

Detailed Answer Key N433 Exam 1 Practice Questions

1. The medical-surgical float nurse is assigned to the pediatric unit for the first time and states that the skills are “the same as general nursing since children are little adults with smaller bodies.” What component of pediatric nursing contraindicates this statement?

- A. Pediatric nursing involves care based on the developmental level of the patient.

Rationale: This is correct. Pediatric nursing involves not only general nursing care and planning but also the developmental level of the patient. The history of pediatric nursing describes how the role has evolved into a specialty.

- B. Pediatric nursing involves the patient’s family in the plan of care.

Rationale: This is incorrect. Although this is a component of pediatric nurses, it does not answer the concern regarding the “little adults” comment.

- C. Pediatric nursing is based on the prevention of infectious diseases.

Rationale: This is incorrect. Although this is a component of pediatric nurses, it does not answer the concern regarding the “little adults” comment.

- D. Pediatric nursing involves cultural sensitivity in patient care.

Rationale: This is incorrect. Although this is a component of pediatric nurses, it does not answer the concern regarding the “little adults” comment.

2. The culturally sensitive pediatric nurse is aware of the racial makeup of the U.S. population. Which of the following reflects the demographics of the U.S. pediatric population in 2018, based on U.S. Census Bureau data?

- A. The American Indian and Alaska Native populations represent one-fifth of the pediatric population.

Rationale: This is incorrect. The American Indian and Alaska Native populations represent 0.8% of the pediatric population.

- B. About half of the children fall in the category of something other than White non-Hispanic.

Rationale: This is correct. About 50% of the children aged 0 to 17 in 2018 were White non-Hispanic.

- C. The population of Asian children decreased from 2015 to 2018.

Rationale: This is incorrect. There was no change in the population of Asian, non-Hispanic children from 2015 to 2018.

- D. There was no change in the population of non-Hispanic children who represent two or more races between 2015 and 2018.

Rationale: This is incorrect. The population of non-Hispanic children who represent two or more races increased from 4% in 2015 to 5% in 2018.

3. Which statement best describes the common core concepts of the different models of pediatric nursing?

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A. All models focus on open communication between the child and the nurse.

Rationale: This is incorrect. This omits the necessity of family relationships in the care and development of the child.

B. All models focus on the importance of family relationships to the child.

Rationale: This is correct. This is a common core concept in family-centered care, relationship-based care, and pediatric medical home care.

C. All models focus on safeguarding the child's dignity during care.

Rationale: This is incorrect. This is a concept based on patient relationship-based care.

D. All models focus on the coordination of care needs that arise during illness.

Rationale: This is incorrect. This is a component of pediatric medical home care.

4. Which of the following tasks is associated with the pediatric medical home care model of pediatric nursing?

A. The nurse refers the family to a childhood cancer support group prior to discharge from the hospital.

Rationale: This is correct. The pediatric medical home care model coordinates care and includes referrals for community services for nonmedical needs.

B. The nurse includes a simple explanation of the procedure to the child based on the child's developmental level.

Rationale: This is incorrect. This is a core concept of relationship-based care.

C. The nurse includes the family's cultural celebrations and observations while providing care to the child.

Rationale: This is incorrect. This is a core concept of cultural sensitivity and family-centered care.

D. The nurse develops the plan of care with the child and family as the focal point of the interventions.

Rationale: This is incorrect. This is a core concept of relationship-based care.

5. The pediatric nurse is developing interventions for a school-aged child based on the nursing diagnosis of imbalanced nutrition related to a body mass index (BMI) of 37 and poor food choices as evidenced by patient's mother's food diary for the family and child's statements of food preferences. Which of the following would be an appropriate nursing intervention?

A. Provide the child and family with information from <https://www.MyPlate.gov> for healthy food options.

Rationale: This is correct. Providing information on a reliable resource for both the child and family may facilitate adherence and comprehension.

B. Increase the child's activity by incorporating the child's friends into a plan of healthy exercise options.

Rationale: This is incorrect. This may incorporate the child's adherence in exercise due to peer pressure,

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but it would not facilitate adherence within the family unit.

- C. Explain the importance of balancing diet and exercise to prevent obesity to the child and family.

Rationale: This is incorrect. Current trends incorporate the child's family in the plan of care for better adherence. There is no indication that the child would make healthy choices without the support of the family.

- D. Provide information on the increased risk for potential disease processes such as diabetes and hypertension.

Rationale: This is incorrect. Giving information on the increased risk would only inform not educate on healthy choices for disease prevention, which is a current trend in pediatric nursing.

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6. The nurse must obtain data for a routine assessment of the 8-month-old patient. Which of the following are part of that assessment? **Select all that apply.**

Answers cannot be displayed for this alternate item format.

Rationale: Feedback 1. This is correct. The pediatric nurse monitors growth and development, including physical maturation. 2. This is correct. The pediatric nurse monitors growth and development, including physical maturation. 3. This is incorrect. This is an assessment that is not appropriate for an infant, as the infant would not be able to follow directions for this assessment. 4. This is incorrect. The Tanner scale is used to assess the onset of puberty. It is not an appropriate assessment for an infant. 5. This is correct. The pediatric nurse assessment includes listing of required immunizations in preparation for administering the appropriate ones.

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7. Which of the following behaviors serves as an example of the nurse directly upholding the American Nurses Association's (ANA's) Code of Ethics for Nurses?

- A. The nursing union develops a safe patient-to-nurse ratio.

Rationale: This is correct. Provisions 5 and 6 of the ANA code describe how the nurse establishes and improves health-care environments and conditions of employment conducive to quality of health care.

- B. The nurse joins a professional specialty organization.

Rationale: This is incorrect. Although this may facilitate duties to self and others, it is not a direct effect from the Code of Ethics for Nurses.

- C. The nurse maintains sterile technique during procedures.

Rationale: This is incorrect. This is a fundamental nursing skill. It is not a direct effect from the Code of Ethics for Nurses.

- D. The nurse develops a plan of care for a community-wide illness.

Rationale: This is incorrect. Although the nurse practice involves developing plans of care, it may not involve a Code of Ethics for Nurses stance.

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8. Which of the following statements serves as an example of the nurse directly upholding the ANA Pediatric Nursing: Scope and Standards of Practice?

A. The nursing union develops a safe patient-to-nurse ratio.

Rationale: This is incorrect. Provisions 5 and 6 of the ANA code, not the Pediatric Nursing: Scope and Standards of Practice, describe how the nurse establishes and improves health-care environments and conditions of employment conducive to quality of health care.

B. The nurse uses disengagement to remain in difficult situations with the patient.

Rationale: This is incorrect. Disengagement is an extreme of the relationship continuum and should be avoided.

C. The nurse maintains therapeutic relationships with the family and patient.

Rationale: This is correct. It is required for therapeutic relationships to be at the core of pediatric nursing care for the Pediatric Nursing: Scope and Standards of Practice.

D. The nurse develops a plan of care for a community-wide illness.

Rationale: This is incorrect. Although the nurse practice involves developing plans of care, it may not involve the Pediatric Nursing: Scope and Standards of Practice stance.

9. The nurse understands that the nursing profession has standards of care that promote the covenant between patient and nurse. Which of the following is an example of this covenant?

A. The nurse adheres to strict guidelines regarding medication administration and procedures.

Rationale: This is incorrect. This is safe nursing practice and may promote trust between the nurse and patient, but it does not directly promote the covenant.

B. The nurse develops a care plan with mutually developed goals and interventions with the patient.

Rationale: This is correct. This develops a level of trust and empathy between the patient and nurse (keyword: mutual goal and interventions).

C. The nurse attends continuing education courses to maintain competency in skills.

Rationale: This is incorrect. Although this may increase the nurse's competence, it does not directly affect the trust between the patient and nurse.

D. The nurse considers each patient's cultural practices without bias or judgment.

Rationale: This is incorrect. Although this may facilitate respect from the nurse, it may not promote trust between the nurse and patient.

10. The nurse is providing care to an adolescent patient with cystic fibrosis in the acute-care setting. The patient tells the nurse, "You are my favorite because you always listen to me, not like the other nurse who hates me." Which

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response by the nurse is **most** appropriate?

- A. "I will report the other nurse immediately, and you won't have to see her again."

Rationale: This is incorrect. This is unprofessional and facilitates splitting of the staff. The patient is chronically ill and may have repeated hospital admissions.

- B. "If you have any concerns, I can ask the charge nurse to talk to you, but we all work as a team."

Rationale: This is correct. Acknowledgment of the patient's statement and referring the matter to a neutral party may prevent splitting of the staff members. This can avert adversarial responses from the patient.

- C. "That's nice of you to say. I will try hard to keep you happy while here as my patient."

Rationale: This is incorrect. This is not therapeutic and strengthens the patient's splitting behavior.

- D. "I understand. She has been reported by the other staff members for playing favorites."

Rationale: This is incorrect. This is not therapeutic, strengthens the patient's splitting behavior, and is not proper to discuss other staff members to patients.

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11. Which of the following nursing actions is an example of a function of the Code of Ethics for Nurses directly relating to the health-care environment? **Select all that apply.**

Answers cannot be displayed for this alternate item format.

Rationale: Feedback 1. This is correct. This is provision #6, which states the nurse participates in improving health-care environments and conditions of employment. 2. This is incorrect. Although this is an example of family-centered care, it is not a component of the Code of Ethics for Nurses. 3. This is correct. This could indirectly influence the workplace environment by shaping social policy. This relates to provision #9. 4. This is incorrect. Although this would facilitate communication and cultural sensitivity, it does not directly influence the workplace environment. 5. This is correct. This relates to provision #8, which states that the nurse will collaborate with other health professionals to meet health needs of the facility and community. An example is how the two patient-identifier practice was started by a group of concerned nurses.

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12. The nurse is assessing an infant during a well-baby visit in the family practice clinic. During this assessment, the nurse asks the mother several routine questions regarding the infant's progress and notes that the mother nods her head but is looking at her cell phone. Which response by the nurse is **most** appropriate in this situation?

- A. Continue the assessment and note the mother's disinterest in the infant's chart.

Rationale: This is incorrect. The mother is the primary source of information for the infant.

- B. Continue to ask the questions repeatedly until an acceptable answer is provided.

Rationale: This is incorrect. This would not be a favorable response, and it will take essential time away from the care of the infant.

- C. Ask the mother if she could please put the phone down and discuss her infant's progress.

Rationale:

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This is correct. Attempting to interact with the mother is imperative, as she is the primary source of information.

- D. Contact the facility's social worker for a referral to child protective services for an in-home visit.

Rationale: This is incorrect. There is no cause to contact child protective services in this scenario.

13. The nurse is assessing a pediatric patient in the emergency room for injuries sustained from a fall. The nurse asks the parents how the child was injured. Which response by the parent uses the **most** productive communication pattern?

- A. "My partner forgot to check the baby gate like I asked."

Rationale: This is incorrect. This is a masked and direct message aimed at the parent's partner, and it does not answer the question.

- B. "I am the only one who checks the baby gate all the time."

Rationale: This is incorrect. This is a masked and indirect message that is aimed at the household members, and it does not answer the question.

- C. "It's typical. My partner just doesn't follow directions."

Rationale: This is incorrect. This is a generalized statement and does not answer the question.

- D. "I forgot to check the baby gate when I came home."

Rationale: This is correct. This is a direct and clear message stating that the baby gate was not latched without displacing the blame.

14. The nurse is providing care to a 17-year-old patient in the family practice clinic. The patient reports concern for the parents, as she is the last one of the four children to leave the home. She is concerned that her parents may "fall apart" when she leaves for college in the fall. What is the **best** response from the nurse based on the family systems theory?

- A. "Although changes that occur in one family member's life affects the entire family, keep in mind that your family is dynamic."

Rationale: This is correct. This is an example of how changes in one family member's life affect the entire family and that the family is dynamic.

- B. "Each member of the family has to differentiate themselves, whether good or bad, to influence family relationships."

Rationale: This is incorrect. This response reflects Bowen's family system theory.

- C. "Although this may put a strain on their relationship, a healthy family recognizes the need love and growth."

Rationale: This is incorrect. This response does not exemplify any of the family theories, and it is a nontherapeutic answer to the patient's concerns.

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- D. "Although the family is growing apart, this is a time for your parents to refocus on extended family relationships."

Rationale: This is incorrect. This response exemplifies Duvall's family development theory.

15. The nurse is providing care to a 4-year-old child who is recovering from an orthopedic injury in the hospital. The nurse notes there are two siblings who are ages 6 years and 1 year. The father is the primary caregiver, and the mother is the primary wage earner. During the assessment, the nurse notes that the 6-year-old seems to be the primary nurturer of the 1-year-old, while the father tends to the 4-year-old, and the mother talks on her cell phone. Which nursing diagnosis is appropriate for this family?

- A. Compromised family coping r/t insufficient reciprocal support between the parents as evidenced by family behavior during hospital visits.

Rationale: This is correct. The lack of interaction may be the family dynamics, or it can be the result of the crisis of hospitalization.

- B. Risk for delayed development r/t lack of parental involvement as evidenced by family behavior, mother and siblings not interacting.

Rationale: This is incorrect. This may be a reaction to the crisis to the child's hospitalization; the mother may be distracted due to work constraints.

- C. Ineffective family health management r/t family conflict as evidenced by mother's inability to interact with the child during hospitalization.

Rationale: This is incorrect. This may be a reaction to the crisis to the child's hospitalization; the mother may be distracted due to work constraints.

- D. Interrupted family processes r/t hospitalized child as evidenced by lack of full family interactions during hospitalization.

Rationale: This is incorrect. This may be a reaction to the crisis to the child's hospitalization, where there are subsets of relationships with the older and younger sibling. The mother may be distracted due to work constraints.

16. The nurse is providing care to an 11-month-old child who is hospitalized with pneumonia. Which nursing interventions are appropriate for this child? **Select all that apply.**

Answers cannot be displayed for this alternate item format.

Rationale: Feedback 1. This is correct. This would provide family-centered care and note the parent's role in the child's life and well-being. 2. This is incorrect. This would be appropriate for a toddler-aged patient, not an infant. 3. This is incorrect. This would be appropriate for a child with a grasp on verbal skills, such as a toddler or preschooler, not an infant. 4. This is correct. This can gain the infant's attention. 5. This is correct. This would promote a sense of comfort for the child.

17. The nurse is providing care for a pediatric patient whose family is from another culture. Which action is **best** when

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the nurse notices the patient is eating poorly at meals and rejecting snacks?

- A. Ask the family members to share the types of foods preferred by the patient.

Rationale: This is incorrect. Asking the family about which foods are preferred by the patient may or may not be the most effective action by the nurse.

- B. Encourage the family to prepare and bring favorite foods to the patient.

Rationale: This is correct. Unless the patient has dietary restrictions, the most effective action by the nurse is to encourage the family to prepare and bring the patient's favorite foods to the hospital. Dietary preferences are part of an individual's culture and adequate nutrition is important.

- C. Offer the patient a variety of healthy and nutritious foods every 2 hours.

Rationale: This is incorrect. Offering the patient a variety of healthy and nutritious snacks every 2 hours may or may not improve the patient's nutritional status. It is more effective to ensure that culturally preferred foods are available to the patient.

- D. Contact the health-care provider and ask that dietary supplements be ordered.

Rationale: This is incorrect. It is unlikely that the pediatric patient will be prone to drink/eat dietary supplements. The nurse needs to take actions to provide the patient with culturally preferred foods.

18. The nurse is completing the admission process for a pediatric patient by obtaining information related to the patient's culture. Which area of assessment is **most** important if the patient is an infant?

- A. The religious beliefs of the patient's family

Rationale: This is incorrect. The religious beliefs of the patient's family are not the most important cultural assessment due to the age of the patient. However, the nurse will ascertain if the parents have certain religion-based needs.

- B. The family's perception of the current health status

Rationale: This is correct. Because of the age of the patient, the most important area of cultural assessment is the family's perception of the current health status. The nurse will need to know if the medical condition or treatments are impacted by cultural beliefs or practices.

- C. The patient's food preferences

Rationale: This is incorrect. Food preferences are not the most important area of cultural assessment due to the age of the patient.

- D. The typical daily schedule followed by family and patient

Rationale: This is incorrect. Due to the age of the patient, the daily schedule followed by the patient and family is not the most important cultural assessment.

19. A child who is 10 years of age is brought to the clinic with symptoms of a serious lower respiratory infection. The

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attending adult self-identifies as a grandparent. The child states the grandparent is the only family of the patient. Which is the **most** important information for the nurse to acquire prior to treatment?

A. How to reach one of the patient's parents

Rationale: This is incorrect. The nurse may at some point need to ascertain how to contact one of the patient's parents; however, this is not the most important information for the nurse to determine prior to treatment.

B. Which other family members live with the patient

Rationale: This is incorrect. It is not important for the nurse to acquire information about the other family members who live with the patient prior to treatment.

C. If the grandparent has legal custody of the patient

Rationale: This is correct. It is most important for the nurse to acquire information regarding whether the grandparent is the legal guardian of the patient. Only a legal guardian can give consent for treatment of a pediatric patient.

D. What caused the grandparent to seek medical care

Rationale: This is incorrect. At some point it is important for the nurse to ascertain why the grandparent is seeking medical care for the patient. However, determining legal guardianship is the most important information prior to treatment.

20. The new nurse on the pediatric unit asks not to be assigned a child whose family is from the Middle East. Which personal questions does the nurse manager suggest the nurse contemplate as a method to develop self-awareness related to cultural differences? **Select all that apply.**

Answers cannot be displayed for this alternate item format.

Rationale: Feedback1. This is correct. The nurse manager should suggest the nurse explore the nurse's experiences with those of different cultures. The nurse should explore if those experiences were either positive or negative. 2. This is incorrect. The nurse manager is not likely to suggest that the nurse determine whether they are bothered by political differences between countries. Nursing care is provided to all patients equally without personal or political bias. 3. This is incorrect. Nurses are not expected to reject their own cultural beliefs or values to provide culturally unbiased care to patients and their families. 4. This is correct. To understand personal feelings, the nurse should ask if there are conflicting values between the patient/family and the nurse. The answer to this question will help the nurse recognize differences and work toward resolution. 5. This is incorrect. There is not enough information in the question to ascertain that the nurse feels either guilt or shame for not accepting another culture.

21. The nurse is conducting a health assessment on a 10-year-old who has rows of round bruises on his arms and back. The bruises appear to have occurred at the same time. The child states that their family practices "folk-medicine." The nurse is familiar with alternative medicine but should evaluate the patient by asking which questions? **Select all that apply.**

Answers cannot be displayed for this alternate item format.

Rationale:

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Feedback1. This is correct. Being familiar with alternative medicine may cause the nurse to suspect the bruising is a treatment. However, this is an appropriate early question to rule out accidental injury. 2. This is incorrect. Being hungry is not related to these bruises. 3. This is correct. It is essential to know about specific cultural practices regarding health, as well as definitions of and beliefs about health and illness. The nurse needs to validate the use of alternative medicine as a source of the bruising. 4. This is incorrect. Playing sports in school is most likely unrelated to the bruises. 5. This is correct. Life experiences such as immigration and refugee status may include a history of violence, oppression, and trauma. Even though the nurse suspects bruising from alternative medicine, trauma still needs to be specifically ruled out.

22. The nurse is presenting information to pregnant couples about the “safe to sleep” campaign to prevent sudden infant death syndrome (SIDS). One attendee states, “Babies sleep best on their bellies. What difference does position make?” Which answer by the nurse is **best**?

- A. “Positioning on the back opens the airway fully.”

Rationale: This is correct. The nurse should always educate parents to put their infants on their backs to sleep to help prevent SIDS by keeping the airway fully open.

- B. “Sleeping face down increases the risk of aspiration.”

Rationale: This is incorrect. Placing the infant face down may increase the risk of aspiration if the infant vomits or spits up. However, the best answer is the one that defends how the parents can avoid the incidence of SIDS, which is the primary cause of unexpected infant death.

- C. “The most dangerous time is 2 to 4 months of age.”

Rationale: This is incorrect. The nurse can share that the most vulnerable age for SIDS is between 2 and 4 months of age. However, this does not reinforce the physiological reason why infants need to sleep on their back.

- D. “Of greater importance is not using blankets.”

Rationale: This is incorrect. Parents are instructed to keep blankets and other objects that can cause suffocation out of the infant’s crib. However, this comment does not reinforce the physiological reason why infants need to sleep on their back.

23. The hospice nurse is providing care for a 12-year-old patient who is receiving end-of-life care. Parents and younger siblings are at the bedside and involved with patient care. Which comment by the nurse exemplifies appropriate communication?

- A. “Please let me know if you have pain so that I can make you more comfortable.”

Rationale: This is correct. End-of-life communication with the patient needs to be compassionate and developmentally appropriate. The nurse needs to communicate a caring attitude about the patient’s pain and comfort status. This comment is appropriate.

- B. “Do not be sad; know your son is going to heaven, and all of you will be together in the future.”

Rationale: This is incorrect. When the nurse expresses personal beliefs, the cultural beliefs of the patient and family are violated. Telling a parent not to be sad is suggesting that their grief is

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inappropriate.

- C. "Your brother is suffering, and you need to be strong and brave for him now."

Rationale: This is incorrect. Telling a sibling younger than 12 years of age that their brother is suffering is likely to cause anguish to the sibling. Encouraging the sibling to be strong and brave is suggesting denial of feelings.

- D. "I understand you will be ready to move away from this life and on to the next."

Rationale: This is incorrect. When the nurse expresses feelings related to the patient's impending death, the nurse is interjecting personal feelings into the patient's situation; the nurse needs to focus on the patient's and family's feelings.

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24. The nurse works in a pediatric hospice unit in an acute care facility. The nurse is currently providing care to an infant. Which assessment tool does the nurse use to identify the infant's level of pain?

- A. FACES Pain Scale

Rationale: This is incorrect. The FACES Pain Scale is only for patients aged 3 years and older; the child must be developmentally able to read and recognize faces drawn with various levels of painful expressions. This pain scale asks the child to choose the face that best represents his or her pain level. The patient is too young for this scale.

- B. FLACC (faces, legs, activity, cry, consolability) Scale

Rationale: This is correct. The FLACC Scale is used for newborn to 7 years. This assesses the patient's facial expression, leg positioning and flexion, activity level, crying level, and consolability. This is the appropriate scale for this patient.

- C. Visual Analogy Scale (VAS)

Rationale: This is incorrect. The VAS is for children aged 7 years and older who have the developmental ability to use the traditional pain scale based on numbers 0 to 10 for pain rating. The patient is too young for this scale.

- D. Neonatal and Infant Pain Scale (NIPS)

Rationale: This is incorrect. NIPS is for newborns. This assesses the newborn's cry, facial expression, respiratory pattern, position and flexion of the arms and legs, and level of alertness. The scale is better suited for newborns.

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25. The pediatric nurse is providing care for a terminally ill patient who is 17 years of age. The patient has been resistant to aggressive chemotherapy because of undesirable side effects. The patient states, "I have finally convinced my parents to sign a DNR (do not resuscitate) order. It is my life, and I should be able to decide how I want to live." Which legal consideration causes the nurse **greatest** concern?

- A. A DNR order can be reversed at any time by the legal guardians.

Rationale: This is correct. The nurse is aware that the patient is a minor and only legal guardians can determine a minor's DNR status. The patient's sense of satisfaction is the nurse's greatest

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concern, because legal guardians can reverse a DNR decision at any time.

- B. The primary health-care provider can deny a DNR if the patient is a minor.

Rationale: This is incorrect. Primary physicians cannot deny a DNR order just because the patient is a minor. The legal guardians have the right to request the order and the health-care provider has the responsibility to make sure they understand all aspects of the decision.

- C. The patient does not understand all aspects of the DNR order.

Rationale: This is incorrect. The minor patient may or may not understand all aspects of a DNR order; this is not likely to be the nurse's greatest legal concern.

- D. A DNR can be written to provide partial life-sustaining interventions.

Rationale: This is incorrect. It is true that a DNR order can be written to provide partial or limited life-sustaining interventions. This is not the nurse's greatest legal concern.

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26. The nurse is providing end-of-life education to parents of a child diagnosed with a terminal illness. Which topics of education are important for the nurse to provide? **Select all that apply.**

Answers cannot be displayed for this alternate item format.

Rationale: Feedback 1. This is correct. The nurse needs to cover the topic of how the progression of the disease will affect their child. This information will help the parents to distinguish between expected and unexpected changes. 2. This is correct. The nurse needs to cover the topic of the physical changes that will occur during the dying process. Some topics will include skin alterations, breathing alterations, altered consciousness, and changes in verbalization. 3. This is incorrect. End-of-life education does not involve providing a list of funeral homes to contact prior to the death. Families may have a funeral home in mind, and planning before the death may be offensive to some families. 4. This is incorrect. Pain management may or may not interfere with communication. The parents need to be encouraged to talk to their child even when two-way communication is not possible. 5. This is correct. The nurse needs to cover the topic of what to expect after death. Some families are concerned that the physical appearance is grossly altered. The parents also need to know about how the body will be cared for and about making funeral arrangements.

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27. The caregiver of a 9-month-old infant asks the nurse about what toys are age appropriate. Using Piaget's theory of development, which toy does the nurse recommend?

- A. Building blocks

Rationale: This is incorrect. The nurse would not expect an infant of 8 months of age to play with building blocks.

- B. Colorful mobiles

Rationale: This is incorrect. An 8-month-old infant may or may not be interested in a colorful mobile. Tactile stimulation from this would be limited for safety reasons.

- C. Picture books

Rationale:

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This is incorrect. An infant's interest in picture books is more likely to occur in Piaget's stage 6: inventions of new means/mental combinations, which occurs between 18 and 24 months.

- D. Musical rattles

Rationale: This is correct. At 8 months, the infant should be in Piaget's stage 4: coordination of secondary schemata. To achieve a desired effect, the infant will repeat an action, such as repeatedly shaking a rattle to make sounds. The nurse will recommend a variety of rattles as appropriate toys for this patient.

28. The nurse is visiting the home of a new mother and a 2-month-old infant. The nurse notices the infant vigorously sucking on the fist and whining but not crying. The mother validates that the behavior is common. Which information does the nurse need to obtain from the mother?

- A. If the mother is breast or bottle feeding

Rationale: This is incorrect. Freud's psychosexual theory states that from birth to 1 year, sexual gratification is achieved orally. However, it is not important if the mother breast or bottle feeds her infant.

- B. How long the infant sleeps at night

Rationale: This is incorrect. The infant may be attempting to gratify sexual urges with oral behaviors such as sucking, biting, chewing, and eating. It is not important to the nurse how long the infant sleeps at night.

- C. What type of feeding schedule is followed

Rationale: This is correct. Normal development requires not depriving oral gratification, such as weaning too soon or a rigid feeding schedule. Because of the infant's vigorous fist sucking, the nurse needs to ascertain what type of feeding schedule is being followed.

- D. If the infant draws up the legs when crying

Rationale: This is incorrect. Asking if the infant draws up the legs when crying may be assessing for the presence of colic; the information is not related to the infant's fist-sucking behavior.

29. The school nurse in a high school setting expresses concern to school administration regarding the increase in student complaints about bullying, physical violence, and rejection. Which concern related to psychosocial development does the nurse share as being **most** important?

- A. Students are preoccupied with how they are seen in the eyes of others.

Rationale: This is incorrect. During the identity versus role confusion stage of Erikson's theory, 12- to 18-year-olds are preoccupied with how they are seen in the eyes of others. However, this manifestation exists even in the absence of peer violence.

- B. Students who are bullied will develop issues related to sexual orientation.

Rationale: This is incorrect. Sexual orientation issues are not manifestations of bullying; however, sexual orientation can cause a person to be a target for bullying and other violence.

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- C. Students may be unable to provide a meaningful definition of self.

Rationale: This is correct. The nurse's concern is focused on the possibility the students involved in any aspect of bullying, physical violence, and rejection will be unable to provide a meaningful definition of self, which places them at risk for role confusion in one or more roles throughout life.

- D. Students who are aggressive will develop a strong sense of guilt as adults.

Rationale: This is incorrect. Students who are aggressive may develop a strong sense of guilt as adults, but this is just one aspect of the impact of bullying, physical violence, and rejection—not the most important one.

30. The nurse is teaching a parenting class being held in a community clinic. The nurse is focusing on behaviors that will assist in increasing the number of children who score well in kindergarten readiness screening. Which comment by a parent indicates the need for additional information?

- A. "I am not athletic, but the kids would love an outdoor play area."

Rationale: This is incorrect. The nurse's information is adequate if a parent recognizes the importance of physical activity and development, even though the parent identifies as being nonathletic.

- B. "Practicing counting with the kids while traveling is a good idea."

Rationale: This is incorrect. The nurse's information is adequate if a parent recognizes the value of using "lost" time for learning.

- C. "I like the suggestion to label basic items for word recognition."

Rationale: This is incorrect. The nurse's information is adequate if a parent understands that labeling items will lead to word recognition.

- D. "In our family, we watch TV; books are a waste of money."

Rationale: This is correct. The nurse needs to provide additional information to the parent who thinks books are a waste of money. The parent needs to be aware of community agencies that will supply books to children and of programs that provide reading/story times.

31. Erickson's psychosocial development theory proposes that the school-aged child between ages 6 and 12 years is in the stage of industry vs. inferiority. Based on this theory, how will the pediatric nurse design activities as part of a diversional program for children who are in a long-term medical facility? **Select all that apply.**

Answers cannot be displayed for this alternate item format.

Rationale: Feedback1. This is incorrect. Play during this stage is known as cooperative play and involves more than one person. 2. This is correct. The school-aged child enjoys working in groups and forming social relationships. 3. This is correct. Developing a sense of industry provides the child with purpose and confidence in being successful; participation in small tasks will fulfill this need. 4. This is correct. If a child is unable to be successful, this can result in a sense of inferiority. Success needs to be recognized and rewarded. 5. This is correct. The school-aged child in this stage follows the rules and likes order.

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32. The school nurse is asked to assess a student in the third grade who is failing to demonstrate academic success. Which statement(s) made by the child indicate an unmet need according to Maslow's hierarchy? **Select all that apply.**

Answers cannot be displayed for this alternate item format.

Rationale: Feedback1. This is correct. If the student in question goes to bed every night at 10:00 the nurse recognizes a physiological need that is not being met. Children need more sleep than adults. Sleep deprivation can impact the growth and development of a child and cause delays.2. This is correct. If the student in question expresses worry about fighting between parents, the nurse recognizes the child has the need to be protected from harm and may not feel safe. Fear and worry can interfere with developmental achievements.3. This is incorrect. When the student in question expresses pleasure during family game and movie nights, the student feels loved and has a sense of belonging.4. This is correct. Negative feedback interferes with the development of esteem, which is related to the need to respect one's self and be respected by others.5. This is incorrect. The student is expressing the feeling of self-esteem related to successfully teaching a sibling a physical skill.

33. A nurse is caring for a client who is desiring their wound care to be provided at 1400. The nurse returns at 1400 to perform wound care for the client. Which of the following ethical principles is the nurse demonstrating?

A. Fidelity

Rationale: Fidelity is an ethical principle that ensures trust between the client and the nurse by keeping agreements. Nurses should uphold their agreements made with their clients, which builds trust in the nurse-client relationship.

B. Autonomy

Rationale: Autonomy is an ethical principle that refers to the client's right to make their own decisions. The client has a right to refuse treatment or procedures at any time and the nurse should respect and honor the client's decision.

C. Justice

Rationale: Justice is an ethical principle that ensures fairness. Nurses are responsible for providing care that is impartial and fair for all clients.

D. Veracity

Rationale: Veracity is an ethical principle that ensures truth telling. Nurses should establish trust with their client by answering questions truthfully.

34. A nurse is teaching a newly licensed nurse about ethical principles. Which of the following is an example of beneficence?

A. A nurse provides nonpharmacological pain interventions to each client equally.

Rationale: Treating each client equally is an example of the ethical principle of justice. The nurse should

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provide fair and adequate pain relief to clients regardless of age, ethnicity, or history, such as substance use disorder, or limited social and economic resources.

- B. A nurse gives a client the choice to take a pain medication via intramuscular or oral route.

Rationale: Giving a client a choice in route of a medication is an example of autonomy.

- C. A nurse fulfills a promise to a client that they will return with their pain medication.

Rationale: Fulfilling a promise to a client is an example of fidelity.

- D. A nurse administers scheduled pain medication for a client who is having pain.

Rationale: Administering scheduled pain medication for a client who is having pain is an example of beneficence. Beneficence is doing good or acting in the best interest of the client.

35. A nurse is teaching a newly licensed nurse about ethical principles. The nurse should include that working to not cause harm to a client, while trying to achieve the best possible outcome, is an example of which of the following ethical principles?

- A. Justice

Rationale: Treating each client equally is an example of the ethical principle of justice. The nurse should provide fair and adequate pain relief to clients regardless of age, ethnicity, or history, such as substance use disorder, or limited social and economic resources.

- B. Autonomy

Rationale: Giving a client a choice in route of a medication is an example of autonomy.

- C. Fidelity

Rationale: Fulfilling a promise to a client is an example of fidelity.

- D. Nonmaleficence

Rationale: Nonmaleficence is providing care for a client in a way to avoid causing harm or hurt while trying to achieve the best possible outcome. Providing scheduled pain medication for a client who is having pain, without causing harm to the client, is an example of nonmaleficence.