Detailed Answer Key
Pediatric

1. 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.

2. 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.

3. A nurse teaching the parents of a 10-month-old infant about home safety. Which of the following information should the nurse include in the teaching? (Select all that apply.)

- A. Serve food in small, non-circular pieces.

B. Tie plastic bags in knots before discarding them.

C. Install accordion style gates.

D. Set the water heater at 65.6° C (150° F).

E. Fit the mattress so that it is snug against the sides of the crib.

Rationale: Serve food in small, non-circular pieces is correct. Infants have small airways. Food items are a common cause of aspiration. The foods most associated with choking and aspiration are hot dogs, candy, nuts, and grapes.Tie plastic bags in knots before discarding them is correct. Tying the bags in knots prevents the child from placing the plastic over her head.Install accordion style gates is incorrect. This type of gate can cause the child to pinch herself or to become entangled in the openings.Set the water heater at 65.6 C (150 F) is incorrect. Water heaters should be set to a temperature of 48.9 C (120 F) or lower to prevent burns.Fit the mattress so that it is snug against the sides of the crib is correct. The mattress should be fit snugly to prevent the child from being caught between the slats of the crib and the mattress.

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4. A nurse is obtaining the length and weight of a 6-month-old infant. Which of the following actions should the nurse take? (Select all that apply.)

A. Weigh the infant in a diaper.

B. Use a stadiometer to measure the infant.

C. Place a disposable covering on the scale.

D. Measure the infant from crown of the head to the heels of feet.

E. Balance the scale to 0 prior to use.

Rationale: Weigh the infant in a diaper is incorrect. To obtain an accurate weight, the nurse should weigh a child who is 36 months of age or younger without a diaper or clothing.Use a stadiometer to measure the infant is incorrect. The nurse should place the infant in a recumbent position and use a length board to obtain the infant's length. The nurse should use a stadiometer, a wall-mounted unit, for measuring the height of individuals who can stand independently.Place a disposable covering on the scale is correct. The nurse should use a thin disposable cover to promote safety and minimize transmission of pathogens.Measure the infant from crown of the head to the heels of feet is correct. The nurse should place the infant in a recumbent position, keeping the head against the top of the board and the heels against the footboard. The nurse can also help extend the infant's body by gently holding the infant's legs down against the board.Balance the scale to 0 prior to use is correct. The nurse should balance the scale to 0 prior to weighing the infant to ensure an accurate measurement.

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5. A nurse is caring for a preschooler who has a partial-thickness burn on her right forearm. Which of the following findings should the nurse expect?

A. Dry surface

B. Sensitive to touch

C. Wound blanches with pressure

D. Intact epidermis

E. Blisters

Rationale: Dry surface is incorrect. A full-thickness burn typically has a dry surface. A partial-thickness burn is wet and shiny, with a weeping surface.Sensitive to touch is correct. A partial-thickness burn is sensitive to touch.Wound blanches with pressure is correct. A partial-thickness burn blanches with pressure.Intact epidermis is incorrect. A superficial burn has intact epidermis.Blisters present on skin is correct. A partial-thickness degree burn has blisters.

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6. A nurse is caring for an infant who has a tracheoesophageal fistula. Which of the following findings should the nurse expect? (Select all that apply.)

A. Coughing

B. Apnea

C. Sunken abdomen

D. Cyanosis

E. Frothy saliva

Rationale: Coughing is correct.Coughing is a finding associated with a tracheoesophageal fistula.Apnea is correct. Apnea is a finding associated with a tracheoesophageal fistula.Sunken abdomen is incorrect. Abdominal distension, rather than a sunken abdomen, is a finding associated with a tracheoesophageal fistula.Cyanosis is correct. Cyanosis is a finding associated with a tracheoesophageal fistula.Frothy saliva is correct. Frothy saliva is a finding associated with a tracheoesophageal fistula.

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7. A nurse is preparing to discharge a child who has a new prescription for an oral antibiotic. Which of following information should the nurse include in the discharge instructions? (Select all that apply.)

A. The reason why the child is taking the medication

B. Written information about the medication

C. Stopping the medication when the child feels better

D. The adverse effects of the medication

E. Using a kitchen spoon to administer the medication

Rationale: The reason why the child is taking the medication is correct. The nurse should include the reason why the child is taking the medication in the discharge instructions.Written information about the medication is correct. The nurse should include written information about the medication in the discharge instructions.Stopping the medication when the child feels better is incorrect. The child should finish taking the medication.The adverse effects of the medication is correct. The nurse should include the adverse effects of the medication in the discharge

instructions.Using a kitchen spoon to administer the medication is incorrect. A kitchen spoon should not be used to administer the medication.

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8. A nurse is caring for a 3-year-old child whose parents report that she has an intense fear of painful procedures, such as injections. Which of the following strategies should the nurse add to the child's plan of care? (Select all that apply.)

- A. Have a parent stay with the child during procedures.
- B. Cluster invasive procedures whenever possible.
- C. Perform the procedure as quickly as possible.
- D. Allow the child to keep a toy from home with her.
- E. Use mummy restraints during painful procedures.

Rationale: Have a parent stay with the child during procedures is correct. Maintaining parent-child contact is one of the most supportive interventions for toddlers and preschoolers undergoing painful procedures.Cluster invasive procedures when possible is incorrect. Clustering creates an unnecessarily lengthy and painful period for the client, which is likely to increase her fear.Perform procedures as quickly as possible is correct. Moving quickly through the steps of a painful procedure is a supportive intervention for children undergoing painful procedures.Allow the child to keep a toy from home with her is correct. Having familiar and cherished objects nearby is therapeutic for children during their hospitalization.Use mummy restraints during painful procedures is incorrect. Mummy restraints help to immobilize very young children and keep them safe during procedures, but it is likely to increase fear in toddlers and preschoolers.

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9. A nurse is caring for an infant who has gastroesophageal reflux. The nurse should recognize that which of the following findings are associated with this condition? (Select all that apply.)

- A. Vomiting
- B. Weight loss
- C. Rigid abdomen
- D. Wheezing
- E. Fever

Rationale: Vomiting is correct. Vomiting is associated with gastroesophageal reflux.Weight loss is correct. Weight loss is associated with gastroesophageal reflux.Rigid abdomen is incorrect. A rigid abdomen is associated with appendicitis.Wheezing is correct. Wheezing is associated with gastroesophageal reflux.Fever is incorrect. Fever is associated with appendicitis.

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10. A nurse is caring for a child who is having a seizure. Which of the following actions should the nurse take? (Select all that apply.)

A. Assess the client's airway patency.

B. Place a tongue depressor in the client's mouth.

C. Remove objects from the client's bed.

D. Place the client in a side-lying position.

E. Restrain the client.

Rationale: Assess the client's airway patency is correct. The nurse should continually assess the client's airway during a seizure.Place a tongue depressor in the client's mouth is incorrect. Placing something in the client's mouth can cause injury.Remove objects from the client's bed is correct. The nurse should remove objects that can cause injury to the client during a seizure.Place the client in a side-lying position is correct. The client should be positioned side-lying to prevent aspiration of secretions or vomit.Restrain the client is incorrect. Restraining the client can cause injury.

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11. A nurse is assisting with the admission of a child who has measles. Which of the following isolation precautions should the nurse initiate?

A. Airborne

Rationale: The nurse should initiate airborne precautions for a child who has measles, which is transmitted via droplet nuclei smaller than 5 microns. The nurse should place the child in a negative-pressure airflow room and wear a mask when providing client care.

B. Contact

Rationale: The nurse should initiate contact precautions for clients who have infections such as *Clostridium difficile*, scabies, and shigella. The nurse should wear gloves and a gown when providing client care.

C. Protective environment

Rationale: The nurse should initiate a protective environment for a child who is immunocompromised, such as while undergoing a stem cell transplant. The nurse should place the client in a positive-pressure airflow room.

D. Droplet

Rationale: The nurse should initiate droplet precautions for clients who have an infection spread by droplet nuclei larger than 5 microns. These infections include rubella, pertussis, and mumps.

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12. A nurse is preparing to assist with applying a cast to a preschooler's arm. Which of the following actions should the nurse take?

A. Wrap the arm of the child's doll or toy prior to the procedure.

Rationale: The nurse should consider the developmental age before the cast is applied. A preschooler might fear bodily harm and fantasize about the loss of an extremity. Using a doll or stuffed

animal helps to explain the procedure. During this stage of development, the child is a "magical thinker" and might believe stuffed animals are alive. This action shows the child that it does not hurt the doll or stuffed animal, and, in turn, will not hurt the child.

B. Tell the child, "This will make your arm feel better."

Rationale: A preschooler would not be comforted by these words. A child in this age group is unable to associate a "cause and effect" and has a limited understanding of the cause, but knows what it feels like. It would be more appropriate to tell the child that the cast might feel "warm." The child would be able to understand this information, and it would provide reassurance and alleviate the preschooler's fear of bodily harm.

C. Place a heated fan at the bedside to facilitate drying.

Rationale: Heated fans or dryers should not be used. These promote drying from the outside to the inside. The heat conduction could also cause a burn. The cast should remain uncovered and allowed to dry from the inside out.

D. Support the casted arm with a firm grasp.

Rationale: The nurse might need to provide support but should not use a firm grasp. A wet plaster cast should be supported by a pillow that is covered in plastic and held by using the palms of the hands. This will prevent indentions, which can cause pressure areas.

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13. 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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14. 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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15. 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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16. 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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17. 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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18. 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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19. 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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20. 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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21. 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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22. 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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23. 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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24. 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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25. 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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26. 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.

27. 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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28. 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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29. 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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30. 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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31. 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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32. A nurse is teaching a parent of a child who has hemophilia how to control a minor bleeding episode. Which of the following statements by the parent indicates a need for further teaching?

A. "I will have my child rest."

Rationale: Supportive measures to control a minor bleeding episode include resting.

B. "I will elevate the affected part."

Rationale: Supportive measures to control a minor bleeding episode include elevation.

C. "I will compress the site."

Rationale: Supportive measures to control a minor bleeding episode include compression.

D. "I will apply heat."

Rationale: Supportive measures to control a minor bleeding episode include applying cool compresses.

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33. A nurse is caring for a child who is having a tonic-clonic seizure and vomiting. Which of the following actions is the nurse's priority?

A. Place a pillow under the child's head.

Rationale: There is another action that the nurse should perform first.

B. Position the child side-lying.

Rationale: This is the priority nursing action. To prevent aspiration due to vomiting, the nurse should place the child in a side-lying position.

C. Loosen restrictive clothing.

Rationale: There is another action that the nurse should perform first.

D. Clear the area of hazards.

Rationale: There is another action that the nurse should perform first.

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34. A nurse is collecting data from a child who is descending stairs by placing both feet on each step and holding on to the railing. The nurse should understand that these actions are developmentally appropriate at which of the following ages?

A. 3 years

Rationale: At age 3, children can typically ascend stairs using alternating feet but still descend by placing both feet on each step.

B. 4 years

Rationale: By age 4, children can descend stairs using alternating feet and holding the railing.

C. 5 years

Rationale: By age 5, children's balance improves but they continue hold the railing when ascending and descending stairs.

D. 6 years

Rationale: At age 6, balance improves so that children are proficient at ascending and descending stairs.

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35. A nurse is assessing an adolescent who has an exacerbation of Graves' disease. Which of the following findings should the nurse expect?

A. Weight gain

Rationale: An adolescent who has an exacerbation of Graves' disease is more likely to have weight loss instead of weight gain. The adolescent's metabolic rate is greatly increased, which leads to weight loss despite an increased appetite.

B. Bradycardia

Rationale: An adolescent who has an exacerbation of Graves' disease is likely to have tachycardia due to increased sympathetic nervous system activity, as well as increased thyroid hormone stimulation of the heart.

C. Lethargy

Rationale: An adolescent who has an exacerbation of Graves' disease is likely to have irritability, hyperactivity, tremors, and insomnia due to increased sympathetic nervous system activity.

D. Heat intolerance

Rationale: An exacerbation of Graves' disease can cause heat intolerance due to an increased metabolic rate, which leads to warm flushed moist skin and extreme diaphoresis.