

M_PediatricNursePQ (300+ Questions) - Quiz

Questions with Answers

1.

Which of the following circumstances is likely to be the greatest barrier to a child's access to medical care?

Living in a rural area.

Being homeless.

Lacking an extended family.

Having a single parent.

Explanation:

The circumstance that is likely to be the greatest barrier to a child's access to medical care is being homeless. People who are homeless often move from shelter to shelter or other temporary living situations, and their medical care is often provided through emergency departments or free clinics, so there is little consistency in care or follow-up. Children who are homeless are often exposed to others who are ill and may not have facilities for adequate hygiene.

2.

Considering Erikson's developmental stages, before carrying out assessment and treatment on a preschooler (ages 3 to 6), the pediatric nurse should:

pretend the assessment/treatment is a game.

sedate the child to lessen anxiety.

allow the child to play with medical equipment.

give detailed explanations of the purpose of interventions.

Explanation:

Considering Erikson's developmental stages, before carrying out assessment and treatment on a preschooler (ages 3 to 6), the pediatric nurse should allow the child to play with the medical equipment to lessen the child's anxiety because strange equipment may frighten the child. The parent/caregiver should assist with the assessment/treatment when possible, such as by holding the child, and the pediatric nurse should explain to the child in simple terms that are age-appropriate what the assessment/treatment will entail.

3.

When rehydrating a young child with severe diarrhea, how much rehydration fluid is generally recommended for fluid replacement for each diarrhea stool?

10 mL/kg.

15 mL/kg.

25 mL/kg.

50 mL/kg.

Explanation:

When rehydrating a young child with severe diarrhea, generally 10 mL/kg of fluid replacement is given for each diarrhea stool. If the child presents with dehydration, usually the child is initially given 50 mL/kg to 100 mL/kg fluid over 4 hours in addition to the replacement fluid for diarrhea stools. If dehydration is mild to moderate, fluids may be taken orally. If dehydration is severe, fluids should be provided intravenously.

4.

If a child receiving isotonic IV fluid gains 0.5 kg (1 lb.) of weight overnight, this likely represents fluid retention of:

100 mL.

250 mL.

400 mL.

500 mL.

Explanation:

If a child receiving isotonic IV fluid gains 0.5 kg (1 lb.) of weight overnight, this likely represents fluid retention of about 500 mL. One can estimate that each ounce of added weight is equal to about one fluid ounce (30 mL) of fluid and each tenth of a kilogram is equal to about 100 mL. Careful control of IV volume and intake and output measurement is critical to maintaining adequate fluid balance.

5.

In order to prevent food-borne infection in HIV-positive children, parents should be advised to:

use soap and water to clean kitchen surfaces.

use a sponge to clean dishes.

prevent the child from eating raw cookie dough.

wash cutting board between use for meats and vegetables.

Explanation:

In order to prevent food-borne infection in HIV-positive children, parents should be advised to prevent the child from eating raw cookie dough and other raw doughs and anything containing raw eggs. Kitchen surfaces should be cleaned with bleach solution and separate cutting boards used for meats and vegetables. Disposable cloths or newly washed cloths should be used to wash dishes and other items and sponges, which can harbor bacteria, avoided.

6.

Contact dermatitis is an example of which type of hypersensitivity reaction?

Type 1.

Type 2.

Type 3.

Type 4.

Explanation:

Contact dermatitis is an example of type 4 hypersensitivity reaction. This type of reaction does not involve antibodies but rather antigens cause T-cells to release cytokines, which lead to inflammation and damage of the tissue from the release enzymes by macrophages. Other examples of type 4 hypersensitivity reactions include poison oak reaction, tuberculin skin test reaction, and graft-vs.-host disease. The reaction is usually delayed for one or two days because of the time needed to mobilize T cells and macrophages.

7.

During a patient's history, the pediatric nurse discovers that the child is allergic to kiwi fruit, bananas, and avocados. These allergies put the child at risk for:

asthma.

latex allergy.

penicillin allergy.

hay fever.

Explanation:

If, during a patient's history, the pediatric nurse discovers that the child is allergic to kiwi fruit, bananas, and avocados, these allergies put the child at risk for latex allergy because the plants are related. Patients (and healthcare providers) who are exposed to latex also risk developing latex allergy. About a third of children who have undergone 3 or more surgeries and about 70% of children with spina bifida develop latex allergy.

8.

When doing a heel prick or blood draw on a young infant, which of the following usually provides the best pain relief?

Non-nutritive sucking with pacifier.

Sucking with pacifier dipped in 24% sucrose.

Caressing the infant.

Holding the infant.

Explanation:

When doing a heel prick or blood draw on a young infant, the best pain relief is likely derived from having the infant suck on a pacifier dipped in 24% sucrose solution. The sucrose is believed to act in the brain in a manner similar to opioids. While non-nutritive sucking alone can provide some comfort for the infant, the addition of sucrose provides better control of pain. The child should be given the pacifier 1 to 2 minutes prior to the procedure. Analgesia last 3-5 minutes.

9.

An 11-year old child with extensive second- and third-degree burns is most at risk for which type of dehydration?

Isotonic.

Hypertonic.

Hypotonic.

Either isotonic or hypertonic.

Explanation:

An 11-year-old child with extensive second- and third-degree burns is most at risk for hypotonic dehydration. This type of dehydration results from excessive loss of sodium in relation to fluid. Hyponatremia occurs, forcing extracellular fluid to shift to intracellular spaces. The sodium level should be checked frequently and electrolytes provided with fluid replacement. Hypotonic dehydration can also occur with severe nausea and vomiting, diarrhea, and kidney disease.

10.

A 12-year-old child on hemodialysis is at risk for hyperkalemia. When developing the patient's plan of care, the pediatric nurse should advise the child to avoid high potassium foods, such as:

asparagus and blueberries.

dried apricots and avocados.

broccoli and cheese.

cucumbers and cabbage.

Explanation:

If a 12-year-old child on hemodialysis is at risk for hyperkalemia, when developing the patient's plan of care, the pediatric nurse should advise that the child avoid foods high in potassium, such as dried apricots and other dried fruits, avocados, salmon, acorn squash, spinach and other greens, white beans, low fat dairy products, white beans, and bananas. Asparagus, blueberries, broccoli, cheese, cucumbers, and cabbage are low in potassium.

11.

The pediatric nurse notes that an alert 3-year-old speaks in a monotone voice, has a limited vocabulary, and follows directions poorly. The pediatric nurse suspects:

hearing deficit.

cognitive impairment.

autism spectrum disorder.

physical abuse.

Explanation:

If the pediatric nurse notes that an alert 3-year-old speaks in a monotone voice, has a limited vocabulary, and follows directions poorly, the pediatric nurse should suspect a hearing deficit. Other behaviors that suggest hearing deficit include, asking repeated questions, answering inappropriately, appearing inattentive, playing alone, and sitting very close to the TV or radio or turning the volume up very high. If hearing deficit is suspected, the child should have hearing tests to identify the cause and treatments.

12.

The Mexican parents of a child hospitalized for pneumonia repeatedly remove certain foods from the child's food trays. The pediatric nurse should:

advise them that the child needs a balanced diet to recover.

arrange for the child to receive more ethnic foods.

ask if the parents prefer the child eat certain foods with illness.

assume the child dislikes these foods.

Explanation:

If the Mexican parents of a child hospitalized for pneumonia repeatedly remove certain foods from the child's food trays, the pediatric nurse should ask if the parents prefer the child eat certain foods with illness. Mexicans traditionally believe that some foods are "hot" (unrelated to temperature) and some are "cold" and that these hot or cold foods should be avoided with certain types of illnesses. A "cold" disorder, such as an upper respiratory infection, is treated with "hot" foods and vice versa.

13.

The genetic disorder that puts the child at risk for developing aortic aneurysm later in life is:

Marfan syndrome.

sickle cell disease.

Gaucher disease.

fragile X syndrome.

Explanation:

The genetic disorder that puts the child at risk for developing aortic aneurysm later in life is Marfan syndrome. Marfan syndrome is an autosomal dominant disorder of the connective tissue characterized by elongated head, long arms and legs, scoliosis, crowded teeth, unusual stretch marks, and cardiac abnormalities, including aortic enlargement, which can result in rupture and sudden death. Some children have evidence of aortic enlargement at birth, but many are not diagnosed until later in life when signs and symptoms become more evident.

14.

A child with a congenital heart defect is at risk for systemic venous congestion. Signs of this complication include:

tachycardia and prolonged capillary refill time.

tachypnea, wheezing, and cough.

pallor and cool extremities.

hepatomegaly, ascites, and peripheral edema.

Explanation:

If a child with congenital heart defect is at risk for systemic venous congestion, the signs of this complication include hepatomegaly, ascites, and peripheral edema. With pulmonary venous congestion, the child has respiratory symptoms, including tachypnea, wheezing, and cough. When cardiac output is restricted, tachycardia, diminished peripheral pulses, hypotension, and prolonged capillary refill time are common. The child may be pale and have cool extremities from inadequate oxygenation.

15.

Genetic testing to determine if the child will develop a disease should be delayed until adulthood if the child is at risk for:

cystic fibrosis.

Marfan syndrome.

fragile X syndrome.

Huntington's disease.

Explanation:

Genetic testing to determine if the child will develop a disease should be delayed until adulthood if the child is at risk for Huntington's disease. If there is treatment or interventions that may cure, slow progress, treat symptoms, or prevent complications of the disease, then early testing serves a purpose. However, there is no treatment at this time for Huntington's disease, so the child should wait until adulthood when the individual can make an informed decision about testing.

16.

The three steps involved in medication reconciliation include:

verification, clarification, and reconciliation.

identification, question, and reconciliation.

identification, exploration, reconciliation.

verification, identification, and reconciliation.

Explanation:

The three steps involved in medication reconciliation include:

- *Verification: Collecting lists of medications or actual medications, including herbal preparations, vitamins, and supplements.*
- *Clarification: Reviewing the medication lists to determine if the medications and dosages are correct and appropriate for the patient's needs.*
- *Reconciliation: Noting medications that should be currently administered and documenting any discrepancies or order changes.*

17.

The 5 rights of medication administration include (1) right patient, (2) right drug, (3) right dose, (4) right route, and (5) right:

time.

reason.

response.

documentation.

Explanation:

The 5 rights of medication administration include (1) right patient, (2) right drug, (3) right dose, (4) right route, and (5) right time. While these rights are a good reminder, some authorities feel that they are inadequate to prevent medication errors and other items should be considered, such as the reason for the medication, the patient response, and the correct documentation.

18.

To effectively use guided imagery and visualization as a relaxation technique to reduce anxiety and pain, the child should generally be:

over 4 years old.

over 6 years old.

over 10 years old.

over 12 years old.

Explanation:

To effectively use guided imagery and visualization as a relaxation technique to reduce anxiety and pain, the child should generally be over 6 years old. Younger children usually have difficulty focusing the attention for a prolonged period. To teach the child, the pediatric nurse should ask the child to imagine a favorite place, such as a park or Disneyland, and try to image the sights, sounds, smells, touches, and feelings and to think about what it's like to be there.

19.

The pediatric nurse applies EMLA cream to the puncture site before a child's chemotherapy treatment. To be effective, the EMLA cream should be applied:

5 to 10 minutes before the procedure.

20 to 30 minutes before the procedure.

30 to 60 minutes before the procedure.

1 to 2 hours before the procedure.

Explanation:

If the pediatric nurse applies EMLA cream (Eutectic Mixture of Local Anesthetics—lidocaine 2.5% and prilocaine 2.5%) to the puncture site before a child's chemotherapy treatment, to be effective, the EMLA cream should be applied at least 1-2 hours before the procedure but reaches peak analgesia after 2-3 hours. The EMLA cream should be applied to the skin and covered by an occlusive dressing, such as plastic wrap.

20.

The best holding position for a young child who must have a nasogastric tube inserted is:

hug-hold.

supine.

bracing.

side sitting.

Explanation:

The best holding position for a young child who must have a nasogastric tube inserted is bracing. The child is held in supine position in the caregiver's arms and braced against the chest or shoulder to prevent movement of the head. This is also a good position for or examination or treatment of the mouth or other parts of face. It's less frightening for the child if a caregiver, such as a parent, holds the child rather than a healthcare provider.

21.

The pediatric nurse should advise parents to secure children in rear-facing car seats until at least age:

12 months.

18 months.

2 years.

3 years.

Explanation:

While state laws vary somewhat, generally the pediatric nurse should advise parents to secure children in rear-facing car seats until at least age 2 years, or to the maximum weight specified by the manufacturer. Children in rear-facing seats are likely to experience less severe injuries in a motor vehicle crash. Once the child outgrows the car seat, the child should be secured in a booster seat until at least age 6 or according to state laws regarding age and weight/size.

22.

If a 3-year-old child persists in scratching a rash until the skin bleeds, the type of restraint that is most indicated is:

mitten restraint.

elbow restraint.

mummy restraint.

extremity restraint.

Explanation:

If a 3-year-old child persists in scratching a rash until the skin bleeds, the type of restraint that is most indicated is a mitten restraint. If the child needs some use of the hands or is able to remove the mittens, then an elbow restraint may help to minimize scratching although the child still has access to parts of the body. Restraints should be checked at least every hour and the least restrictive restraint used.

23.

The defense mechanism that a 9-year-old child is utilizing when the child insists that she has no memory of abuse despite evidence of numerous fractures and bruises is:

regression.

repression.

rationalization.

fantasy.

Explanation:

The defense mechanism that a 9-year-old child is utilizing when the child insists that she has no memory of abuse despite evidence of numerous fractures and bruises is repression, which involves involuntary forgetting. Children may repress memories or emotions that are too painful for them to handle. Children also often regress to an earlier behavioral norm, rationalize feelings or events, or create a fantasy to deal with fear and apprehension.

24.

When administering the Denver II assessment of the child's ability to follow an item with the eyes to and past midline, the pediatric nurse should hold and move a piece of yarn:

4 inches above the child's face.

8 inches above the child's face.

12 inches above the child's face.

18 inches above the child's face.

Explanation:

The Denver Developmental Screening Test II (Denver II) is used for infants from 0 to 6 years to test language, gross motor skills, personal/social abilities, and fine motor/adaptive skills. As part of fine motor/adaptive skills, the pediatric nurse tests the child's ability to follow the movement of a piece of yarn with the eyes. The yarn is held 8 inches above the child's face and moved in a 180-degree arc. The child should be able to follow the full arc at about 2.5 to 5 months.

25.

When examining an infant's ears, the pediatric nurse notes that the tympanic membranes appear amber. This likely indicates:

normal finding.

infection.

blood (middle ear).

serous fluid (middle ear).

Explanation:

If when examining an infant's ears, the pediatric nurse notes that the tympanic membranes appear amber, this likely indicates serous fluid in the middle ear. The tympanic membrane is red with an infection although if the child is crying, the tympanic membrane may appear slightly red. If there is blood present in the middle ear, the tympanic membrane may appear to be a deep reddish-purple or blue color.

26.

When assessing the growth and development of an 18-month-old child, the pediatric nurse finds that the chest circumference is greater than the head circumference. This indicates:

normal finding.

abnormal brain development.

respiratory disorder.

skeletal abnormality.

Explanation:

If when assessing the growth and development of an 18-month-old child, the pediatric nurse finds that the chest circumference is greater than the head circumference, this indicates a normal finding. Usually these circumferences are relatively equal for the first 12 months of life and then the chest circumference becomes greater than the head circumference.

27.

Which of the following findings in a 7-year-old African American girl may be an indication of premature pubertal development?

Breast budding.

Sparse, light pubic hair along the labia.

Slight enlargement of the areola.

Growth of 2 inches in past year.

Explanation:

An indication of premature pubertal development in a 7-year-old African American girl may be sparse, light pubic hair along the labia. Girls usually don't begin to exhibit pubic hair before age 8. However, breast budding with slight enlargement of the areola may begin as early as 6 years for African American girls and 7 years for Caucasians (most common between 9 and 14 years). Normal growth for children is about 2.5 inches each year until they reach puberty.

28.

A child is stung by a bee and develops severe facial edema, dyspnea, and hypotension, indicating anaphylaxis. The treatment that is most critical is:

diphenhydramine.

epinephrine.

prednisone.

oxygen.

Explanation:

If a child is stung by a bee and develops severe facial edema, dyspnea, and hypotension, indicating anaphylaxis, the treatment that is most critical is epinephrine because it reverses the vasodilation and constriction of the airway. In addition to epinephrine, diphenhydramine, and antihistamine, as well as steroids, such as prednisone, may be administered. Prompt fluid resuscitation is also necessary to reverse hypotension. Oxygen may be administered to relieve dyspnea.

29.

A 5-year-old child develops severe diarrhea during an outbreak of O157:H7 *Escherichia coli* infections and progresses to hemolytic uremic syndrome (HUS). Which of the following treatments is generally contraindicated?

IV fluids.

ACE inhibitors.

Antibiotics.

Blood transfusions.

Explanation:

Antibiotics are contraindicated with infections caused by Escherichia coli because they may cause an increase in the release of toxins. They are reserved for use if the child develops sepsis. In some cases, blood transfusions may be needed. IV fluids and electrolytes are essential treatments. With HUS, plasmapheresis may be used to remove antibodies, protein limited to spare kidney, and ACE inhibitors given to prevent permanent damage to the kidneys.

30.

Because of frequent co-morbidity, children with Down syndrome (trisomy 21) should be screened for:

celiac disease.

lactose intolerance.

diabetes.

Crohn's disease.

Explanation:

Because of frequent co-morbidity (up to 13%), children with Down syndrome (trisomy 21) should be screened for celiac disease, a gluten-sensitive enteropathy that results in chronic malabsorption because of damage to the villi from toxins released as a reaction to gluten-containing grains (wheat, barley, rye, oats). Symptoms include chronic diarrhea, abdominal discomfort, and failure to thrive. Treatment is primarily through diet control, eliminating gluten.

31.

A 14-year-old male patient has had recurrent tinea pedis (athlete's foot) despite treatments. The pediatric nurse should advise the patient to:

wear only sandals.

wear 100% cotton socks.

wash and dry feet 3 to 4 times daily.

soak feet in vinegar solution daily.

Explanation:

If a 14-year-old male patient has had recurrent tinea pedis (athlete's foot) despite treatments, the pediatric nurse should advise the patient to wear 100% cotton socks and to change them twice daily. The patient should try to keep the feet clean and dry and can apply talcum powder

to help absorb moisture. Wearing sandals may help by keeping the feet cool but isn't always practical, such as during the winter or sports activities.

32.

A 9-year-old child is receiving enteral feedings but has developed diarrhea. An appropriate initial intervention is:

increase sodium in formula.

elevate head of bed during feedings.

increase rate of feedings.

slow rate of feedings.

Explanation:

If a 9-year-old child is receiving enteral feedings but has developed diarrhea, an appropriate initial intervention is to slow the rate of feeding or use a continuous drip. Medications should be evaluated to determine if they may be causing the diarrhea, and decreasing sodium and increasing fiber in formula may be indicated. The tubing should be changed at least every 24 hours to prevent bacterial growth and feedings should not be hung for more than 4 hours.

33.

The most significant risk factor for the development of diabetes mellitus, type 2, in children is:

family history.

obesity.

immobility.

malnutrition.

Explanation:

The most significant risk factor for the development of diabetes mellitus, type 2, in children is obesity, which may be related to diets high in simple carbohydrates and fats and lack of adequate exercise. Diabetes mellitus, type 2, may be diagnosed as early as 4 years but is most commonly diagnosed during puberty, increasing risk for developing hypertension. Generally, diet and exercise interventions need to be aimed at the entire family rather than just the child.

34.

When preparing a 16-year-old patient for a renal ultrasound, preparation includes:

drinking two 8-ounce glasses of water an hour before the ultrasound.

remaining NPO for 6 hours before the ultrasound.

emptying the bladder immediately before the ultrasound.

emptying the bladder 1 hour before the ultrasound.

Explanation:

When preparing a 16-year-old patient for a renal ultrasound, preparation includes drinking two 8-ounce glasses of water an hour before the ultrasound to ensure that the bladder is full. Ultrasound can show fluid accumulation, the movement of blood through the kidney, masses,

malformations (congenital abnormalities), change in size of the kidney or other structures, and obstructions, such as renal calculi. The ultrasound is usually done with the patient lying in supine position or turned to the side.

35.

The typical manifestations of roseola include:

acute low-grade fever, diarrhea, and vomiting.

acute high fever, conjunctivitis, cough, anorexia, and malaise.

acute low-grade fever, headache, sore throat, anorexia, and maculopapular rash.

acute high fever for 3 to 8 days followed by maculopapular rash for 1-2 days.

Explanation:

The typical manifestations of roseola include acute high fever to 40.5° C (105° F) lasting 3 to 8 days and followed by a maculopapular rash (pink) lasting for 1-2 days. The child usually retains a good appetite and generally feels fairly well and behaves normally, but some children may develop febrile seizures, so measure should be taken (acetaminophen, lukewarm baths) to reduce high fevers. Complications, such as encephalopathy, are rare but may occur.

36.

When a child is utilizing patient-controlled analgesia (PCA), the limit (total dosage that can be delivered in a set time) is usually set at:

12 hours.

8 hours.

6 hours.

4 hours.

Explanation:

When a child is utilizing patient-controlled analgesia (PCA), the limit (total dosage that can be delivered in a set duration of time) is usually set at 4 hours. The PCA must be reset every 4 hours to ensure that the patient's use of medication is monitored, to avoid the chance of overdose, and to respond to changes in condition and changing need for medication. The lockout interval is the time required between dosages. The PCA may deliver boluses or continuous infusion.

37.

A parent states that his 6-year-old son seems tired much of the time but gets a full 7 to 8 hours of sleep at night. The most appropriate response is:

"Your child is getting enough sleep for a child this age."

"Your child needs 10 to 11 hours of sleep at this age."

"Your child needs 8 to 9 hours of sleep at this age."

"You should encourage your child to take short naps."

Explanation:

If a parent states that his 6-year-old son seems tired much of the time but gets a full 7 to 8 hours of sleep at night, the most appropriate response is: "Your child needs 10 to 11 hours of sleep at this age." Many children stay up too late or have irregular bedtimes and fail to get enough sleep, and this can interfere with their general health and their academic ability.

38.

For adolescents treated with isotretinoin (Accutane®) for severe acne, the iPledge program requires that the patient:

have had a negative pregnancy test within 2 months.

agree to abstain from all sexual activity.

agree to use two forms of birth control.

avoid taking vitamin supplements that contain vitamin D.

Explanation:

For adolescents treated with isotretinoin (Accutane®), which contains a form of vitamin A and is severely teratogenic, for severe acne, the iPledge program requires that the patient agree to use two forms of birth control during treatment. The primary form (usually birth control pills) must begin 30 days prior to beginning treatment and continue for 30 days after termination. The patient must have a negative pregnancy test 30 days before beginning therapy. The patient must also have a negative pregnancy test before each medication refill.

39.

If 3-year-old child has become infested with head lice, the recommended treatment is:

permethrin 1%.

lindane 1%.

isopropyl alcohol.

olive oil.

Explanation:

If a 3-year-old child has become infested with head lice, the recommended treatment is permethrin 1% rinse, which is applied to the hair and left in place for 10 minutes. The hair is then combed to remove nits and the treatment repeated in 7 to 10 days because it does not effectively kill nits. Lindane should be avoided in infants and young children because it can be absorbed and can have neurotoxic effects. Olive oil, alcohol, and other home remedies are generally ineffective.

40.

If a 10-year-old child experiences an asthma attack, the initial medication for quick relief should be a:

corticosteroid (budesonide).

anticholinergic (ipratropium).

long-acting beta2-agonist (salmeterol).

short-acting beta2-agonist (albuterol).

Explanation:

If a 10-year-old child experiences an asthma attack, the initial medication for quick relief should be a short-acting beta2-agonist, such as albuterol, levalbuterol, or pirbuterol. The child should experience relief within 5 to 10 minutes. If the child does not achieve symptom control, a low-dose inhaled corticosteroid may be given 15 minutes after the short-acting beta2-agonist. Children with persistent asthma should also be on maintenance medications to prevent exacerbations.

41.

A 12-year-old patient tells the pediatric nurse: "I think I'm gay." The most appropriate response is:

"You have reason to think you're gay?"

"Why do you think you're gay?"

"You're probably too young to know if you're gay."

"Have you told your parents?"

Explanation:

If a 12-year-old patient tells the pediatric nurse, "I think I'm gay," the most appropriate response is to reflect back what the child has said and let the child guide the conversation: "You have reason to think you're gay?" The pediatric nurse should avoid probing questions, such as "Why do you think you're gay" and allow the child to determine what to disclose and should avoid making any type of judgmental statement or telling the child to talk to the parents.

42.

The laboratory results of a child with kidney disease are likely to include:

elevated BUN and creatinine.

hypokalemia and albuminuria.

hypocalcemia and hypophosphatemia.

polycythemia and thrombocytosis.

Explanation:

The laboratory results of a child with kidney disease are likely to include elevated BUN and elevated creatinine. Other findings may include hyperkalemia and hyperphosphatemia. Calcium levels may be low, and the child's hemoglobin may fall, resulting in anemia. The child is at risk for marked metabolic acidosis, hyperparathyroidism, and volume overload. As the child's condition worsens, the child will need renal replacement therapy or kidney transplantation.

43.

After an outbreak of norovirus-associated diarrhea in the pediatric unit, the virus may remain viable on environmental surfaces, such as upholstered furniture, for up to:

48 hours.

3 days.

7 days.

12 days.

Explanation:

After an outbreak of norovirus-associated diarrhea, the virus may remain viable on environmental surfaces for up to 12 days. Infection may occur is proper hand washing

procedures are not followed, especially when changing infants' diapers. Hands should be washed with soap and water rather than simply with alcohol-based rubs. Environmental surfaces should be thoroughly cleaned with bleach solution and carpeting and upholstered materials steam-cleaned.

44.

Infants with moderately severe congenital heart defects should:

be encouraged to cry lustily.

avoid crying for prolonged periods.

tolerate crying with no problem.

never be allowed to cry for more than 30 seconds.

Explanation:

Infants with moderately severe congenital heart defects should avoid crying for prolonged periods because this may result in cyanosis and hypoxemia. Infants can usually tolerate a few minutes of normal crying but should be comforted and needs attended to as quickly as possible. Non-nutritive sucking, such as with a pacifier, may help to calm a fussy infant. Rocking the infant, singing to the infant, or holding the infant with skin-to-skin contact may also help to calm the infant.

45.

When educating families about gun safety, the most important rule to stress is to:

educate the child about gun safety.

teach the child to shoot and handle guns.

warn the child not to touch guns or ammunition.

place the gun and ammunition in locked, secure containers.

Explanation:

While it's important to teach children about gun safety and to warn them not to touch guns or ammunition, these alone are not sufficient to keep children safe. Young children, especially, may believe guns are toys. All guns and ammunition should be placed in secure, locked containers/cabinets that the children cannot access. Securing guns and ammunition in separate containers/cabinets provides an extra measure of safety.

46.

If a mother carries a gene for an X-linked recessive disorder, such as Duchenne muscular dystrophy, those at risk of developing the disorder include:

all sons.

all daughters.

half of sons.

half of daughters.

Explanation:

If a mother carries a gene for an X-linked recessive disorder, such as Duchenne muscular dystrophy, those at risk of developing the disorder include half of sons. Because females inherit

two X chromosomes, the normal one compensates and the female may become a carrier. However, since males only inherit an X chromosome from the mother, the presence of the gene causes disease in the male. Half of female children are at risk for being carriers. A male child with the disease does not pass on the defective gene.

47.

A 4-year-old child with Kawasaki disease is treated with IVIG to reduce the risk of coronary artery aneurysm. The child's high fever and discomfort is treated with:

high dose aspirin.

acetaminophen.

ibuprofen.

alternating acetaminophen and ibuprofen.

Explanation:

While aspirin is usually avoided in small children because of the risk of Reye's syndrome with viral infections, high doses of aspirin are used to control high fever and discomfort in children with Kawasaki disease. The usual dose is 80 to 100 mg/kg/day administered in 4 divided doses. This is reduced to a lower dose after the child remains afebrile for 2 to 3 days. Kawasaki disease is likely caused by an unknown infectious agent that causes a severe immune response.

48.

A child with long QT syndrome is at increased risk of:

atrial fibrillation.

ventricular fibrillation.

heart block.

premature ventricular contractions.

Explanation:

A child with long QT syndrome, which includes ventricular tachycardia, is at increased risk of ventricular fibrillation. Long QT syndrome is an inherited condition that can result in sudden death. Instances of dysrhythmias may be triggered by various factors, including hypokalemia, strenuous exercise, and emotional reaction, depending on the genetic form of the disorder. Some children are most at risk during sleep. Treatment includes beta blockers and, in some cases, an ICD.

49.

An adolescent with type 1 diabetes mellitus is pale, sweating and irritable and has tremors and difficulty speaking clearly. The pediatric nurse's initial response should be to:

administer 15 grams of oral carbohydrate.

administer glucagon parenterally.

administer insulin according to correction scale.

administer additional dose of insulin at regular dosage.

Explanation:

If an adolescent with type 1 diabetes mellitus is pale, sweating, and irritable and has tremors and difficulty speaking, these are indications of hypoglycemia. Since the adolescent is still conscious, the initial response should be to administer 15 grams of oral carbohydrate. If the medicinal form is not available, one-half cup of fruit juice or regular soda (such as cola) can be substituted. If the blood glucose level remains ≤ 70 mg/dL and symptoms persist, a repeat dose of carbohydrate should be given.

50.

A 5-year-old child recovering from cardiac surgery is convinced that the cardiac monitor is what is causing her to have chest pain. The type of preoperational thought that this represents is:

egocentrism.

animism.

transductive reasoning.

centration.

Explanation:

If a 5-year-old child recovering from cardiac surgery is convinced that the cardiac monitor is what is causing her to have chest pain, the type of preoperational thought (common to preschoolers ages 3 to 6) that this represents is transductive reasoning. The child is assuming a cause-and-effect relationship exists between the cardiac monitor and the pain because they are both occurring simultaneously. The pediatric nurse should not assume that young children understand circumstances and should provide information in age-appropriate terms.

51.

When assessing a 3-year-old, the pediatric nurse should anticipate a cardiac rate range of:

100 to 170.

80 to 130.

70 to 120

60 to 100.

Explanation:

The normal cardiac rate tends to slow as the child ages. A normal cardiac rate range in neonates is 100 to 170 (average 120); up to 2 years, 80 to 130 (average 110), and 2 to 6 years, 70 to 120 (average 100). Between ages 6 and 10 years, the normal cardiac rate range is 70 to 110 (average 90), dropping to 60 to 100 (average 85) after age 10, approximating the adult cardiac rate range. The cardiac rate should be assessed with the child at rest because it may be elevated if the child is crying or stressed.

52.

When auscultating a child's abdomen to assess bowel sounds, the pediatric nurse would expect bowel sounds to occur:

constantly.

every 30 to 40 seconds.

every 3 to 4 seconds.

every 10 to 30 seconds.

Explanation:

When auscultating a child's abdomen to assess bowel sounds, the pediatric nurse would expect bowel sounds to occur every 10 to 30 seconds; however, they should not be considered absent until each quadrant has been assessed for 5 minutes. Normal bowel sounds are relatively high-pitched and metallic sounding although, if the child is hungry, borborygmi (very loud gurgling) sounds may be heard. It's important to assess for bowel sounds before palpating the abdomen, which may stimulate hyperactive sounds.

53.

The pediatric nurse participates in a health fair at a local high school with a high percentage of African American students and takes students' vital signs, screening for hypertension. This is an example of:

primary prevention.

secondary prevention.

tertiary prevention.

quaternary prevention.

Explanation:

If the pediatric nurse participates in a health fair at a local high school with a high percentage of African American students and takes students' vital signs, screening for hypertension, this is an example of secondary prevention. Primary prevention aims to prevent disease and may include diet counseling and exercise. Secondary prevention aims to identify current disease in order to treat or prevent recurrence. Tertiary prevention aims to manage existing disease in order to prevent deterioration or worsening of the condition, such as through rehabilitation programs.

54.

If the family meets eligibility requirements for the WIC (Nutrition for Women, Infants, and Children) program, the child may participate in the nutritional program until age:

1 year.

3 years.

5 years.

7 years.

Explanation:

If the family meets eligibility requirements for the WIC (Nutrition for Women, Infants, and Children) program, the child may participate in the nutritional program until age 5. WIC provides nutrition education, vouchers for healthy foods, and referrals to other health services for infant (0-1 year), children (1-5 years), and qualifying women who are pregnant, breastfeeding, or recently had a child. A woman can stay on the WIC program for 6 months if bottle feeding and one year if breastfeeding.

55.

Which of the following is a milestone in gross motor abilities for a 9-month old child?

rolling over.

climbing on furniture.

crawling.

pulling self to standing.

Explanation:

Pulling self to standing position is a milestone in gross motor abilities for a 9-month-old. Infants usually are able to roll over by 4 months and sit without support by 6 to 8 months. Most infants are able to crawl by 20 months and walk alone by around 12 months. Children gain the strength and dexterity to climb onto furniture by about 2 years and are also able to walk up and down stairs.

56.

At about what age does the pediatric nurse expect a child's anterior fontanel to close?

2 to 3 months.

6 to 8 months.

8 to 12 months.

to 18 months.

Explanation:

The anterior fontanel usually closes between 12 and 18 months. Prior to this time, the fontanel can be used to help assess hydration status (depressed or bulging) and increased intracranial pressure (bulging). The posterior fontanel is smaller and closes earlier, between 2 and 3 months. The normal open fontanel feels soft but firm and is slightly concave. Sunken or bulging fontanels (usually just the anterior fontanel) is always cause for concern.

57.

A 10-year-old child is scheduled for a thoracentesis. The pediatric nurse should position the child:

with head of bed elevated to 30-45° and torso rotated to the side.

lying prone in bed with pillow under lower legs.

sitting on the side of the bed and supported by the nurse.

leaning forward in a chair onto a tray table.

Explanation:

If a 10-year-old child is scheduled for a thoracentesis, the pediatric nurse should position the child with the head of bed elevated to 30 to 45 degrees and the torso twisted to the side, exposing the affected area. The child may be given a sedative prior to the procedure. The pediatric nurse should explain the procedure in age-appropriate terms to the child and should encourage the parents to remain with the child during the procedure.

58.

When educating parents about child safety, the pediatric nurse should note that the slats of cribs should be no further apart than:

6 cm.

8 cm.

10 cm.

12 cm.

Explanation:

When educating parents about child safety, the pediatric nurse should note that the slats of cribs should be no further apart than 6 cm (2 and 3/8 inches). Newer cribs are built to these specifications but many parents use hand-me-down cribs, and these older cribs may not be built to current safety standards. If the slats are further apart, the child's head may become entrapped and result in the child strangling. The mattress should also fit snugly to the sides of the crib.

59.

A 7-year-old male patient has begun experiencing night terrors and cries out during the night and often appears awake but disoriented but has no memory the next day. The most appropriate response for the parent is to:

attempt to awaken the child in order to stop the night terrors.

take the child into the parent's bed to provide comfort.

comfort the child by speaking softly until the child falls back asleep.

discuss giving the child a sedative with the physician.

Explanation:

If a 7-year-old male patient experiences night terrors and cries out during the nights, and often appears awake but disoriented but has no memory the next day, the most appropriate response for the parent is to comfort the child by speaking softly until the child falls back asleep. Sleep terrors are not uncommon in children age 3 and older but usually stop at puberty (although they may recur in early adulthood). Night terrors are sometimes associated with seizure disorders, so the child should be evaluated.

60.

The primary purpose of risk management is to:

decrease liability, financial loss, and harm to patients.

determine risk factors for disease.

reduce injuries to staff members and patients.

educate staff about avoiding negligence.

Explanation:

The primary purpose of risk management is to decrease liability, financial loss, and harm to patients. Risk management works to decrease costs because of changes in insurance reimbursement and also works to improve the overall quality of care to decrease liability related to harm to patients. Risk management assesses an organization for risk exposure and institutes corrective measures that must be monitored in an ongoing process and modified as needed.

61.

Which of the following is an intervention that is indicated to help achieve the Healthy People 2030 objective of increasing “the proportion of children who do enough aerobic physical activity?”

Telling children to exercise more.

Giving children candy only after they exercise.

Providing a more nutritious diet.

Limiting television and computer usage.

Explanation:

An intervention that is indicated to help achieve the Healthy People 2030 objective of increasing “the proportion of children who do enough aerobic physical activity” is limiting television and computer usage. Children often sit for hours in front of television and computer screens rather than engaging in more active play. Telling children to exercise more alone is rarely successful unless the child has an incentive. However, offering candy in return for exercise, increases the risk of obesity, which is one of the reasons to increase physical activity.

62.

A parent calls the pediatric nurse on the telehealth line and states that his 7-year-old child has a severe sore throat that has persisted for 4 days and white patches are evident in the back of the throat. The pediatric nurse should advise the parent to:

call 9-1-1.

make a same-day appointment for examination.

take the child to an emergency department as soon as possible.

make an appointment for 24 to 48 hours.

Explanation:

If a parent calls the pediatric nurse on the telehealth line and states that his 7-year-old child has a severe sore throat that has persisted for 4 days and white patches are evident in the back of the throat, the pediatric nurse should advise the parent to make a same-day appointment for an examination because, while this is not an emergent situation, the child may need to begin antibiotics for treatment of a Strep throat.

63.

A child whose visions appeared normal in the neonatal period should have the next routine vision screening at:

1 to 2 years.

2 to 3 years.

3 to 4 years.

5 to 6 years.

Explanation:

A child whose vision appeared normal in the neonatal period should have the next routine vision screening at 3 to 4 years unless the parents/caregivers have reason to believe that the child's vision is impaired, such as the inability of a child to recognize pictures in a book. Between ages 3 and 4, children are better able to cooperate with testing, and vision deficit may become more obvious as the child becomes more active and interacts more with others.

64.

The primary purpose of providing parents with a password to use when they telephone the pediatric unit for information about their child is to:

reassure parents that their child is safe.

reduce the number of calls.

save time when answering calls.

comply with HIPAA regulations.

Explanation:

The primary purpose of providing parents with a password to use when they telephone the pediatric unit for information about their child is to comply with HIPAA regulations. Patient information must remain confidential and can only be provided to those with a legal right to the information, such as parents of a child. Because it can be difficult to verify identity over the telephone, providing a password adds a layer of security.

65.

A parent brings a 6-year-old child to the emergency department with a spiral fracture of the forearm and numerous scattered bruises in various stages of healing. The child states that his adolescent brother pulled his arm and hit him, but the parent insists that the child fell and is prone to lying. The pediatric nurse should:

notify child protective services.

believe the parent.

refer the parent to a counseling service.

inform the parent that she is lying, not the child.

Explanation:

If a parent brings a 6-year-old child to the emergency department with a spiral fracture of the forearm and numerous scattered bruises in various stages of healing and the child states that his adolescent brother pulled his arm and hit him, but the parent insists that the child fell and is prone to lying, the pediatric nurse should notify child protective services because a nurse is a mandatory reporter and these injuries are consistent with abuse. The nurse should not directly confront the parent.

66.

An infant or young child is usually first classified as failure to thrive if the child's:

weight is $\leq 5\%$ of normal.

height is $\leq 5\%$ of normal.

weight is $\leq 10\%$ of normal.

weight is $\leq 15\%$ of normal.

Explanation:

An infant or young child is usually first classified as failure to thrive if the child's weight is $\leq 5\%$ of normal. Height may also sometimes be considered because chronic malnutrition, for example, may stunt a child's growth. Failure to thrive may result from physical causes (such as renal disease), psychosocial factors (such as poverty or neglect), or idiopathic causes.

67.

A necessary element of informed consent for parents and children includes:

costs of treatment.

list of all follow-up treatments.

risks and benefits of treatments.

long-term prognosis.

Explanation:

A necessary element of informed consent for parents and children includes a discussion of the risk and benefits of both having treatment and not having treatment as well as alternative options (regardless of cost or insurance coverage) for treatment and their risks and benefits. Informed consent should also include an explanation of the diagnosis and the nature of treatment or procedure and the reason it is recommended. All 50 states require informed consent.

68.

Assessing a child for scoliosis should be done by observing the child from the:

back only, standing and bent at the waist 60°.

back, front, and side, standing and bent at the waist 90°.

front and back, standing and bent at the waist 60°.

back and side, bent at the waist 90°.

Explanation:

Children should be screened for scoliosis before their growth spurt is completed, usually during grades 5 to 10. The child should be examined at a distance of 5 to 8 feet from the front, back, and side with the child first standing upright and then bent over at the waist 90 degrees. Scoliosis is more responsive to conservative treatment, such as exercises and braces, if identified before growth is completed. A positive finding should be confirmed by a second screening.

69.

The disciplinary approach that parents use if they discuss problem behavior and explain why it's inappropriate is:

behavior modification.

reasoning.

scolding.

consequences.

Explanation:

Reasoning is the disciplinary approach that parents use if they discuss problem behavior and explain why it's inappropriate. Behavior modification involves the use of positive reinforcement for good behavior while ignoring bad behavior. Consequences involves specific consequences for inappropriate behavior (such as losing computer privileges). Scolding and corporal punishment are negative approaches to discipline. Time out is a form of consequences in which children have to be away from activities for a specified period of time.

70.

The deaf parents of a deaf infant have decided not to have cochlear implants for the child but to raise the child in the deaf community with sign language. The pediatric nurse should:

remain supportive of the parents' decision.

remind the parents of the advantage of cochlear implants.

encourage the parents to reconsider.

tell the parents they have a right to make the decision.

Explanation:

If the deaf parents of a deaf infant have decided not to have cochlear implants for the child but to raise the child in the deaf community with sign language, the pediatric nurse should remain supportive of the parents' decision. There remains controversy in the deaf community about cochlear implants, and deaf parents may not be able to provide the vocal stimulation that the child needs to have, and they may identify strongly with the deaf community.

71.

The pediatric nurse notes a 2-year-old patient trying to climb over the side rails of his crib in the pediatric unit. The pediatric nurse should recommend:

placing the child in an adult hospital bed.

placing restraints on the child.

having a fulltime attendant with the child.

placing a dome on the crib.

Explanation:

If the pediatric nurse notes a 2-year-old patient trying to climb over the side rails of his crib in the pediatric unit, the pediatric nurse should recommend placing a dome on the crib. The domes allow the child to stand and allows access to the child, but the dome prevents the child

from climbing over the side rails. Climbing is common behavior for a 2-year-old and should always be anticipated as part of fall prevention.

72.

A parent who shows considerable warmth and affection for her child but provides little guidance and imposes few limits on the child is exhibiting what type of parenting?

Indifferent.

Authoritarian.

Permissive.

Authoritative.

Explanation:

A permissive parent shows considerable warmth and affection for the child and communicates well with the child but provides little guidance and imposes few limits. The freedom this allows the child often results in children who are creative and extroverted but don't necessarily play well with others. The child may become impulsive and have difficulty in social relationships. Because the child's negative behavior was not corrected, the child may become aggressive and bully others.

73.

The pediatric nurse is a member of the shared governance council and proposes changes in current policies and procedures to ensure they are current and evidence-based. The pediatric nurse is serving in the role of:

change agent.

administrator.

mentor.

clinical content expert.

Explanation:

If the pediatric nurse is a member of the shared governance council and proposes changes in current policies and procedures to ensure they are current and evidence-based, the pediatric nurse is serving in the role of change agent. A change agent is aware of the need for change and takes steps to convince others of the need and to implement changes.

74.

A one-month-old infant has an apnea monitor because of persistent periods of apnea. If the alarm sounds, indicating apnea, for what period of time should the pediatric nurse attempt to stimulate the child to breathe prior to beginning CPR?

1-2 seconds.

10-15 seconds.

20-30 seconds.

30-60 seconds.

Explanation:

If a one-month-old infant has an apnea monitor because of persistent periods of apnea and the alarm sounds, indicating apnea, the pediatric nurse should attempt to stimulate the child to

breath for 10 to 15 seconds prior to beginning CPR. Stimulating the child by rubbing the child's back or flicking the soles of the feet is often successful in reestablishing breathing for infants with periods of apnea although the child must be carefully monitored.

75.

A 6-year-old has a pacemaker in place. Indications of mild pacemaker syndrome include:

fever.

discomfort at implantation site.

agitation, jumpiness.

pulsation in neck and abdomen.

Explanation:

Indications of mild pacemaker syndrome include:

- *Pulsations in neck and abdomen.*
- *Cardiac palpitations.*
- *Headache and feeling of anxiety.*
- *General malaise and unexplained weakness.*
- *Pain or "fullness" in jaw, chest.*

With pacemaker syndrome, synchronicity between atrial and ventricular contractions is impaired, resulting in decreased cardiac output and increased peripheral vascular resistance.

76.

A 16-year-old patient experienced a fractured nose while playing football. The pediatric nurse notes clear fluid draining from the nostrils. The initial response should be to:

apply pressure to the nostrils.

place the patient flat in supine position.

elevate the patient's head.

administer IV fluids.

Explanation:

If a 16-year-old patient experienced a fractured nose while playing football and the pediatric nurse notes clear fluid draining from the nostrils, the initial response should be to elevate the patient's head. Cerebrospinal fluid may drain from the nostrils with a nasal fracture and is usually treated conservatively and will seal spontaneously. The patient should be kept on bedrest and should avoid straining until healed.

77.

The pediatric assessment triangle (PAT) consists of:

appearance, breathing, and circulation.

physical, social, and emotional.

heart, lungs, and mental status.

intake and output, vital signs, and level of consciousness.

Explanation:

The pediatric assessment triangle (PAT) consists of:

- *Appearance: Tone, ability to interact, response to stimuli, gaze, general appearance.*
- *Breathing: Respiratory status, dyspnea, abnormal breath sounds, nasal flaring, sternal retraction, positioning.*
- *Circulation: Skin color (normal and abnormal), cyanosis, vital signs.*

PAT is used to gain an initial general impression of a child's condition. Each element is evaluated as normal or abnormal with any abnormal findings requiring further assessment.

78.

A 15-year-old girl who reports being sexually active with her 15-year-old boyfriend. The pediatric nurse should:

notify child protective services.

inform the parents.

provide information about safe sex and contraception.

advise the girl to practice abstinence.

Explanation:

Although the patient is younger than the age of consent, her boyfriend is near her age, so their sexual relationship is generally not considered statutory rape. Once an adolescent becomes sexually active, the adolescent usually does not become abstinent again, so the most appropriate response is for the pediatric nurse to provide information about safe sex and contraception. The pediatric nurse should remain nonjudgmental but should assess the girl for physical, sexual and/or emotional abuse and STDs.

79.

On a pediatric unit, the responsibility for quality improvement lies with:

team leaders.

supervisor.

administration.

all staff.

Explanation:

On a pediatric unit, the responsibility for quality improvement lies with all staff. Every staff member should not only look for opportunities for quality improvement but should actively support quality improvement initiatives. Quality improvement efforts don't always have to apply to the entire organization but can improve workflow or outcomes in one area. Utilizing the Plan-Do-Check-Act (PDCA) method is especially well-suited for solving specific problems, such as on a unit.

80.

Which of the following is a boundary violation?

Spending private time researching treatments.

Sitting with a patient on days off to give parents a break.

Accepting a box of chocolates intended for the entire staff.

Donating toys to the pediatric unit.

Explanation:

Sitting with a patient on days off to give parents a break is a boundary violation. The pediatric nurse is establishing a friendship relationship outside of the professional role, and this can set up expectations that the nurse may not be able to fulfill. Researching and donating toys for the unit rather than just a favorite child is not a boundary violation. Unless specifically prohibited by policy, accepting a box of chocolates intended for the entire staff is usually all right.

81.

In order to motivate an adolescent patient to be adherent to treatment, the most effective strategy is to:

ensure parents supervise treatment.

explain the necessity of adherence.

explain the health effects of nonadherence.

engage the patient in the plan of care.

Explanation:

In order to motivate an adolescent patient to be adherent to treatment, the most effective strategy is to engage the patient in the plan of care. The patient should be given as much choice in how the treatment plan is to be carried out as possible because independence and control are important to adolescents. The pediatric nurse should listen carefully to the concerns of the patient and remain supportive, always showing respect.

82.

A conflict among two team members on the pediatric unit has made working together difficult and impacted the entire team. The first step in resolving this conflict is to:

warn the team members to resolve the issue.

allow both sides to describe their perceptions of the conflict.

assign one team member to a different team.

explain the effect the conflict is having on the other team members.

Explanation:

If a conflict among two team members on the pediatric unit has made working together difficult and impacted the entire team, the first step in resolving this conflict is to allow both sides to express their perceptions of the conflict without passing judgment. Then, the pediatric nurse should try to help them to reach resolution through negotiation and compromise although it's best not to try to force resolution because both parties may become resentful and more upset.

83.

The pediatric unit has moved toward family-centered care. When working with a family, the first step to family-centered care is to:

create a family genogram.

educate the family regarding family-centered care.

carry out a comprehensive family assessment.

discuss cost savings associated with family-centered care.

Explanation:

If the pediatric unit has moved toward family-centered care, when working with a family, the first step should be to carry out a comprehensive family assessment. It's necessary to understand the family structure, the availability of extended family, the socio-economic status, and the culture and ethnicity as well as attitudes the family have and the degree of health literacy. The family is considered an equal voice in providing care for the child and must be involved in all aspects of the plan of care.

84.

The pediatric nurse notes that a 6-year-old child has used a red pen to draw cuts and bruises on her doll. The best response is:

"Why did you draw on your doll?"

"You shouldn't draw on your doll."

"You must be very upset."

"I see your doll has been hurt."

Explanation:

If the pediatric nurse notes that a 6-year-old child has used a red pen to draw cuts and bruises on her doll, the best response is: "I see your doll has been hurt." This is a reflective statement of what the nurse is observing without judgment and allows the child to respond however the child wants. The pediatric nurse should avoid asking the child directly about why the child is drawing on the doll or what it means as this may increase the child's anxiety.

85.

A 4-year-old postoperative patient needs to take deep breaths but resists using the incentive spirometer. An alternative strategy is to:

ask the child to try to whistle.

have the child blow bubbles in a glass of water.

ask the child to imitate the nurse breathing deeply.

offer the child a reward for using the incentive spirometer.

Explanation:

If a 4-year-old postoperative patient needs to take deep breaths but resists using the incentive spirometer, an alternative strategy is to have the child blow bubbles in a glass of water. The child may also be encouraged to blow on a pinwheel to make it spin. Incorporating deep breathing exercises into play and fun activities is less intimidating to the child than using medical devices.

86.

When transporting a 12-month-old child from the child's room to the treatment room, about 20 feet down the hall, the most appropriate transportation method is:

carrying the child.

pushing the child in the crib.

placing the child on a gurney.

placing the child in a wheelchair.

Explanation:

When transporting a 12-month-old child from the child's room to the treatment room, about 20 feet down the hall, the most appropriate transportation method is carrying the child. Carrying an infant or small child is acceptable for short distances, but for longer distances or distances outside of the unit, the child should be transported in a crib. Older children may be transported on a gurney or in wheelchairs (with a safety belt if necessary to ensure safety).

87.

A Vietnamese child is admitted with high fever, and the nurse notes a number of vertical ecchymotic areas in rows up and down the child's back. This most likely indicates:

a severe rash.

child abuse.

coining.

hemorrhage.

Explanation:

If a Vietnamese child is admitted with high fever and the nurse notes a number of vertical ecchymotic areas in rows up and down the child's back, this most likely indicates the parents have used coining, a common practice in Asian cultures to reduce fever or release negative energy. A hard item, such as a coin, is scraped up and down lubricated skin until bruising occurs. The procedure may be painful, but the intent is not to harm the child.

88.

Anticipatory guidance most appropriate for a male child during early adolescence (11-14) includes:

age-appropriate sports activities.

abstinence, safe sex, and contraception.

risk taking behaviors (drugs, drinking, smoking, speeding).

bodily changes and secondary sex characteristics.

Explanation:

Anticipatory guidance most appropriate for a male child during early adolescence (11-14) includes bodily changes and development of secondary sexual characteristics. The child will undergo changes in thought patterns and awareness so the child's feelings about academic responsibilities should be explored. The child may begin to experience peer pressure to conform to the norms of a group, so the pediatric nurse should begin discussions about issues such as gangs, tobacco, drugs, alcohol, and abusive relationships (which should be explored more during adolescence).

89.

The ethnic and cultural group that has a high risk of having children with cystic fibrosis is:

African Americans.

Ashkenazi Jews.

Pennsylvania Amish.

Middle Easterners.

Explanation:

The ethnic and cultural group that has a highest risk of having children with cystic fibrosis is Ashkenazi Jews with risk 100 times higher than in non-Jewish populations. Risk is similarly high for Tay-Sachs disease and Gaucher disease. Northern Europeans also have increased rates of cystic fibrosis. Pennsylvania Amish have high rates of phenylketonuria; African Americans, sickle cell disease; and Middle Easterners, beta-thalassemia.

90.

If a child has been placed on a strict ketogenic diet as a treatment for refractory epilepsy, the child's diet should be characterized by:

low carbohydrate, adequate protein, and high fat.

high carbohydrate, low fat, and adequate protein.

high carbohydrate, high fat, and low protein.

low carbohydrate, high protein, and low fat.

Explanation:

If a child has been placed on a strict ketogenic diet as a treatment for refractory epilepsy, the child's diet should be characterized by low carbohydrate, adequate protein, and high fat. The low carbohydrate diet results in the body burning fat as the primary source of energy, increasing the ketone level in the blood. The elevated ketone level decreases the incidence of seizures in some children who are not adequately responsive to anticonvulsants.

91.

The teenage mother of a 5-month-old child expresses concern that the child does not seem to grasp the concept of "no." The most appropriate response is:

“Babies all develop understanding at different rates.”

“You have unrealistic expectations of your baby.”

“Just relax and don’t worry so much about your baby.”

“Infants usually begin to understand ‘no’ between 9 and 12 months.”

Explanation:

If the teenage mother of a 5-month-old child expresses concern that the child does not seem to grasp the concept of “no,” the most appropriate response is: “Infants usually begin to understand ‘no’ between 9 and 12 months.” The information provided should be as specific as possible. Inexperienced mothers may have unrealistic expectations because of lack of knowledge about children, and they should be provided growth and development charts so that they know what to expect.

92.

An 18-month-old patient no longer cries when the parents leave and seems content with all caregivers. The pediatric nurse suspects that the child is:

in the protest stage of separation anxiety.

in the despair stage of separation anxiety.

in the denial/detachment stage of separation anxiety.

no longer suffering from separation anxiety.

Explanation:

If an 18-month-old patient no longer cries when the parents leave and seems content with all caregivers, the pediatric nurse should suspect that the child is in the denial stage of separation anxiety, common to toddlers and preschoolers.

Separation anxiety

Protest stage *Child cries and clings to parents and refuses comfort from other adults.*

Despair stage *Child appears sad and withdrawn and cries on return of parents.*

Denial/Detachment stage *Child no longer shows emotions related to parents' leaving and appears happy with caregivers.*

93.

The pediatric nurse is assessing the fine motor ability of a 2-year-old child by observing the child playing with blocks. The pediatric nurse expects the child to be able to:

build a tower 2-blocks high.

build a tower 4-blocks high.

build a complex structure with at least 6 blocks.

bang blocks together or throw them only.

Explanation:

If the pediatric nurse is assessing the fine motor ability of a 2-year-old child by observing the child playing with blocks, the pediatric nurse expects the child to be able to build a tower 4-blocks high. The child should also be able to scribble on paper but does not yet draw forms and

should be able to throw a ball. The child also usually begins to undress but is not yet able to put clothes on.

94.

A 16-year patient is overweight and must lose weight to help control hypertension. The best strategy is likely to:

target 2 or 3 dietary changes initially.

cut calories to 1000 per day.

encourage a low carbohydrate, high protein diet.

advise the girl to develop his/her own diet plan.

Explanation:

If a 16-year-old patient is overweight and must lose weight to help control hypertension, the best strategy is likely to target 2 or 3 dietary changes initially, such as cutting out sugar-containing soft drinks and French fries. Placing a teenager on a drastic diet, such as 1000 calories, usually ends in frustration, hunger, and diet failure. The patient should be encouraged to have a well-balanced diet that includes all food groups but is low in simple carbohydrates.

95.

A 12-year-old child was in a bicycle-motor vehicle accident and fractured ribs 7 and 8 on the left side. The location of these injuries increases risk of:

tracheal or bronchial injury.

hepatic trauma.

renal trauma.

pneumothorax or hemothorax.

Explanation:

If a 12-year-old child was in a bicycle-motor vehicle accident and fractured ribs 7 and 8 on the left side, the location of these injuries increases risk of pneumothorax or hemothorax because the fractured ribs may penetrate the lung tissue. With injuries to ribs 1 through 4, there is increased risk of tracheal or bronchial injury, and with injury to ribs 10 through 12, trauma to the liver, kidneys, and/or spleen.

96.

The pediatric nurse is serving as an advocate for an adolescent patient when:

telling the parents how cooperative the patient is.

encouraging the parents to allow the patient to manage his diabetes.

encouraging the parents to manage the patient's diabetes.

telling the patient that he must be independent in diabetic management.

Explanation:

The pediatric nurse is serving as an advocate for an adolescent patient when encouraging the parents to allow the patient to manage his diabetes. Adolescents often want to assert their independence and don't want to rely on parents for disease management. While the pediatric

nurse should avoid pressuring the patient to manage his disease, the patient should be included in all aspects of the care plan and educated about diabetic management.

97.

Which pain assessment tool is most appropriate for a 2-year-old child?

CRIES.

FACES.

CHEOPS.

0-10 scale.

Explanation:

CHEOPS: This tool is most appropriate for a 2-year old as it is used for children ages 1-7. The tool is based on scores of 6 different characteristics (crying, facial expression, verbalization, torso, upper extremities, lower extremities) with scores of 0-2 except for crying, which is scored 0-3. A score >4 indicates pain. FACES (Wong-Baker): Facial expression scale for children over age 3 and nonverbal adults. CRIES: Assesses crying, requirement for O₂ or SaO₂ <95%, increased VS, expression, and sleep to evaluate pain in neonates and infants 6 months or younger. 0-10 pain intensity scale: Used for adolescents and adults.

98.

A child experiencing a severe asthma attack had exhibited pulse paradoxus of 30 mm Hg, but the pulse paradoxus is now absent. This finding likely indicates:

imminent respiratory arrest.

increased oxygen saturation.

electrolyte imbalance.

imminent cardiac arrest.

Explanation:

If a child experiencing a severe asthma attack had exhibited pulse paradoxus of 30 mm Hg but the pulse paradoxus is now absent, this finding likely indicates that respiratory arrest is imminent. The child may require mechanical ventilation. Other indications for mechanical ventilation include severe hypoxia, bradycardia, apnea, and depressed mental status. Children may also require mechanical ventilation if they become exhausted or breath sounds are markedly diminished with no audible wheezing and if the PaO₂ is <70 mm Hg on 100% oxygen.

99.

When participating in the development of the Individualized Education Plan (IEP) for a child with mild intellectual disability and IQ of 65, the pediatric nurse should explain that the child should be educable to about the:

8th grade level.

6th grade level.

4th grade level.

2nd grade level.

Explanation:

When participating in the development of the Individualized Education Plan (IEP) for a child with mild cognitive impairment and IQ of 65, the pediatric nurse should explain that the child should be educable to about the 6th grade level. The child should be able to master many skills and may, as an adult, be able to work and live independently or with minimal supervision, so this should be an ultimate goal.

100.

If a child has a high fever from a viral infection, which of the following should be avoided?

Acetaminophen.

Ibuprofen.

Tepid baths.

Aspirin.

Explanation:

If a child has a high fever from a viral infection, aspirin should be avoided. If a child with a viral infection, such as a common cold or flu-like symptoms, takes aspirin, it may trigger Reye's syndrome. Children younger than 19 should generally not receive aspirin or any medication containing salicylates when they have a fever. Reye's syndrome results in hepatic and cerebral swelling and symptoms similar to encephalitis or meningitis: alterations in consciousness, seizures, coma, and death.

101.

When a 14-year-old patient with diabetes mellitus, type 1, is learning to self-inject insulin and manage her diet and disease, the most effective method of ensuring proper technique and knowledge is a(n):

written test.

teach-back demonstration.

oral test.

observation.

Explanation:

When a 14-year-old patient with diabetes mellitus, type 1, is learning to self-inject insulin and manage her diet and disease, the most effective method of ensuring proper technique and knowledge is a teach-back demonstration. Because the patient has to explain during the procedures, this helps to pediatric nurse to assess both the patient's knowledge and ability to carry out the correct steps in procedures.

102.

A 6-year-old child has a fever of 39.4° C (103° F), pulse rate of 108, respiratory rate of 30, and severe sore throat. The child insists on sitting upright and is drooling with chin thrust forward and having difficulty swallowing. These symptoms are consistent with:

croup.

laryngotracheitis.

epiglottitis.

laryngotracheobronchitis.

Explanation:

If a 6-year-old child has a fever of 39.4° C (103° F), pulse rate of 108, respiratory rate of 30, and severe sore throat; and the child insists on sitting upright and is drooling with chin thrust forward and having difficulty swallowing, these symptoms are consistent with epiglottitis, which is a life-threatening emergent condition. The edema associated with epiglottitis can progress rapidly and cause airway obstruction. Epiglottitis is most commonly caused by infection with Haemophilus influenzae, streptococcus, and staphylococcus.

103.

Which of the following laboratory results for a 9-year-old male patient should be immediately reported to the physician?

Serum creatinine: 3.5 mg/dL.

BUN: 11.0 mg/dL.

Total WBC: 12,000.

Platelet count: 300,000.

Explanation:

The laboratory result for a 9-year-old male patient that should be immediately reported to the physician is a serum creatinine of 3.5 mg/dL. The normal value for a child 6 to 10 years old ranges from 0.51-0.81 mg/dL and the critical value for a non-dialysis patient is 3.8 mg/dL (compared to a critical value of 7.4 m/dL for adults). Creatinine is the end product of creatine metabolism, released into the blood stream from the muscles for excretion. If the kidneys are not functioning properly, the creatinine level increases.

104.

The nursing diagnosis that applies to all pediatric patients who are hospitalized for invasive procedures is:

risk for impaired gas exchange.

risk for impaired skin integrity.

risk for fluid volume imbalance.

risk for infection.

Explanation:

While all of these nursing diagnoses may apply to children hospitalized for invasive procedures, depending on the child's condition and type of procedures, the nursing diagnosis that applies to all children in that situation is risk for infection. Hospital-acquired infections are common and the risk increases with the length of hospital stay and the number and type of invasive procedures. Children must be monitored carefully for early signs of infection, especially fever and erythema.

105.

A 10-year-old child is to wear a Holter monitor for 48 hours in order to monitor cardiac dysrhythmias. Instructions for the procedure should include:

avoid all sports activities.

carry out normal activities.

cover the Holter monitor with a plastic bag when showering.

stay at rest until the monitoring period is over.

Explanation:

If a 10-year-old child is to wear a Holter monitor for 48 hours in order to monitor cardiac dysrhythmias, instructions for the procedure should include to carry out normal activities in order to determine the effect they have on the heart rate and rhythm. The child should not bathe, shower, or swim or do anything to wet the electrodes while wearing the Holter monitor. Generally, the child or parent must keep a diary that describes the child's activities and times so that they can be compared with the ECG recording.

106.

A 6-month-old patient has been happy in her mother's arms but immediately begins to cry and struggle when the pediatric nurse comes into the room and takes the child so the child can be weighed and measured. This is likely an expression of:

pain or discomfort.

fear of procedures.

stranger anxiety.

separation anxiety

Explanation:

If a 6-month-old patient has been happy in her mother's arms but immediately begins to cry and struggle when the pediatric nurse comes into the room and takes the child so the child can be weighed and measured, this is likely an expression of stranger anxiety. Infants usually experience stranger anxiety from about the time they are 6 months old, when they have established attachment to the parent or primary caregiver.

107.

If an 8-year-old patient is taking digoxin for congestive heart failure and is to be discharged, discharge planning should include reminding the parents that the child should avoid taking:

acetaminophen.

diuretics.

vitamin C.

macrolide antibiotics.

Explanation:

If an 8-year-old patient is taking digoxin for congestive heart failure, discharge planning should include reminding the parents that the child should avoid taking macrolide antibiotics (such as erythromycin) and beta lactams (such as cefazolin) because these drugs may interact with the digoxin and other healthcare providers may be unaware of the risk. The parents or caregivers should be educated about all medications and treatments as well as signs and symptoms of complications before the child is discharged.

108.

By which age does the pediatric nurse generally expect a child to have an understanding of death similar to adult understanding?

6 to 8.

9 to 10.

11 to 12.

13 to 14.

Explanation:

The pediatric nurse should generally expect a child by age 9 to 10 to have an understanding of death similar to adult understanding. The child may have a delayed reaction to death and may be reluctant to talk about it but may have various somatic complaints and academic difficulties. Preschoolers often confuse death with falling asleep or going away and expect a person or animal that has died to return. By 6 years of age, the child usually understands that death is permanent and that the person or animal is not going to return.

109.

If an 11-year-old patient who will be undergoing surgery for acute appendicitis appears terrified and repeatedly denies the need for surgery, begging the parents to take him home, the most effective response is:

“Surgery can be pretty scary.”

“You’ll be just fine, so don’t worry.”

“You’re old enough to understand the need for surgery.”

“You’ll feel much better after surgery.”

Explanation:

If an 11-year-old patient who will be undergoing surgery for acute appendicitis appears terrified and repeatedly denies the need for surgery, begging the parents to take him home, the most effective response is: “Surgery can be pretty scary.” It’s important to acknowledge and take the

child's fears seriously and to try to determine the cause and to talk about it with the child. The child, for example, may be afraid that he will never wake up.

110.

An example of lateral violence is:

a team member disagrees with the team leader about a plan of care.

a nurse complains to the supervisor about forced overtime.

a nurse insults and denigrates a colleague.

a nurse reports another nurse for committing a medical error.

Explanation:

An example of lateral violence is when a nurse insults and denigrates a colleague. Lateral violence (AKA horizontal violence) can include physical as well as verbal abuse and may be overt or covert. For example, a staff member may attempt to undermine another's accomplishments or to backstab the person in order to engage fellow staff members in similar abusive behavior. Lateral violence can take a large emotional toll on a victim.

111.

When the pediatric nurse provides in-service training for other nurses regarding child safety and fall prevention, the pediatric nurse is serving in the role of:

change agent.

mentor.

clinical content expert.

preceptor.

Explanation:

When the pediatric nurse provides in-service training for other nurses regarding child safety and fall prevention, the pediatric nurse is serving in the role of clinical content expert. In this role, the pediatric nurse may carry out formal training (such as in-service classes) but may also be called up to provide expert advice in clinical practice and may suggest changes in policies or procedures based on research and best practices.

112.

When considering Maslow's Hierarchy of needs, which of the following nursing diagnoses (NANDA) for a 15-year-old patient with anorexia would have priority?

Risk of self-injury.

Risk for loneliness.

Imbalanced nutrition: Less than body requirements.

Bathing/hygiene self-care deficit.

Explanation:

Considering Maslow's hierarchy, the priority nursing diagnosis for a 15-year-old patient with anorexia is imbalanced nutrition, less than body requirements because this poses a real

physiological risk. Nursing diagnoses and Maslow's hierarchy:

- 1. Physiological needs: Imbalanced nutrition.*
- 2. Safety needs: Risk of self-injury.*
- 3. Love/belonging needs: Risk for loneliness.*
- 4. Esteem needs: Bathing/hygiene self-care deficit.*

In reality, multiple needs may be addressed simultaneously but physiological needs should always be attended to first because they place the patient most at risk for worsening condition or even death.

113.

A 12-year-old female patient with cystic fibrosis has had repeated hospitalizations for respiratory infections and fecal impactions. The parents admit that they are lax about carrying out chest physiotherapy, keeping follow-up appointments, and monitoring the patient's diet and treatment. The patient and family may most benefit from the services of a(n):

case manager.

occupational therapist.

respiratory therapist.

social worker.

Explanation:

Patients who have repeat hospitalizations, such as the 12-year-old female patient with cystic fibrosis, because of the failure of parents to follow through with appointments, treatments, and diet will most likely benefit from the services of a case manager who can more closely monitor the patient's ongoing treatment, coordinate services with other healthcare providers, and determine what community services, such as transportation, may be available to provide some help in ensuring follow-through.

114.

A 16-year-old patient with celiac disease has developed severe abdominal pain, nausea, and diarrhea and confesses to the pediatric nurse that she has not been following the gluten free diet but has been going out for fast-food with her friends. The most likely reason for this is:

lack of knowledge about the disease.

desire to be like her peers.

anger at the disease process.

desire to be self-destructive.

Explanation:

If a 16-year-old patient with celiac disease has developed severe abdominal pain, nausea, and diarrhea and confesses to the pediatric nurse that she has not been following the gluten free diet but has been going out for fast-food with her friends, the most likely reason for this is the desire to be like her peers. Adolescents want to fit in with friends and may begin to feel invincible, convinced that nothing will happen to them if they fail to follow medical directions.

115.

A 3-year-old patient with sickle cell disease presents in the emergency department with fever, chest pain, back pain, dyspnea, cough, and oxygen saturation of 91%. The most likely complication the child is experiencing is:

aplastic crisis.

vaso-occlusive crisis.

splenic sequestration.

acute chest syndrome.

Explanation:

If a 3-year-old patient with sickle cell disease presents in the emergency department with fever, chest pain, back pain, dyspnea, cough, and oxygen saturation of 91%, the most likely complication the child is experiencing is acute chest syndrome. This complication most commonly affects children ages 2 to 4 and results from infiltration of the lungs with the abnormally-shaped red blood cells. This in turn can lead to infection, fat embolism, and pulmonary infarct and can progress to respiratory failure and death.

116.

On the clinical ladder (Benner), a pediatric nurse who is able to look at situations holistically and can adapt care plans to changing needs is classified as:

advanced beginner.

competent.

proficient.

expert.

Explanation:

Proficient. Clinical ladder:

*1. **Novice:** little experience and depends on rules and learned behavior, not adaptable.*

*1. **Advanced beginner:** Some experience in coping with new situations and able to formulate some principles of action.*

2. **Competent:** 2 to 3 years of experience and has some mastery of new situations and goals, lacks flexibility
3. **Proficient:** Looks at situations holistically and relies on experience to determine goals and plans and can adapt plans to changing needs.
4. **Expert:** Wealth of experience and can provide care intuitively rather than relying on rules and maxims.

117.

If an adolescent patient routinely takes high dosages of vitamins for “body building,” the pediatric nurse should advise the patient that the vitamin that may cause liver damage if taken in high amounts is:

vitamin B-6.

vitamin B-12.

vitamin C.

vitamin A.

Explanation:

If an adolescent patient routinely takes high dosages of vitamins for “body building,” the pediatric nurse should advise the patient that the vitamin that may cause liver damage if taken in high amounts is vitamin A. Vitamin A is stored in fat cells and can cause toxic reactions. Symptoms of toxicity include dry skin, hair loss, nausea and vomiting, and visual disturbances. Over time, the individual may develop cirrhosis of the liver.

118.

If a 17-year-old patient with a spinal cord injury at T6 has sudden severe headache, blurred vision, diaphoresis and flushing below level of injury and pallor above, the initial emergent response should be to:

elevate the patient's head.

identify cause.

administer hydralazine.

loosen clothing.

Explanation:

If a 17-year-old patient with a spinal cord injury at T6 has sudden severe headache, blurred vision, diaphoresis and flushing below level of injury and pallor above, the initial emergent response should be to elevate the patient's head to reduce blood pressure. These signs and symptoms are consistent with autonomic dysreflexia, so the next step is to identify and remedy cause (tight clothes, full bladder, full rectum, increased temperature). If symptoms do not reverse. Then IV antihypertensives, such as hydralazine, and antispasmodics may be necessary.

119.

According to the pattern of temperament (Chess and Thomas), which of the following characterizes the "difficult" child?

Interacts slowly with the environment.

Adapts quickly to new situations.

Has irregular sleeping patterns.

Plays well with others.

Explanation:

According to the pattern of temperament (Chess and Thomas), the “difficult child” often has irregular sleeping habits as well as irregular eating and elimination habits, so the parents find establishing a routine schedule problematic. The child may be “cranky” and react intensely to environmental stimuli. The “slow to warm up child,” on the other hand, adapts slowly to new situations and is more cautious and may withdraw initially. The “easy child” is usually positive, adapts well, has a regular pattern of eating, sleeping, and elimination, and gets along well with others.

120.

A 5-year-old male patient is very active and frequently bangs on the bed, calls out, tears things apart, and disrupts the pediatric unit. The best solution is likely to:

admonish the child to behave better.

plan regular periods of active play throughout the day.

keep the room quiet and lights dimmed.

reward the child with a treat for good behavior.

Explanation:

Active children may find hospitalization particularly difficult. If a 5-year-old patient is very active and frequently bangs on the bed, calls out, tears things apart, and disrupts the pediatric unit, the best solution is likely to plan regular periods of active play throughout the day. If the child is bedbound, then throwing and catching a soft ball or stuffed animal, building something with Legos®, or playing with toy cars may help to release energy.

121.

When serving as a mentor for a newly licensed nurse, the primary role of the pediatric nurse is to:

assess the nurse's skills.

provide support and guidance.

assign duties.

supervise patient care.

Explanation:

When serving as a mentor for a newly licensed nurse, the primary role of the pediatric nurse is to provide support and guidance. The nurse should feel free to bring questions and concerns to the mentor. Skills that enhance mentoring include nurturing, providing clinical expertise, motivating, modeling, and providing feedback. Mentoring is usually one-on-one relationship although a pediatric nurse may also serve as a mentor to a group.

122.

A 10-year-old patient with an extended hospital stay repeatedly states that he wants to go home. An empathetic response is:

"You know you can't go home yet."

"I wish you could go home, too."

"Why don't you try to think about something else?"

"It's hard to be away from family and friends."

Explanation:

If a 10-year-old patient with an extended hospital stay repeatedly states that he wants to go home, an empathetic response is: "It's hard to be away from family and friends." Empathetic responses include making observations about what the pediatric nurse observes ("You seem upset"), acknowledging what the child says ("I understand"), and recognizing feelings and concerns. The pediatric nurse should provide information as honestly as possible and reply to the child's questions and address concerns.

123.

The physical manifestations of Down syndrome (trisomy 21) include:

flat occiput, hypotonia, short limbs, and congestive heart defect.

rocker bottom feet, micrognathia, and low-set ears.

polydactyly, cleft lip and/or palate, and small or absent eyes.

microcephaly, high-pitched cry, and low-set abnormally shaped ears.

Explanation:

The physical manifestations of Down syndrome (trisomy 21) include flat occiput, hypotonia, short limbs, and congestive heart defect. Children may have epicanthal folds, high-arched palate that results in protrusion of the tongue, and a small nose. After birth, the neonate fails to exhibit the Moro reflex. The degree of intellectual impairment varies from profoundly mentally challenged to near normal intelligence. Some children with Down syndrome may eventually be able to live independently or with minimal supervision and to be employed.

124.

An example of a measurable outcome is:

child will participate in decision-making.

diet will contain adequate nutrition.

child will exercise regularly.

fasting blood sugar will remain between 110 and 130.

Explanation:

An example of a measurable outcome is: Fasting blood sugar will remain between 110 and 130. While it's not possible to apply a measurable outcome to all nursing diagnosis and interventions, a measurable component should be included whenever possible. For example, instead of saying, "The child will exercise regularly," the outcome could be stated as "The child will exercise for 20 minutes at least 4 times weekly." General terms, such as "adequate nutrition," may be interpreted differently by the patient and healthcare providers.

125.

When conducting a history and physical examination, which cultural group should be asked specifically about lactose intolerance?

Native Americans.

Asians.

Mediterraneans.

Jews.

Explanation:

When conducting a history and physical examination, the cultural group that should be asked specifically about lactose intolerance is Asians. Asians traditionally do not drink milk beyond infancy and lack the enzyme (lactase) necessary to digest lactose. African Americans and Hispanics are also often lactose intolerant. Symptoms of lactose intolerance usually occur within 2 hours of ingesting milk products and may include abdominal distention, cramping, gas, and diarrhea. Milk products that are lactose free and lactase supplements are available.

126.

When examining an infant, the pediatric nurse expects most inborn reflexes to be extinguished by ages:

2 to 4 months.

4 to 6 months.

6 to 8 months.

8 to 10 months.

Explanation:

When examining an infant, the pediatric nurse should expect most inborn reflexes to be extinguished by 6 to 8 months. During this time period, the infant's growth slows and the infant is able to bang items and transfer them from one hand to the other. Most infants are able to sit unsupported by 8 months and can support weight and bounce up and down on legs if supported. The child is beginning to recognize some words, such as the child's name.

127.

The Tdap immunization is usually given to children beginning at age:

2 months.

6 months.

7 years.

11 years.

Explanation:

The Tdap (tetanus, diphtheria, and acellular pertussis) immunization (one dose) is usually given to children between age 11 and 12. The Dtap (diphtheria, tetanus, and acellular pertussis) series of 5 injections is usually given at 2, 4, 6, 15-18 months and at 4-6 years. While the Dtap immunization establishes immunity to these diseases during childhood, the Tdap, which has lower dosages of the diphtheria and pertussis vaccines, provides a booster that carries the immunity into adulthood. Tetanus boosters need to be taken every 10 years.

128.

A 4-year-old child screams loudly when about to have blood drawn. The most appropriate response is to:

acknowledge the child's fear.

reassure the child that the procedure won't hurt.

ignore the child's response.

admonish the child to stop screaming.

Explanation:

If a 4-year-old child screams loudly when about to have blood drawn, the most appropriate response is to acknowledge the child's fear and allow the child to cry and scream, providing comfort and soothing words. The pediatric nurse should not reassure the child that the procedure won't hurt because it may, in fact, hurt, causing the child to mistrust the nurse. Treatments are often frightening to young children, so a parent should be encouraged to hold the child when possible.

129.

A new mother brings her 4-month-old infant to a well-baby clinic and states that she has started to give her baby meat so the child will be healthy and strong. The pediatric nurse should advise the mother that:

meat is a good source of iron.

meat should be given in small amounts.

the infant's kidneys may not be mature enough for meat.

meat should be mixed with vegetables rather than fed separately.

Explanation:

If a new mother brings her 4-month-old infant to a well-baby clinic and states that she has started to give her baby meat so the child will be healthy and strong, the pediatric nurse should advise the mother that the infant's kidneys may not be mature enough for meat, and that meat should be started around 10-12 months. Current guidelines advise that infants receive only milk during the first 6 months and begin other foods with rice cereal, which is easy to digest and contains iron.

130.

A parent is concerned that the back of the baby's head is quite flat from being placed in supine position. The pediatric nurse should advise the parent to:

place the infant on the side or in prone position for sleep.

place the infant on the side or in prone position during supervised awake time.

alternate the infant from side to prone position for sleep.

ignore the flat head as it will resolve automatically over time.

Explanation:

If a parent is concerned that the back of the baby's head is quite flat from being placed in supine position, the pediatric nurse should advise the parent that while the infant should always sleep in supine position, the child can be placed on the side or in prone position for supervised awake time. Prone position encourages the child to lift his/her head and strengthens the neck and shoulder muscles and is the position that encourages the infant to learn to crawl.

131.

The pediatric nurse notes that a parent placed an infant properly in a secured infant seat but that an unsecured booster seat sometimes needed for an older sibling was next to the infant seat. The pediatric nurse should:

advise the parent to always keep the booster seat secured.

take no action as the infant is properly secured.

assure that the older sibling will not be in the car unsecured.

advise the parent to place the booster seat on the floor.

Explanation:

If the pediatric nurse notes that a parent placed an infant properly in a secured infant seat but that an unsecured booster seat sometimes needed for an older sibling was next to the infant seat, the pediatric nurse should advise the parent to always keep the booster seat secured by both its tether and the seatbelt because, in the event of a vehicle accident, the booster seat could fly about the car and injure the infant or others.

132.

The Braden Q Scale is most appropriate for children who are:

3 weeks to 8 years.

5 to 8 years.

8 to 14 years.

15 to 18 years.

Explanation:

The Braden Q Scale is most appropriate for children who 3 weeks to 8 years while the Braden Scale is used for older children. The Braden Q scale assess the risk of pressure ulcers for children related to immobility. Seven categories are scored from 1 (severe) to 4 (normal): mobility, activity, sensory perception, moisture, friction-shear, nutrition, and tissue perfusion and oxygenation. Possible scores range from 7 to 28 with a score of 16 or higher indicating increased risk.

133.

A postoperative patient receiving 30 mg of oral morphine has developed pruritis and is to switch to oral codeine at an equianalgesic dose of:

30 mg.

60 mg.

75 mg.

120 mg.

Explanation:

A patient receiving 30 mg of oral morphine for acute pain has developed pruritis and is to switch to oral codeine at an equianalgesic dose of 120 mg. Other equianalgesic doses include: hydromorphone 7.5 mg, levorphanol 4 mg, methadone 10 mg, and oxycodone 20 mg. Children should receive adequate analgesia but in the lowest effective dose and should switch to non-opiates as soon as possible because of the potential for adverse effects.

134.

When solid foods, such as pieces of fruit, are added to the toddler's diet, the food should be cut into pieces no greater than:

1/4-inch diameter.

1/2-inch diameter.

3/4-inch diameter.

1-inch diameter.

Explanation:

When solid foods, such as pieces of fruit, are added to the toddler's diet, the food should be cut into pieces no greater than 1/2-inch in diameter. Raw foods that are hard, such as carrots and broccoli, should be cooked before giving them to a child, and the child should not eat seeds, popcorn, hard candy and nuts, which can easily choke the child. Some foods, such as slices of hot dogs, can easily lodge in a toddler's throat and obstruct the air supply. Sticky foods, such as marshmallows, spoons of peanut butter, or melted cheese also pose choking hazards.

135.

The type of breath sound that the pediatric nurse would anticipate hearing when a child has a foreign object partially obstructing his airway is:

mild wheeze.

crackles.

stridor.

stertor.

Explanation:

The type of breath sound that the pediatric nurse would anticipate hearing when a child has a foreign object partially obstructing his airway is stridor. Stridor is a high-pitched sound that indicates that the air is obstructed in its flow through the upper airway. The sound is more pronounced on inspiration and can usually be heard without auscultation. The most common areas for obstruction in children are the larynx and tracheobronchial area. Stridor may also be present with croup and with epiglottitis.

136.

Which of the following injuries of a 7-year-old child should most cause the pediatric nurse to suspect physical abuse?

Scattered bruises on the legs.

Circular ecchymotic areas (approximately equal in size) about the back.

Fractured wrist from reported fall off of bicycle.

Glove-like burn on one hand.

Explanation:

The injury of a 7-year-old child that should most cause the pediatric nurse to suspect physical abuse is a glove-like burn on one hand. Children are not likely to plunge a hand into a hot or boiling liquid, and this type of one-sided and symmetric burn is likely to result from someone forcing the child's hand into the liquid. Scattered bruises on the legs are common in children. Wrist fractures may occur with falls. Fractures that should raise suspicion include spiral fractures of the arm and facial fractures. Equal-size circular ecchymotic areas probably result from cupping.

137.

According to Freud, a preschooler (ages 3 to 6) is in the:

anal stage.

oral stage.

phallic stage

genital stage.

Explanation:

According to Freud, a preschooler (ages 3-6) is in the phallic stage. Stages:

Oral 0-1 year Comfort/pleasure through mouth.

Anal 1-3 years Gratification from controlling excretions (urine, feces).

Phallic 3-6 years Identification with parent of opposite gender and then same gender.

Latency 6-12 years Desire for privacy and to understand the body.

Genital 12-18 years Concerned with genital functions (sex) and relationships.

138.

During which stage of development is a child most likely to believe that sickness results from bad behavior?

0-1 year.

3 to 6 years.

6-12 years.

13-15 years.

Explanation:

A child is most likely to believe that sickness results from bad behavior or thoughts during the preschool years from ages 3 to 6. This is an example of magical thinking. The best approach is to explain what causes the child's illness and to reassure the child. Other common thought characteristics include egocentrism, in which the child tends to view the world only from personal perception, and transductive reasoning in which the child believes a cause and effect relationship exists between two events because they occur together.

139.

The pediatric nurse examines a child's abdominal incision on the second post-operative day and notes that it is clean, dry, and non-tender but has slight erythema and edema along the incision line. This most likely represents:

normal inflammatory process.

wound infection.

hematoma.

beginning dehiscence.

Explanation:

If the pediatric nurse examines a child's abdominal incision on the second post-operative day and notes that it is clean, dry, and non-tender but has slight erythema and edema along the incision line, this most likely represents a normal inflammatory process, part of healing. Wound infection is usually accompanied by tenderness and more pronounced erythema and edema as well as purulent discharge. Dehiscence is indicated by gaps in the incision line and can lead to evisceration.

140.

A 10-year-old child who is being treated for leukemia has been very ill but is now to be discharged and continue outpatient treatments, and the parents are very anxious. Which of the following referrals may provide the best support?

Psychologist.

Social worker.

Spiritual counselor.

Leukemia family support group.

Explanation:

While parents differ in their needs when a child (such as a 10-year-old child with leukemia) is ill, they often find some comfort from interacting with parents in the same situation, such as those in a leukemia family support group. Parents may feel more able to express their fears and discuss problems they are facing with other parents than with healthcare providers. In some cases, peer support groups are also available for children.

141.

A 14-month-old patient who had been developing normally has suffered an arm fracture and rib fracture from falls. On examination, the pediatric nurse notes that the infant's sclerae appears blue-tinged and the child's muscles seem weak. These findings are suggestive of:

osteogenesis imperfecta I.

physical abuse.

rickets.

fibrous dysplasia.

Explanation:

If a 14-month-old patient who had been developing normally has suffered an arm fracture and rib fracture from falls and, on examination, the pediatric nurse notes that the infant's sclera appears blue-tinged and the child's muscles seem weak, these findings are suggestive of osteogenesis imperfecta I. OI-I is the mildest form of OI and fractures usually don't occur until the child begins to walk and experiences falls. The child is susceptible to fractures until puberty at which time the risk decreases. Most children attain normal stature.

142.

When suctioning a child's tracheostomy, the pediatric nurse should use a suction catheter that is:

20% the size of the tracheostomy.

30% the size of the tracheostomy.

50% the size of the tracheostomy.

75% the size of the tracheostomy.

Explanation:

When suctioning a child's tracheostomy, the pediatric nurse should use a suction catheter that is 50% the size of the tracheostomy in order to allow ventilation to continue during suctioning. The vacuum pressure should range from 80 to 100 mm Hg, and the catheter should not be inserted more than 0.5 cm beyond the end of the tube because the catheter may damage tissue or perforate the trachea. No suction should be used during insertion and only intermittent suction used during withdrawal.

143.

The cultural group in which grandmothers often have an active role in childcare or are primary caregivers is:

Middle Eastern.

Asian.

Mexican.

African American.

Explanation:

The cultural group in which grandmothers often have an active role in child care or are primary caregivers is African American. Extended family is very important among African Americans and children are expected to be obedient and respectful. Children often avoid eye contact as a sign of respect, and this can be misinterpreted as being evasive. High rates of obesity are common among children and increase risk of hypertension and diabetes.

144.

The pediatric nurse is carrying out a history and physical examination of a 15-year-old female patient with abdominal pain and needs to ask about sexual history during the exam but the patient's parents are present. The best approach is to:

ask the patient if she wants her parents to stay during the history and exam.

ask the patient about her sexual history while the parents are present.

defer questions about sexual history for the physician to ask.

ask the parents to rejoin the patient after the history and exam is completed.

Explanation:

If the pediatric nurse is carrying out a history and physical examination of a 15-year-old female patient with abdominal pain and needs to ask about sexual history during the exam but the patient's parents are present, the best approach is to ask the parents to rejoin the patient after the history and physical examination is completed. Young patients who are sexually active may be reluctant to disclose this information in front of parents and may ask to have parents present, not realizing that sexual history will be discussed.

145.

A hospital utilizes order sets for specific diagnoses and interventions, such as hyperglycemia and diabetes discharge orders. Order sets:

can be implemented by the pediatric nurse based on assessment of need.

must be implemented by the prescribing physician or practitioner.

are automatically implemented for all patients with a specific diagnosis.

are the same as protocols and guidelines.

Explanation:

Order sets are sets of orders for a specific disease or condition so that the prescribing physician or practitioner does not have to write out all of the orders each time. Order sets must be evidence-based in accordance to national standards and approved by physicians in cooperation with pharmacy and nursing. Order sets must be implemented by the physician or

practitioner in person or through a telephone order each time they are used and cannot be automatically implemented.

146.

A 14-year-old male patient has undergone an AK amputation for osteosarcoma. Which of the following behaviors indicates a readiness to learn about self-care?

The patient plays video games during dressing changes.

The patient is cheerful and acts as though nothing has changed.

The patient looks at the stump and asks questions.

The patient is withdrawn and states he wants to go home.

Explanation:

If a 14-year-old male patient has undergone an AK amputation for osteosarcoma, the behavior that indicates a readiness to learn about self-care is when the patient looks at the stump and asks questions. Playing video games suggests the patient is practicing avoidance, and being overly cheerful or withdrawn may indicate denial and the inability to deal with the amputation. The pediatric nurse should remain supportive and give the patient time to come to terms with the change in his body image.

147.

The parent of a child with severe cardiomyopathy has become increasingly depressed, withdrawn, and weepy. The parent is most likely experiencing:

anticipatory grief.