria**. When the host controls the environment, healing is not impaired by these bacteria. When wound bed preparation is not achieved and wound management is not effective, then bacteria will begin to replicate. If there is an increase in the numberof bacteria, depending on the virulence of those bacteria, this process can begin to

overwhelm the host. **Col-onisation means** Bacteria multiply, but there is **no host response. Critical colonization** is the proliferation of bacteria in the host, resulting in delayed wound healing, but **still without an overt host reaction**. Critical colonization is usually associated with increased pain previously not reported by the patient. When **a wound is infected**, it now has the presence of replicating bacteria that are invading the tissue whether superficially orby deep penetration. Again, the host response will show a local reaction or a systemic reaction, and infectionis a clinical diagnosis based on signs and symptoms, not just the presence of bacteria or the number of bacteriain the wound.

Bacterial colonies can impede wound healing and threaten the health of the patient. It is important for wound bed preparation to manage bacterial levels to prevent infection, improve patient comfort and reduce the risk ofcomplication. Health care professionals should examine patients for signs of bacterial colonization such as tissue damage, odour, fever, inflammation and exudate. If infection is suspected, wounds should be cleaned with an antiseptic solution and treated with appropriate topical and/or systemic therapies. Antimicrobial dress-ings can help reduce the bacterial load in the wound area. It is also important to debride the wound area regularly to reduce the presence of biofilms that may be resistant to topical antibiotics.

M = Moisture Management

Wound moisture is a critical component of the wound healing process. A moist wound environment can pro- mote rapid healing, aid cellular activities, and prevent eschar formation. However, excessive moisture can cause maceration of the wound area and impede healing. It is important that health care professionals assessand actively manage the wound's moisture balance to improve patient outcomes. A key component of main- taining the optimal moisture balance in the wound is exudate management.. Exudate (drainage), a liquid pro-duced by the body in response to tissue damage, is present in wounds as they heal. It consists of fluid that has leaked out of blood vessels and closely resembles blood plasma. Exudate can result also from conditionsthat cause oedema, such as inflammation, immobility, limb dependence, and venous and lymphatic insuffi- ciency. However, in many cases the wound will produce too much or too little exudate, thereby creating subop-timal conditions. Dry wounds should be treated with an occlusive, semi-occlusive or appropriate moisture- donating dressing to help create a moist environment. Excessively moist wounds should be treated with a dressing that absorbs and traps exudate, such as a foam dressing

E = Edge Management

After providing appropriate wound bed preparation, including the management principles of tissue/debridement, infection, inflammation and moisture balance, if wound repair and healing are stalled with no progress made within two to four weeks, advanced treatments may be considered when the epithelium fails to migrate.In a properly healing wound, the epidermal margins should contract, reducing the size of the wound. If this process is not occurring, or if it is occurring too slowly, it is important for health care professionals to attempt to identify potential problems that may be preventing the wound from healing. In many cases, these causes may be related to other elements of the TIME model of wound bed preparation. Dry or excessively moist woundedges, infection, epibolic (rolled wound edges), necrotic tissues and biofilms can all prevent the epidermal margin from migrating. Performing regular assessments of the wound area and the advancement of wound edges can help identify these issues early on

3) Describe along with a well labelled diagram the tringle of wound assessment.

The Triangle of Wound Assessment

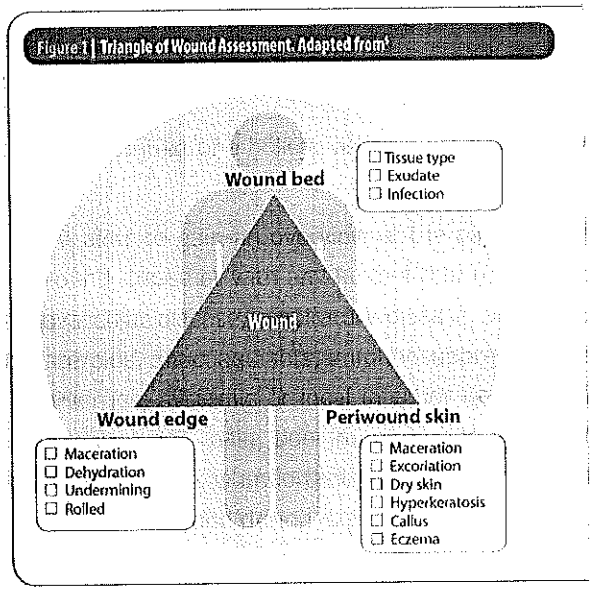
The Triangle of Wound Assessment is a holistic framework that allows practitioners to assess and manage allareas of the wound, including the periwound skin. The Triangle of Wound Assessment is a new tool that ex- tends the current concepts of wound bed preparation and TIME beyond the wound edge. It divides assessmentof the wound into three areas:

- the wound bed
- the wound edge and
- the periwound skin.

It should be used in the context of a holistic assessment that involves the patient, caregivers and family.

A holistic assessment aims to gain an overview of the patient's medical condition, the cause, duration and status of the wound, together with any factors that may impede healing including: comorbidities, e.g. diabetes,cardiovascular disease, respiratory disease, venous/arterial disease, malignancy, medications, e.g. cortico- steroids, anticoagulants, immunosuppressants, chemotherapeutic agents, nonsteroidal anti-inflammatorydrugs, systemic or local infection (e.g. osteomyelitis) ,reduced oxygenation and tissue perfusion, increased age, pain, poor nutrition and hydration, lifestyle, e.g. high alcohol intake, smoking, obesity. In addition, it is important to understand how the wound is affecting patient daily living, e.g. pain levels between and during dressing changes, sleep disturbance, strikethrough and malodour

Figure 1 | Triangle of Wound Assessment. Adapted from[1]



The Triangle of Wound Assessment identifies three distinct, yet interconnected, zones:

Wound bed: look for signs of granulation tissue, while seeking to remove dead or devitalised tissue, manage exudate level and reduce the bioburden in the wound

THEORY 1st - IN-SEM EXAMINATION			
SESSION: 2022-23(SUMMER SEMESTER)			
B.Voc/M.Voc	Semester	5TH	
Course name / Module	Sexual health (Open elective)		
Course code	SHP 1111		
Date			
Name of the Student		Reg. No.	

INSTRUCTIONS
• Maximum Marks: **20** • Duration of Examination: **01 Hour** • Attempt all questions. • Any other instruction may be included, If required.

1. **Section A** (05 objective type questions, each question carries 01 mark)	**05×1 = 05**

1. In a healthy relationship your partner will?

a. Trust you
b. Abuse you
c. Will not accept you
d. Ignore you

2. Have you ever been hit, kicked, shoved, or had things thrown at you, this helps you to identify that you are in which type of relationship

a. Healthy relationship
b. Abusive relationship
c. Loving relationship
d. None of the above

3. In which type of communication does the person uses threats or force?

a. Aggressive
b. Passive
c. Assertive
d. Both a and b

4. Assertive is a type of communication in which a person

a. Dominates others
b. Think of themselves first ,at the expense of others
c. Use threats
d. Stand up for their rights without denying other people

5. Which among these is not a safety tip while you are in or leaving an abusive relationship?

a. Stay in touch with friends and be involved in activities
b. Keep important phone numbers with you at all times
c. Consider telling your parents, teachers, or other trusted adults
d. Never share your feelings with your loved ones

2. Section B (03 short answer type questions, each question carries 02 marks)	**03×02 = 06**

1) Mention the periods of human development.

Periods of Human Development

1. Prenatal Development
2. Infancy and Toddlerhood
3. Early Childhood
4. Middle Childhood
5. Adolescence
6. Early Adulthood
7. Middle Adulthood
8. Late Adulthood

2) Write a short note on adolescence.

Adolescence

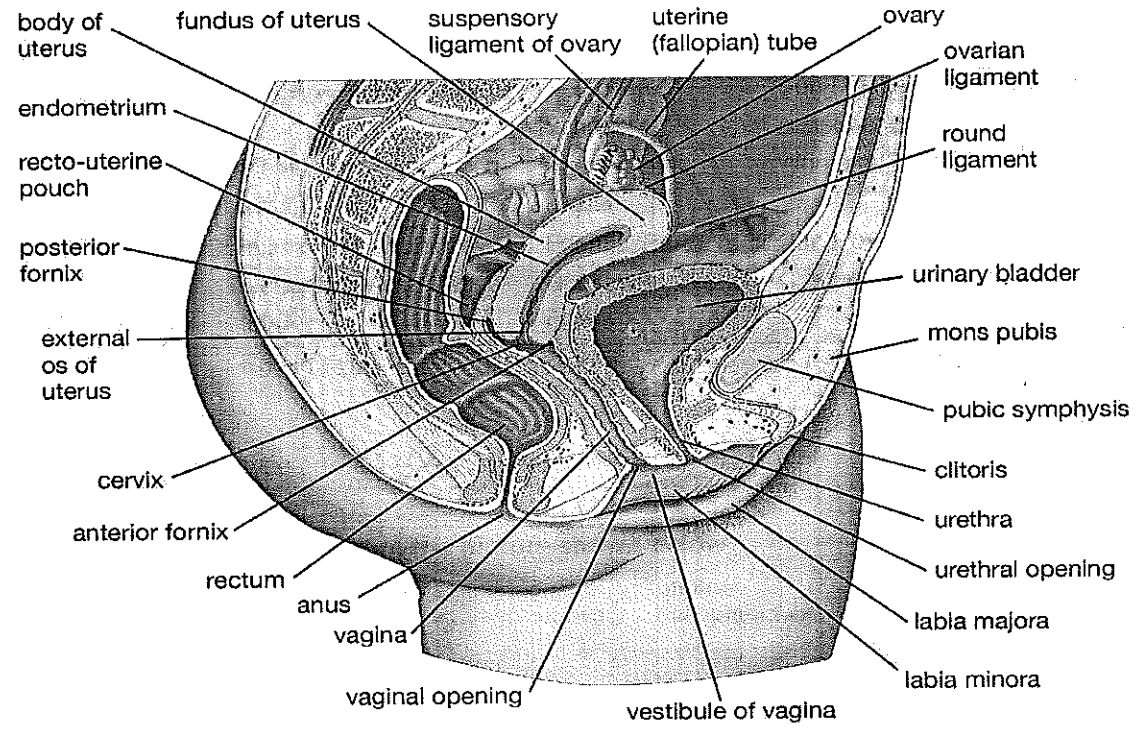
Adolescence is a period of dramatic physical change marked by an overall physical growth spurt and sexual maturation, known as puberty; timing may vary by gender, cohort, and culture. It is also a time of cognitive change as the adolescent begins to think of new possibilities and to consider abstract concepts such as love,fear, and freedom. Ironically, adolescents have a sense of invincibility that puts them at greater risk of dying from accidents or contracting sexually transmitted infections that can have lifelong consequences. Research on brain development helps us understand teen risk-taking and impulsive behavior. A major developmental task during adolescence involves establishing one's own identity. Teens typically struggle to become more independent from their parents. Peers become more important, as teens strive for a sense of belonging and acceptance; mixed-sex peer groups become more common. New roles and responsibilities are explored, which may involve dating, driving, taking on a part-time job, and planning for future academics.

3) Fill in the blank with the existential questions

Approximate Age in years	Virtues	Psycho Social Crisis	Significant Relationship	Existential Question
0 – 2	Hopes	Basic Trust vs. Mistrust	Mother	Can I trust the World?
2 – 4	Will	Autonomy vs. Shame and Doubt	Parents	Is it ok to be me?
4 – 5	Purpose	Initiative vs. Guilt	Family	Is it ok for me to do, move and act?
5 – 12	Competence	Industry vs. Inferiority	Neighbors, School	Can I make it in the world of people and things?
13 – 19	Fidelity	Identity vs. Role of Confusion	Peers, Role Model	Who am I? What can I be?
20 – 24	Love	Intimacy vs. Isolation	Friends, Partners	Can I love?
25 – 64	Care	Generativity vs. Stagnation	Household, Workmates	Can I make my life count?
65 - death	Wisdom	Ego Integrity vs. Despair	Mankind, My Kind	Is it okay to have been me?

3. Section C (03 long type questions, each question carries 03 marks)	**03×03 = 09**

1) Mention the missing labels from the picture shown below



2) Describe the clitoris in your own words.

Clitoris

The clitoris is a small erectile structure composed of two corpora cavernosa separated by a partition. Partially concealed beneath the forward ends of the labia minora, it possesses a sensitive tip of spongy erectile tissue, the glans clitoridis. The external opening of the urethra is some 2.5 cm (about 1 inch) behind the clitoris and immediately in front of the vaginal opening.

The vestibule of the vagina is the cleft between the labia minora into which the urethra and vagina open.The hymen vaginae lies at the opening of the vagina: it is a thin fold of mucous membrane that varies in shape.After rupture of the hymen, the small rounded elevations that remain are known as the carunculae hymenales.The bulb of the vestibule, corresponding to the bulb of the penis, is two elongated masses of erectile tissue that lie one on each side of the vaginal opening. At their posterior ends lie the greater vestibular glands, small mucous glands that open by a duct in the groove between the hymen and each labium minus. They correspond to the bulbourethral glands of the male.The blood supply and nerve supply of the female external genital organs are similar to those supplying corresponding structures in the male.

3) Explain the female reproductive organ vagina along with its functions.

The vagina (the word means "sheath") is the canal that extends from the cervix(outer end) of the uterus within the lesser pelvis down to the vestibule between the labia minora. The orifice of the vagina is guarded by the hymen. The vagina lies behind the bladder and urethra and in front of the rectum and anal canal. Its walls are collapsed; the anterior wall is some 7.5 cm (3 inches) in length, whereas the posterior wall is about 1.5 cm (0.6 inch) longer. The vagina is directed obliquely upward and backward.

Functions of vagina

- Enables you to experience sexual pleasure
- Channel period blood out of your body
- Plays role in pregnancy
- Childbirth during vaginal delivery