Detailed Answer Key
LVN-RN Nursing Care of Children

1. A nurse reports an incident of suspected child abuse. One of the parents of the child becomes upset and demands to know the reason for the nurse's action. Which of the following responses by the nurse is appropriate?

A. "As a nurse, I am required by law to report suspected child abuse."

Rationale: A nurse is required by law to report suspected child abuse. Therefore, this is a truthful, non-accusatory response.

B. "I am unable to discuss this, but I can contact my supervisor to speak with you."

Rationale: This response defers to another authority figure, rather than providing the parent with an answer.

C. "The provider will be coming to explain the situation."

Rationale: This response does not answer the parent's concern. Although the provider will speak with the family, the nurse should address the parent's question.

D. "I reported the incident to my supervisor who decided to contact the authorities."

Rationale: Although a nurse supervisor can assist with the process, the nurse is mandated to report suspected child abuse.

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2. A nurse is preparing to administer vaccines to a 1-year-old child. Which of the following vaccines should the nurse give? (Select all that apply.)

A. Measles, mumps rubella (MMR)

B. Diphtheria, tetanus and acellular pertussis (DTaP)

C. Varicella (VAR)

D. Rotavirus (RV)

E. Human papillomavirus (HPV4)

Rationale: Measles, mumps rubella (MMR) is correct. A 1-year-old child should receive the first of two doses of the MMR vaccine.Diphtheria, tetanus and acellular pertussis (DTaP) is incorrect. By 1 year of age, the child should have already received three doses of DTaP: at 2 months, 4 months, and 6 months. The child should receive a fourth dose at 15 months of age.Varicella (VAR) is correct. A 1-year-old child should receive the first of two doses of the VAR vaccine.Rotavirus (RV) is incorrect. A 1-year-old child should have received the RV vaccine in a two or three dose series starting at 2 months of age.Human papillomavirus (HPV4) is incorrect. A child should receive a three dose series of the HPV4 vaccine at 11 or 12 years of age.

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3. A nurse is speaking with the mother of a 6-year-old child. Which of the following statements by the mother should concern the nurse?

A. "The teacher says my child has to squint to see the board."

Rationale:

Squinting to see the board can indicate a vision problem. It is essential to assess children for hearing and vision problems. If not caught early, they lead to frustration and decreased ability to learn.

B. "My child has recently lost both front top teeth."

Rationale: Children begin to lose their deciduous teeth around 6 years of age and replace them with their permanent teeth.

C. "My child often cheats when we play board games."

Rationale: Children who are 5 to 7 years of age often cheat to win at games because they feel winning is most important.

D. "Sometimes my child acts bossy with his friends."

Rationale: Children of this age are learning how to interact with peers. During this gradual process of learning to appreciate the feelings of others, they can remain somewhat egocentric.

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4. A nurse is assessing a toddler at a well-child visit. At what point in the physical examination should the nurse examine the child's tympanic membrane?

A. At the end

Rationale: When examining a toddler, the nurse should follow a modified head-to-toe approach, starting at the head but deferring anything that the toddler is likely to view as invasive and traumatic to the very end. The toddler is likely to resist not only having the ears examined, but also anything that follows.

B. At the beginning

Rationale: The nurse should not examine the tympanic membranes first because the toddler is likely to view examination of the ear canal as invasive and traumatic. The toddler is likely to resist not only having the ears examined, but also anything that follows.

C. Before examining the head and neck

Rationale: The nurse should examine the head and neck before examining the tympanic membrane.

D. Before auscultating the chest and abdomen

Rationale: The nurse should auscultate the chest and abdomen before examining the tympanic membrane.

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5. A school nurse identifies that a child has pediculosis capitis and educates the child's parents about the condition. Which of the following statements by the parents indicates an understanding of the teaching?

A. "All recently used clothing, bedding, and towels must be washed in hot water."

Rationale: Pediculosis capitis is commonly referred to as head lice. All recently used clothing, bed sheets, and towels need to be washed in hot water. Anything that cannot be washed should be sealed in a plastic bag for 10 to 14 days. Unwashable items can include jackets, sweaters, hats, pillows,

bicycle helmets, and stuffed animals. Furniture, carpets, and car seats can be sprayed with a variety of over-the-counter products.

B. "My child must be free from nits before returning to school."

Rationale: The American Academy of Pediatrics opposes requiring children to stay out of school until all nits are gone and instead recommends allowing children to return to school after treatment.

C. "I will treat all the family members to be on the safe side."

Rationale: Only family members who actually have lice should be treated because there are potential adverse effects associated with the treatment.

D. "Toys that can't be dry cleaned or washed must be thrown out."

Rationale: Items that cannot be dry cleaned or washed can be closed up inside a plastic bag for 10 to 14 days.

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6. A child is admitted with a suspected diagnosis of Wilms' tumor. The nurse should place a sign with which of the following warnings over the child's bed?

A. Do not palpate abdomen.

Rationale: Wilms' tumor is a neoplasm of the kidney (nephroblastoma). This tumor is encapsulated, and palpation can cause it to rupture, which would allow seeding of the tumor into the pelvic cavity.

B. No venipuncture or blood pressure in left arm

Rationale: There is no contraindication for venipuncture or obtaining blood pressure in either of the child's arms.

C. Contact precautions

Rationale: There is no indication to place the child on contact precautions.

D. Collect all urine.

Rationale: There is no indication to collect urine for a 24-hr urine specimen.

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7. A nurse is caring for a 2-month-old infant who is postoperative following surgical repair of a cleft lip. Which of the following actions should the nurse take?

A. Encourage the parents to rock the infant.

Rationale: A rocking motion will calm and soothe the infant. Additionally, involving the parents in the infant's care can reduce feelings of helplessness.

B. Offer the infant a pacifier.

Rationale: Sucking on a pacifier can cause pressure on the incision line, which can result in inflammation and trauma to the surgical site.

C. Administer ibuprofen as needed for pain.

Rationale: It is a contraindication for an infant who is younger than 6 months of age to receive ibuprofen.

D. Position the infant on her abdomen.

Rationale: Placing the infant on her abdomen allows the infant to rub the suture line on the bedding, which can result in inflammation and trauma to the surgical site.

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8. A nurse is caring for a child who has otitis media. Which of the following assessment findings should the nurse expect?

A. Tugging on the affected ear lobe

Rationale: Otitis media is a middle ear infection. Expected findings include fever, purulent drainage (if the tympanic membrane is ruptured), and pain, demonstrated by the child tugging at the ear.

B. Clear drainage from the affected ear

Rationale: Otitis media is a middle ear infection. Fluid contained within the middle ear becomes purulent drainage if the tympanic membrane ruptures.

C. Pain when manipulating the affected ear lobe

Rationale: Pain caused by manipulating the ear lobe is a clinical manifestation of otitis externa, swimmer's ear.

D. Erythema and edema of the affected ear

Rationale: Erythema and edema of the affected ear is associated with otitis externa or trauma to the external ear.

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9. A nurse is caring for an adolescent who has spina bifida and is paralyzed from the waist down. Which of the following statements by the client should indicate to the nurse a need for further teaching?

A. "I only need to catheterize myself twice every day."

Rationale: The client has paralysis from the level of the defect down. In the majority of cases, this condition affects bladder and bowel continence. Catheterization should be performed every 4 hr. Infrequent emptying of the bladder can result in stasis and urinary tract infections.

B. "I carry a water bottle with me because I drink a lot of water."

Rationale: Extra fluids help to maintain fluid balance and flush the body's urinary system. Since the client who has spina bifida is at an increased risk for urinary tract infection, maintaining an increased fluid intake is appropriate.

C. "I use a suppository every night to have a bowel movement."

Rationale: Using a suppository to stimulate a bowel movement every 1 to 2 days is appropriate.

D. "I do wheelchair exercises while watching TV."

Rationale: Wheelchair exercises maintain skin condition and upper body strength. Since the client who has spina bifida is at an increased risk for impaired skin integrity, frequently shifting positions while in the wheelchair is appropriate.

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10. A nurse is providing teaching to a parent of a child who has Hirschsprung disease is scheduled for initial surgery. Which of the following statements by the parent indicates an understanding of the teaching?

A. "I'm glad that my child's ostomy is only temporary."

Rationale: Hirschsprung disease is also known as aganglionic megacolon and is characterized by an area of the large intestine without nerve innervation. The child will probably require two surgeries over an 18- to 24-month period before normal bowel function is obtained. The initial surgery creates an ostomy, which relieves the obstructed area and allows the bowel distal to the ostomy to rest.

B. "I'm glad my child will have normal bowel movements now."

Rationale: The child will not have bowel movements after the initial surgery.

C. "I want to learn how to use my child's feeding tube as soon as possible."

Rationale: The child will not have a feeding tube after the surgery.

D. "I want to learn how to empty my child's urinary catheter bag."

Rationale: The child will not have a urinary catheter after the surgery.

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11. A nurse is preparing to perform an abdominal assessment on a child. Identify the sequence the nurse should follow. (Move the steps into the box on the right, placing them in the selected order of performance. Use all the steps.)

A. Inspection

D. Auscultation

B. Superficial palpitation

C. Deep palpitation

Rationale: When performing an abdominal assessment on a child, the nurse should first inspect the abdomen without touching and observe for anything that could indicate a medical concern. Because palpation prior to auscultation can alter the bowel sounds, the nurse should auscultate the abdomen for bowel sounds next. Then, the nurse should palpate the abdomen superficially so the child won't tense her abdominal muscles. Finally, the nurse should perform a deep palpation of the abdomen, making sure to palpate any painful areas last.

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12. A nurse is providing discharge teaching about nutrition to the parents of a child who has cystic fibrosis (CF). Which of the following responses by the parents indicates an understanding of the teaching?

A. "We will give our child pancreatic enzymes with snacks and meals."

Rationale: CF interferes with the availability of pancreatic enzymes necessary for digestion and absorption of nutrients. Therefore, pancreatic enzymes must be taken with all meals and snacks.

B. "We will restrict the amount of salt in our child's food."

Rationale: CF does not cause a child's sodium requirements to decrease. Adequate sodium is required for electrolyte balance, and at times when the child loses excessive fluids due to diaphoresis, additional sodium might be required.

C. "I will limit my child's fluid intake."

Rationale: Fluids should not be restricted. Dehydration due to inadequate fluid intake can aggravate the excessive buildup of tenacious respiratory mucus associated with CF.

D. "I will prepare low-fat meals with limited protein for my child."

Rationale: A diet that is high in calories and protein, and unrestricted in fats and salt, is typically recommended to meet the nutritional needs of the child who has CF.

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13. A nurse is admitting a child who has leukemia. Which of the following clients should the nurse place in the same room with this child?

A. A child who has nephrotic syndrome

Rationale: A child who has leukemia is at risk for infection. Nephrotic syndrome is not an infectious disorder poses no risk to a child who has leukemia.

B. A child recovering from a ruptured appendix

Rationale: A child who has leukemia is at risk for infection. A client recovering from a ruptured appendix can be infectious.

C. A child who has rheumatic fever

Rationale: A child who has leukemia is at risk for infection. A child who has rheumatic fever can still be infectious from the original causative organism.

D. A child who has cystic fibrosis

Rationale: A child who has leukemia is at risk for infection. A client who has cystic fibrosis is likely to be infectious.

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14. A nurse is caring for a 4-year-old child who has croup and wet the bed overnight. When the parents visit the next day, the nurse explains the situation and one of the parents says, "She never wets the bed at home. I am so embarrassed." Which of the following responses should the nurse make?

A. "It is expected for children who are hospitalized to regress. The toileting skills will return when your child is feeling better."

Rationale: A recently learned skill, such as toilet training, is often temporarily lost due to the stress of hospitalization. The nurse should reassure the parents that regression is an expected behavior in children who are hospitalized and that her child will regain bladder control when she is feeling better.

B. "I know this can really be embarrassing. I have kids myself, so I understand, and it doesn't bother me."

Rationale: This response minimizes the parents' feelings by dismissing the concerns.

C. "Your child did not seem upset, so I wouldn't worry about it if I were you."

Rationale: This response minimizes the parents' feelings by dismissing the concerns.

D. "Why does it bother you that your child has wet the bed?"

Rationale: Asking the parent why the child's behavior is bothersome implies criticism, which can make the parents feel defensive.

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15. A parent calls a clinic and reports to a nurse that his 2-month-old infant is hungry more than usual but is projectile vomiting immediately after eating. Which of the following responses should the nurse make?

A. "Bring your baby in to the clinic today."

Rationale: Projectile vomiting followed by hunger are characteristic of pyloric stenosis. The infant needs to be examined in the clinic by a provider as soon as possible.

B. "Burp your baby more frequently during feedings."

Rationale: Burping the infant does not address the cause of the projectile vomiting.

C. "Give your infant an oral rehydration solution."

Rationale: Administering an oral rehydration solution does not address the cause of the projectile vomiting.

D. "Try switching to a different formula."

Rationale: Switching to a different formula does not address the cause of the projectile vomiting.

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16. A nurse is caring for a 12-month-old toddler who is hospitalized and confined to a room with contact precautions in place. Which of the following toys should the nurse recommend in order to meet the developmental needs of the client?

A. Large building blocks

Rationale: Large building blocks are age-appropriate toys for a 12-month-old toddler.

B. Hanging crib toys

Rationale:

A crib gym is not an age-appropriate toy for a 12-month-old toddler. The ability to stand places the toddler at risk of strangling from the strings of the toys.

C. Modeling clay

Rationale: Modeling clay is not an age-appropriate toy for a 12-month-old toddler due to the risk of the child ingesting it.

D. Crayons and a coloring book

Rationale: Crayons and a coloring book are not age-appropriate toys for a 12-month-old client.

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17. A nurse in an emergency department is caring for an infant who has a 2-day history of vomiting and an elevated temperature. Which of the following should the nurse recognize as the most reliable indicator of fluid loss?

A. Body weight

Rationale: Body weight is the most reliable indicator of fluid loss for infants and young children.

B. Skin integrity

Rationale: Impaired skin integrity can indicate dehydration but is not the best indicator of fluid loss.

C. Blood pressure

Rationale: Change in a child's blood pressure can indicate dehydration but is not the best indicator of fluid loss.

D. Respiratory rate

Rationale: Change in a child's respiratory rate can indicate dehydration but is not the best indicator of fluid loss.

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18. A nurse is caring for a child who is 2 hr postoperative following a tonsillectomy. Which of the following fluid items should the nurse offer the child at this time?

A. Crushed ice

Rationale: Cold, clear liquids are well-tolerated following a tonsillectomy. Liquids that are brown or red should be avoided in order to tell the difference between the liquid and fresh or old blood.

B. Orange juice

Rationale: Citrus juices should be avoided as they can be irritating to the throat.

C. Vanilla milkshake

Rationale: Dairy products should be avoided as they increase the viscosity of the mucus, causing the child to frequently clear her throat, which can lead to bleeding.

D. Cranberry juice

Rationale:

Acidic fluids should be avoided as they can be irritating to the throat. Liquids that are red should be avoided in order to tell the difference between the liquid and fresh or old blood.

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19. A nurse is caring for a child who is admitted with suspected acute appendicitis. Which of the following manifestations should indicate to the nurse that the child's appendix is perforated?

A. Sudden decrease in abdominal pain

Rationale: A sudden decrease in abdominal pain should indicate to the nurse that the appendix might be ruptured. If the appendix ruptures, the pain can disappear for a short period and the client might feel suddenly better. However, once peritonitis sets in, the pain returns and can spread into the whole abdomen.

B. Absent Rovsing's sign

Rationale: Rovsing's sign is a manifestation of appendicitis. The sign is positive when tenderness occurs in the right lower quadrant regardless of which of the quadrants is being palpated.

C. Flaccid abdomen

Rationale: The abdomen becomes progressively distended with a perforated appendix.

D. Low-grade fever

Rationale: Low-grade fever is a manifestation of appendicitis, but following perforation the temperature will elevate to 38.8&deg C to 39.4&deg C (102&deg to 103&deg F).

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20. A nurse is caring for a 4-year-old child who has a new diagnosis of diabetes mellitus and is distressed after an insulin injection. Which of the following play activities should the nurse recognize is therapeutic in helping the child deal with the injection?

A. A needleless syringe and a doll

Rationale: Playing with a needleless syringe and a doll is an appropriate therapeutic activity for the child, because they will allow the child to act out feelings of anger and helplessness.

B. A video game

Rationale: Playing a video game is a distraction and is useful for a child who is bored.

C. A story book about a child who has diabetes

Rationale: This activity does not provide an outlet for working out the feelings that the child is unable to verbalize at the age of 4.

D. A period of play in the playroom

Rationale: Playing in the playroom is not a therapeutic activity in this situation.

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21. A school nurse is assessing a child for pediculosis capitis. Which of the following manifestations should the nurse recognize as an indication of this condition?

A. Firmly attached white particles on the hair

Rationale: Pediculus capitis, or head lice, are tiny parasitic insects that live on the scalp and can be spread by close contact with other people. Their eggs (nits) appear much like flakes of dandruff but stick firmly to the hair shaft instead of flaking off of the scalp.

B. Itching and scratching of the head

Rationale: There are many causes of scalp itching, so this is not a definitive indication of pediculosis capitis.

C. Patchy areas of hair loss

Rationale: Alopecia, or patchy areas of hair loss, is a typical finding in ringworm, a superficial infection of the scalp by a fungus.

D. Thick yellow crusted lesion on a red base

Rationale: Thick golden yellow crusted lesions on a red base are a typical finding in impetigo contagiosa, a superficial infection of the skin that often involves the face or scalp.

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22. A nurse is caring for a child who has Addison's disease. Which of the following actions should the nurse take?

A. Teach the parents about cortisol replacement therapy.

Rationale: The nurse should plan to teach the child's parents about cortisol replacement therapy. Administration of glucocorticoids and mineralocorticoids is necessary because inadequate supplies or a sudden cessation of the medications can cause acute adrenal crisis.

B. Place the child on a low-sodium diet.

Rationale: The nurse should ensure the child consumes salt liberally because Addison's disease causes sodium levels to decrease due to decreased aldosterone production.

C. Monitor the child for fluid volume excess.

Rationale: The nurse should monitor the child for fluid volume deficit due to the reduction or absence of cortisol and aldosterone.

D. Discuss the manifestations of hypoglycemia with the parents.

Rationale: The nurse should discuss the manifestations of hyperglycemia with the child's parents because Addison's disease causes blood glucose levels to decrease as cortisol is no longer available to regulate it.

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23. A nurse is reviewing data for four children. Which of the following children should the nurse assess first?

A. A 10-year-old child who has sickle cell anemia who reports severe chest pain

Rationale:

When using the urgent vs. nonurgent approach to client care, the nurse should determine that the 10-year-old child who has sickle cell anemia and reports severe chest pain should be assessed first. This finding is a medical emergency because it is a manifestation of acute chest syndrome.

B. A 7-year-old child who has diabetes insipidus and a urine specific gravity of 1.016

Rationale: A specific gravity of 1.016 is nonurgent because it is within the expected reference range for a 7 year-old child. There is another child the nurse should assess first.

C. A 1-year-old toddler who has roseola and a temperature of 39° C (102.2° F)

Rationale: A temperature of 39° C (102.2° F) is nonurgent because it is an expected finding of roseola. There is another child the nurse should assess first.

D. A 4-year-old child who has asthma and a PCO2 of 37 mm Hg

Rationale: A PCO2 of 37 mm Hg is a nonurgent finding because it is within the expected reference range for a 4 year-old child. There is another child the nurse should assess first.

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24. A nurse is caring for a 17-year-old client who is experiencing a relapse of leukemia and is refusing treatment. The client's mother insists that the client receive treatment. Which of the following actions should the nurse take?

A. Initiate the IV per the parent's request.

Rationale: Starting the IV could be construed as battery, which is nonconsensual touching of a client.

B. Notify the provider of the situation.

Rationale: The nurse should consult with the provider before proceeding. Although the parent must give consent for a minor, the nurse should obtain the minor's assent when the minor is able to give it.

C. Administer a sedative to calm the client.

Rationale: This action violates the client's right to participate in care and does not focus on the client's need to verbalize concerns.

D. Offer the client an antiemetic.

Rationale: There is no data that indicates this is a concern of the client. This intervention is unnecessary.

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25. A nurse is caring for an 18-month-old toddler who has been hospitalized for 10 days. After the toddler's mother leaves the room, the nurse observes the toddler sitting quietly in the corner of the crib, sucking her thumb. When the nurse approaches the crib, the toddler turns away from the nurse. The nurse should understand that these behaviors indicate which of the following developmental reactions?

A. An anxiety reaction

Rationale: Hospitalization is stressful, regardless of the age of the client. However, for an 18-month-old toddler, separation from parents adds to that stress. The toddler's behavior indicates an anxiety

reaction to the stress of hospitalization. Separation anxiety initially causes demonstrations of protest. Remaining sad and quiet when a parent leaves indicates the second response to separation anxiety, which is despair.

B. Regression

Rationale: The toddler's behavior is age-appropriate.

C. Resentment toward the mother

Rationale: This reaction is not age-appropriate.

D. Developing autonomy

Rationale: An 18-month-old toddler might be beginning to develop autonomy. However, remaining sad and quiet without protesting when a parent leaves is an unusual behavior for a toddler and is not related to developing autonomy.

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26. A nurse is caring for a child who was admitted with suspected rheumatic fever. The provider prescribes an anti-streptolysin O (ASO) titer. The parent asks the nurse the purpose of the test. Which of the following responses should the nurse make?

A. "This test will indicate if your child has rheumatic fever."

Rationale: Rheumatic fever is a systemic inflammatory disease that can develop after an infection with streptococcus bacteria and can involve the heart, joints, skin, and brain. There is no specific test that can definitively establish a diagnosis of rheumatic fever.

B. "This test will confirm if your child had a recent streptococcal infection."

Rationale: An ASO titer is a blood test that measures anti-streptolysin O antibodies in the blood. The test determines if the client has recently been infected with Group A streptococcus. The ASO antibody can be detected in the blood for weeks or months after the primary source of the infection has been eradicated.

C. "This test will indicate if your child has a therapeutic blood level of an aminoglycoside."

Rationale: An ASO titer does not measure the level of aminoglycosides in the body.

D. "This test will confirm if your child has immunity to streptococcal bacteria."

Rationale: An ASO titer does not measure a client's immunity to streptococcal bacteria.

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27. A nursing is planning care for an adolescent who is postoperative following scoliosis repair with Harrington rod instrumentation. Which of the following interventions should the nurse include in the plan of care?

A. Keep the head of the bed at a 30° angle.

Rationale: The nurse should plan to maintain the client in a supine position to prevent bending of the spine.

B. Reposition the client by log rolling every 4 hr.

Rationale: The nurse should plan to log roll the client every 2 hr to promote respiratory status.

C. Place the client in protective isolation.

Rationale: The nurse should use standard precautions for a client who is postoperative following scoliosis repair.

D. Initiate the use of a PCA pump for pain control.

Rationale: The nurse should initiate the use of a PCA pump for an adolescent who is postoperative following scoliosis repair. The PCA pump allows the client to control the delivery of pain medications.

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28. A nurse is assessing a 6-month-old infant at a well-child visit. Which of the following findings should the nurse expect?

A. Closed posterior fontanel

Rationale: The infant's posterior fontanel should close by about 8 weeks of age.

B. Uses thumb and index fingers in a pincer grasp

Rationale: A 9-month-old infant should be able to use his thumb and index fingers in a crude pincer grasp.

C. Lateral incisors

Rationale: An infant should develop upper lateral incisors between 9 and 13 months of age and lower lateral incisors at 10 to 16 months of age.

D. Sitting steadily without support

Rationale: At 6 months of age, most infants can sit only with support. An 8-month-old infant should be able to sit without support.

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29. A nurse is caring for a child who has suspected appendicitis. Which of the following provider prescriptions should the nurse clarify?

A. Maintain NPO status.

Rationale: This prescription is appropriate because the client's stomach should be empty in anticipation of the need for surgery and anesthesia.

B. Monitor oral temperature every 4 hr.

Rationale: This prescription is appropriate because appendicitis is an inflammatory process that can cause fever.

C. Medicate the client for pain every 4 hr as needed.

Rationale:

This prescription is appropriate because appendicitis can cause acute pain.

D. Administer sodium biphosphate/sodium phosphate.

Rationale: Enemas and laxatives are contraindicated because they increase the volume in the bowel and can cause the inflamed appendix to rupture, increasing the risk for peritonitis.

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30. A nurse in a PACU is admitting a client who is postoperative following a tonsillectomy. Which of the following actions should the nurse plan to take to prevent aspiration?

A. Place a bedside humidifier at the head of the client's bed.

Rationale: This action does not prevent aspiration.

B. Suction the nasopharynx as needed.

Rationale: This action can cause trauma to the denuded tonsil sockets, leading to hemorrhage. Although suction equipment should always be available at the client's bedside in case of hemorrhage or aspiration, it should only be used in an emergency and in the presence of the provider.

C. Withhold fluids until the client demonstrates a gag reflex.

Rationale: Following a tonsillectomy, the client's gag reflex can be suppressed by local anesthetics or edema. To prevent aspiration, the gag reflex must be present before the client is allowed have fluids.

D. Perform chest physiotherapy.

Rationale: The purpose of chest physiotherapy is to loosen secretions in the airways; it does not prevent aspiration.

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31. A nurse is caring for a child who is postoperative following ventriculoperitoneal (VP) shunt placement. In which of the following positions should the nurse place the client?

A. Trendelenburg

Rationale: Positioning the child in Trendelenburg could result in inadequate functioning of the VP shunt due to the child's head being lower than the rest of his body.

B. Semi-Fowler's

Rationale: Positioning the child in semi-Fowler's could result in a rapid reduction of intracranial fluid.

C. Prone

Rationale: Positioning the child prone could result in inadequate functioning of the VP shunt due to the need to position the child's head to the side.

D. On the unoperated side

Rationale: The nurse should position the child flat on the unoperated side to prevent a rapid reduction of

intracranial fluid and to protect the child for injuring the operative site.

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32. A nurse is performing a pre-college physical assessment on an adolescent. Which of the following immunizations should the nurse anticipate administering?

A. Pneumococcal polysaccharide vaccine

Rationale: The pneumococcal polysaccharide vaccine is recommended for clients who are infants or older adults. It is also given to clients of any age who have a chronic illness.

B. Bacille Calmette-Guérin (BCG) vaccine

Rationale: The BCG vaccine is made of a live, weakened strain of the tuberculosis bacteria. It is used in many countries in which tuberculosis is endemic, but due to the fact that it only provides a small degree of very short lasting protection against tuberculosis, the BCG vaccine is not generally used in the U.S.

C. Meningococcal polysaccharide vaccine

Rationale: Recent studies have shown that college students, especially freshmen living in dormitories, are at an increased risk for meningococcal meningitis. The Centers for Disease Control and Prevention and the American Academy of Pediatrics now recommend that college students and parents be educated about meningococcal disease and consider vaccination.

D. Influenza vaccine

Rationale: The influenza vaccine is a seasonal vaccine that is recommended for clients who are older adults, pregnant women, infants, or health care providers likely to come into contact with influenza. It is also recommended for clients of any age who have chronic illness.

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33. A nurse is caring for a 2-year-old child who is hospitalized and throws a tantrum when his parent leaves. Which of the following toys should the nurse provide to alleviate the child's stress?

A. Set of building blocks

Rationale: Although a set of building blocks is an age-appropriate toy for a 2-year-old child, it is not the most therapeutic toy.

B. Toy hammer and pounding board

Rationale: A toy hammer and pounding board helps the child to express the anger and frustration he feels about the parent leaving but lacks the verbal ability to express.

C. Picture book about hospitals

Rationale: Although a picture book is an age-appropriate toy for a 2-year-old child, it is not the most therapeutic toy.

D. Stuffed animal

Rationale: Although a stuffed animal is an age-appropriate toy for a 2-year-old child, it is not the most

therapeutic toy.

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34. A nurse is caring for a child who ingested kerosene. Which of the following assessments is the nurse's priority?

A. Respiratory rate

Rationale: Using the airway, breathing, circulation approach to client care, the nurse should prioritize assessing the client's respiratory rate. Small amounts of kerosene can enter the lungs and damage them directly, causing a severe aspiration pneumonia. Because the pneumonia is caused by chemical irritation rather than bacteria, antibiotics aren't useful for prevention or treatment. Breathing becomes rapid and gasping, and vomiting and persistent coughing can follow. In severe cases, brain damage can occur.

B. Burns of the mouth

Rationale: Burns to the face, mouth, and esophagus can be initial findings after kerosene ingestion, but checking for burns is not the priority assessment.

C. Bowel sounds

Rationale: Bowel sounds should be assessed due to the ingestion of kerosene, but auscultating bowel sounds is not the priority assessment.

D. Visual acuity

Rationale: Blurred vision can be an initial finding after kerosene ingestion, but checking vision is not the priority assessment.

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35. A nurse is planning care for a 10-year-old child who will be hospitalized for an extended period of time. Which of the following actions should the nurse include in the plan of care to meet the client's psychosocial needs according to Erikson?

A. Arrange for a teacher to provide lesson plans.

Rationale: Erikson's stage of psychosocial development for a 10-year-old child is industry vs. inferiority. By providing school-age children the opportunity to keep up with their school work, they can maintain continue to develop skills and knowledge and maintain a sense of accomplishment.

B. Allow the client to select his own food from the menu.

Rationale: Providing appropriate choices can help the school-age child adjust emotionally to the stress of prolonged hospitalization but allowing decision making is more appropriate for the psychosocial development of a preschooler.

C. Discourage visits from the client's friends.

Rationale: Encouraging visits from friends can help the school-age child adjust emotionally to the stress of prolonged hospitalization.

D. Provide a daily session with a play therapist.

Rationale:

The school-age child needs to play, and a daily therapeutic session with the play therapist will help the child adjust to the stress of prolonged hospitalization. However, this action does not address the child's psychosocial development according to Erikson.

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36. A nurse is assessing a 3-year-old child who has aortic stenosis. Which of the following findings should the nurse expect? (Select all that apply.)

- A. Hypotension
- B. Bradycardia
- C. Clubbing of the nail beds
- D. Weak pulses
- F. Murmur

Rationale: Hypotension is correct. Hypotension with aortic stenosis is a result of decreased cardiac output.Bradycardia is incorrect. Children who have aortic stenosis have tachycardia, rather than bradycardia.Clubbing of the nail beds is incorrect. Clubbing of the nail beds is a clinical manifestation of Tetralogy of Fallot, rather than aortic stenosis.Weak pulses is correct. Weak pulses with aortic stenosis are a result of decreased cardiac output. Murmur is correct. A narrowing of the aortic valve cause a characteristic murmur in children who have aortic stenosis.Murmur is correct. A narrowing of the aortic valve cause a characteristic murmur in children who have aortic stenosis.

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37. A nurse is caring for an 8-year-old child who has acute rheumatic fever. Which of the following assessments is the nurse's priority immediately after admission?

- A. Auscultating the rate and characteristics of the child's heart sounds

Rationale: Using the airway, breathing, circulation approach to client care, the nurse should place priority on auscultating the client's heart rate and heart sounds. Rheumatic fever is an inflammatory disease that begins with a strep throat from a streptococcal infection and can progress to rheumatic heart disease, which is a condition in which the heart valves are damaged by rheumatic fever. Auscultating heart sounds is the priority assessment because tachycardia and cardiac murmur indicate cardiac involvement, which can result in serious, life-threatening, and life-long complications.

- B. Using a pain-rating tool to determine the severity of the joint pain

Rationale: Pain in one or more joints is characteristic of rheumatic fever. However, because joint pain is not life-threatening, and since there are usually no permanent sequelae to the joint involvement in rheumatic fever, this is not the priority assessment.

- C. Identifying the degree of parental anxiety related to the diagnosis

Rationale: The client's parents' anxiety is not life-threatening to the child and should not receive priority during the initial assessment.

- D. Assessing the client's erythematous rash

Rationale:

Because the rash is not life-threatening, this is not the priority assessment.

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38. A parent of a toddler asks a nurse at a well-child visit how the child's frequent temper tantrums can best be handled. Which of the following actions should the nurse suggest to the parent?

A. Restrain the child physically.

Rationale: Restraints can cause the behavior to intensify.

B. Ignore the temper tantrums.

Rationale: Ignoring a negative behavior is a basic concept in behavior modification. The parent should be instructed to make sure that the child is safe, and then appear to ignore the child or walk away. Without an audience, the behavior is more likely to extinguish itself quickly.

C. Tell the child that temper tantrums are not acceptable.

Rationale: This action is not developmentally appropriate. Temper tantrums occur due to an age-appropriate lack of self-control, which is gradually gained as the child matures.

D. Distract the child by offering to play a game.

Rationale: Offering the child an opportunity to play a game provides positive reinforcement for an unacceptable behavior.

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39. A nurse is caring for a 6-week-old infant who has a pyloric stenosis. Which of the following clinical manifestations should the nurse expect?

A. Red currant jelly stools

Rationale: Red currant jelly stools is a clinical manifestation of intussusception.

B. Distended neck veins

Rationale: Distended neck veins is a clinical manifestation of fluid overload.

C. Projectile vomiting

Rationale: Pyloric stenosis is a narrowing of the pylorus, the outlet from the stomach to the small intestine. The narrowing does not allow for emptying of the stomach contents. Vomiting, which is usually mild at first, becomes more forceful and progresses to projectile vomiting.

D. Ridged abdomen

Rationale: A ridged abdomen is a clinical manifestation of appendicitis.

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40. A nurse is assessing a female child in an area struck by an earthquake. The child, who is crying, walks well, can state her first name, and repeatedly says "All done" and "Go bye-bye now" during the assessment. The child has

24 deciduous teeth and her anterior fontanel is closed. Based on these observations, the nurse should estimate that the child is how many months old?

A. 12

Rationale: This age estimate is incorrect.

B. 18

Rationale: This age estimate is incorrect.

C. 24

Rationale: This age estimate is incorrect.

D. 30

Rationale: The nurse should estimate that the child is at least 30 months in age because the child has completed her primary dentition (24 deciduous teeth), which occurs by 30 months (2 ½ years) of age. In addition, the nurse should recognize that the child is at least 18 months of age because the anterior fontanel is closed and should suspect that the child is at least 24 months (2 years) of age because the child speaks in two- and three-word phrases.

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41. A nurse is providing nutritional teaching to the mother of a preschooler and is recommending food options to provide 1 oz of grains. Which of the following foods should the nurse recommend?

A. 1 cup ready-to-eat cereal flakes

Rationale: The child should eat 1 cup of ready-to-eat cereal flakes to consume 1 oz of grains.

B. ½ slice whole wheat bread

Rationale: The child should eat one slice of whole wheat bread to consume 1 oz of grains.

C. 1 cup cooked rice

Rationale: The child should eat a half cup of cooked rice to consume 1 oz of grains.

D. ½ flour tortilla

Rationale: The child should consume one 6 inch flour tortilla to consume 1 oz of grains.

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42. A nurse is planning care for a 6-year-old child who has bacterial meningitis. Which of the following nursing interventions is unnecessary in the client's plan of care?

A. Place the client in a semi-Fowler's position.

Rationale: A semi-Fowler's position, with the head of bed elevated to between 30° and 45°, will help to reduce edema in the brain.

B. Admit the client to a private room.

Rationale:

Isolation for the first 24 hr is indicated for a client who has bacterial meningitis due to the highly contagious nature of some types of bacterial meningitis. Decreasing the environmental stimuli is also an important action in the care of a client who has meningitis.

C. Measure head circumference every shift.

Rationale: The head circumference of a 6-year-old can't increase since the fontanels and sutures have been closed since the child was 18 months old. Therefore, it is unnecessary to measure the child's head circumference.

D. Implement seizure precautions.

Rationale: Seizure precautions are appropriate because the child has an increased risk for seizure activity. The meningitis itself and corresponding brain edema and meningeal irritation can result in seizure activity. Meningitis typically causes a very high fever, which increases the risk of febrile seizure.

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43. A nurse is assessing a toddler who has heart failure. Which of the following findings should the nurse expect?

A. Weight loss

Rationale: A toddler who has heart failure is more likely to have weight gain than weight loss due to systemic venous congestion.

B. Increased urine output

Rationale: A toddler who has heart failure is more likely to have decreased, rather than increased, urine output due to impaired cardiac function and decreased cardiac output.

C. Bradycardia

Rationale: A toddler who has heart failure is more likely to have tachycardia, rather than bradycardia, as a result of sympathetic stimulation of the heart.

D. Orthopnea

Rationale: A toddler who has heart failure has increased venous return to the heart and lungs, which leads to pulmonary congestion. The congestion causes orthopnea, or difficulty breathing, while lying down. Having the toddler sit up decreases venous return, as well as pressure the abdominal organs have on the diaphragm. This decrease in pressure improves breathing and oxygenation.

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44. A nurse is providing discharge instructions to the parent of a 10-year-old child following a cardiac catheterization. Which of the following instructions should the nurse include?

A. Keep the child home for 1 week.

Rationale: The child should avoid strenuous activity but can attend school.

B. Give the child acetaminophen for discomfort.

Rationale:

The child might have minor discomfort at the puncture site. The parent should offer either acetaminophen or ibuprofen due the risk of Reye syndrome associated with taking aspirin.

C. Offer the child clear liquids for the first 24 hr.

Rationale: The child should begin fluid intake with sips of clear liquids but can resume her regular diet as soon as she desires.

D. Assist the child to take a tub bath for the first 3 days.

Rationale: The child should keep the site clean and dry and therefore avoid tub baths for at least 3 days. The parent can remove the dressing the day after the procedure and then cover the site with an adhesive bandage strip for the next 2 days. The child can shower if she is able to keep the site dry.

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45. A nurse is planning care for a 5-month-old infant who is scheduled for a lumbar puncture to rule out meningitis. Which of the following actions should the nurse include in the plan of care?

A. Keep the infant NPO for 6 hr prior the procedure.

Rationale: Fasting is not required prior to a lumbar puncture.

B. Apply a eutectic mixture of lidocaine and prilocaine cream topically 15 min prior to the procedure.

Rationale: The nurse should apply a eutectic mixture of lidocaine and prilocaine cream topically 60 min prior to the procedure.

C. Place the infant in an infant seat for 2 hr following the procedure.

Rationale: The nurse should position the infant flat following the procedure to prevent postural drainage.

D. Hold the infant's chin to his chest and knees to his abdomen during the procedure.

Rationale: During the procedure, the infant is positioned on her side in a fetal position (knees curled to abdomen and chin tucked to chest) to open up the subarachnoid space.

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46. A nurse is caring for a toddler who has acute laryngotracheobronchitis and has been placed in a cool mist tent. Which of the following findings indicates that the treatment has been effective?

A. Barking cough

Rationale: A barking cough is a manifestation of the disease, not an indication of the treatment's effectiveness.

B. Improved hydration

Rationale: Improved hydration is not a purpose of a cool mist treatment.

C. Decreased stridor

Rationale: Laryngotracheobronchitis, or croup, is a condition caused by an infection of the upper airway

(larynx, trachea, and bronchus) and is characterized by a barking cough. Edema and obstruction in the upper airways cause the characteristic cough and stridor (noisy breathing). The direct purpose of a cool mist tent is to humidify the inspired air, which decreases respiratory effort.

D. Decreased temperature

Rationale: A decrease in the child's temperature does not indicate the effectiveness of the treatment.

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47. The parent of a 4-year-old child tells a nurse that the child believes there are monsters hiding in the closet at bedtime. Which one of the following statements should the nurse make?

A. "Let your child sleep in your bed with you."

Rationale: Co-sleeping can develop into a habit that can be difficult to break.

B. "Keep a night light on in your child's room."

Rationale: Fears of the dark and "monsters" are common in preschool-age children who are imaginative thinkers and have difficulty distinguishing between real and make-believe. After the parent reassures the child that there are no monsters, the night light provides enough illumination for the child to see that there is nothing hiding in the closet.

C. "Tell your child that monsters are not real."

Rationale: This is not an appropriate suggestion for a preschool-age child who has difficulty distinguishing between real and make-believe.

D. "Stay with your child until the child is asleep."

Rationale: This behavior can develop into a habit that can be difficult to break.

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48. A nurse is caring for a child who is on a clear liquid diet. At lunch, the child consumed ½ cup of juice, 3 oz gelatin, 1 oz of an ice pop, and 20 mL ginger ale. How many mL should the nurse record as the child's fluid intake?

260 mL

Correct Rationale: To determine the amount of intake the nurse should first convert each source of intake to the same unit of measurement (mL): ½ cup of juice:1 cup = 8 oz ½ cup (8 oz 2) = 4 oz 1 oz = 30 mL 4 oz x 30 = 120 mL ½ cup = 120 mL 3 oz gelatin: 1 oz = 30 mL 3 oz x 30 = 90 mL 1 oz ice pop: 1 oz = 30 mL 20 mL of ginger aleThen, the nurse should total the amounts: 120 mL + 90 mL + 30 mL + 20 mL = 260 mL

InCorrect Rationale: To determine the amount of intake the nurse should first convert each source of intake to the same unit of measurement (mL): ½ cup of juice:1 cup = 8 oz ½ cup (8 oz 2) = 4 oz 1 oz = 30 mL 4 oz x 30 = 120 mL ½ cup = 120 mL 3 oz gelatin: 1 oz = 30 mL 3 oz x 30 = 90 mL 1 oz ice pop: 1 oz = 30 mL 20 mL of ginger aleThen, the nurse should total the amounts: 120 mL + 90 mL + 30 mL + 20 mL = 260 mL

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49. A nurse is preparing to administer digoxin to a 6-month-old infant. Prior to administering the dose, the nurse measures the apical heart rate. The nurse should withhold the dose if the infant's apical heart rate is less than what rate?

90 /min

Correct Rationale: Bradycardia is an adverse effect of digoxin. Expected apical heart rates vary considerably according to age. The nurse should withhold the digoxin dose for heart rate of 60/min or below in an adult, 70/min or below in a child, and 90/min or below in an infant.

InCorrect Rationale: Bradycardia is an adverse effect of digoxin. Expected apical heart rates vary considerably according to age. The nurse should withhold the digoxin dose for heart rate of 60/min or below in an adult, 70/min or below in a child, and 90/min or below in an infant.

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50. A nurse participating in lead screening at a community center. The nurse should instruct parents to bring their children back for rescreening in a year for which of the following laboratory values?

A. 4 mcg/dL

Rationale: A child who has a lead blood level of 4 mcg/dL should return in a year for rescreening.

B. 10 mcg/dL

Rationale: A child who has a lead blood level of 10 mcg/dL should return for follow up testing in 1 month, and every 3 to 4 months after that.

C. 18 mcg/dL

Rationale: A child who has a lead blood level of 10 mcg/dL should return for follow up testing in 1 month, and every 3 to 4 months after that.

D. 44 mcg/dL

Rationale: The nurse should initiate a referral to a clinical center specializing in lead poisoning for a child who has a lead blood level of 44 mcg/dL. The child might undergo chelation therapy.
