Detailed Answer Key
N433 Exam 5 Practice Questions

1. A school nurse conducting a screening for pediculosis capitis identifies several children who require treatment. Which of the following instructions should the nurse give the children's parents?

   A. Soak all combs and hairbrushes in alcohol.

      Rationale: Parents should soak all combs, brushes, and hair clips in a commercial pediculicide (lice-killing product) for 1 hr or in boiling water for 10 min.

   B. Inspect any dogs or cats at home for lice.

      Rationale: Pets do not carry or transmit lice.

   C. Seal nonwashable items in airtight plastic bags.

      Rationale: Parents should seal items they cannot wash, vacuum, or dry clean in airtight plastic bags for 14 days to kill any lice on them.

   D. Spray countertops and sinks with insecticide.

      Rationale: Parents should not spray insecticides in the home because they can pose a hazard to children and pets. Cleaning hard surfaces with household cleaners or disinfectants is appropriate.

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2. A nurse is caring for a child who has tinea pedis. The child's parent asks the nurse what this infection is commonly called. The nurse should respond with which of the following common names?

   A. Shingles

      Rationale: Shingles is the common name for varicella zoster.

   B. Athlete's foot

      Rationale: Athlete's foot is the common name for tinea pedis.

   C. Fever blister

      Rationale: Fever blister is the common name for herpes simplex virus type I.

   D. Valley fever

      Rationale: Valley fever is the common name for coccidioidomycosis.

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3. A nurse is preparing to teach a parent how to care for a child who has impetigo contagiosa. Which of the following information should the nurse plan to include in the teaching?

   A. Keep the child on droplet precautions at home

      Rationale: The nurse should teach the parent that isolation precautions are not necessary, but that direct contact with the child can cause the infection to spread or be transmitted to others.

B. Wash clothing in hot water.

Rationale: The nurse should teach the parent to ensure the child changes her clothes every day and to wash all clothing in hot water.

C. Immunize household contacts for the disease.

Rationale: There is no vaccination for impetigo contagiosa available.

D. Give the child a chlorine bath twice daily.

Rationale: The nurse should teach the parent that a chlorine bath is sometimes given once or twice weekly, but twice daily is too often and can increase skin irritation.

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4. A school nurse is performing a routine health assessment for a school-age child. Which of the following findings indicates the nurse should investigate further for pediculosis capitis?

A. Bald patches on the scalp

Rationale: Pediculosis capitis does not cause patches of baldness on the scalp. There are various causes of bald patches, such as ringworm.

B. Blisters on the scalp

Rationale: Pediculosis capitis does not cause blisters on the scalp. There are various causes of blisters, such as impetigo contagiosa.

C. Pruritus of the scalp

Rationale: Pediculosis capitis is an infestation of head lice. Generally, the only manifestation is scalp itchiness.

D. Dry patches on the scalp

Rationale: Pediculosis capitis does not cause dry patches on the scalp. There are various causes of dry patches, such as eczema.

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5. Which of the following actions should the nurse plan to take?Select the 3 actions the nurse should plan to take.

Answers cannot be displayed for this alternate item format.

Rationale: Collect nasal drainage for culture and sensitivity is incorrect. The infant is being treated with a broad-spectrum antibiotic. The infant's fever has gone down and the drainage has changed color from yellow to white indicating effective treatment response.Cleanse diaper area with soap and water is correct. Perfumed soaps and harsh cleansers should be avoided because they could cause further damage to the skin.Teach caregivers to change diaper when wet is correct. Changing the infant's diaper whenever it is wet will keep the infant's skin as dry as possible, giving the skin time to heal.Instruct caregivers to apply zinc oxide with each diaper change is correct. Zinc oxide is a moisture barrier. It will protect the infant's skin.Teach caregivers to apply talcum powder to creases is incorrect. Although powder is a drying agent, talcum powder should not be used because if it is inhaled it can cause respiratory issues.Have caregivers administer 16 oz of water after each

diarrhea stool is incorrect. The infant is not displaying manifestations of dehydration. Excessive intake of electrolyte-free water can lead to water intoxication, which causes low serum sodium levels and increased fluid in the brain.Use a nasal aspirator after feedings is incorrect. A nasal aspirator should be used before feedings to clear the nasal airway and facilitate breathing during feeding.

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6. A teenager is being cared for in the emergency department after being trapped in a garage fire at her home. Partial-thickness burns are present on the side of the face, as well as on both arms. Which nursing action is the **highest priority**?

A. Apply cool, sterile compresses to the burns.

Rationale: This is incorrect. Applying cool, sterile, normal saline compresses to cool and protect the skin is done after airway, breathing (oxygen), and circulation is established.

B. Remove all clothing from the patient.

Rationale: This is incorrect. Although it is important to remove clothing that is burned, hot in temperature, or contaminated with chemicals, this is not the highest priority.

C. Give pain medication as ordered.

Rationale: This is incorrect. Although pain medication should be administered as needed, this is not the priority action.

D. Give 100% humidified oxygen.

Rationale: This is correct. The priority action is establishing airway, breathing (oxygen), and circulation. The nurse should give 100% oxygen if the individual has been burned severely or if the fire was in a confined space. A pulse oximeter is used to monitor oxygen saturation levels.

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7. The school nurse is educating preschool parents about the management of lice infestation, which has currently become a problem among the students. Which recommendations should the nurse include in the caregiver's education? **Select all that apply.**

Answers cannot be displayed for this alternate item format.

Rationale: Feedback1.This is incorrect. The nurse should assess for history of asthma or allergies before recommending pediculicide shampoos. Nix (permethrin or pyrethrin) is contraindicated for children with ragweed allergies. These products may cause an allergic reaction or an exacerbation of asthma. If use is safe for the individual, it is only used every 7 to 10 days.2.This is correct. A fine-toothed comb can help remove nits from the hair. 3.This is correct. Application of mayonnaise, olive oil, or petroleum jelly has been recommended to suffocate the lice. Parents are instructed to cover the child’s hair with the oil-based product, cover with a shower cap overnight, and shampoo the next morning.4.This is correct. Washing clothing and bedding in hot soapy water and drying on a hot cycle is recommended. Hot air with the removal of existing nits additionally has shown some promise in studies. 5.This is incorrect. Regular shampoo will not kill the insects. A cool blow dryer will not affect them either. Lice are killed by a pesticide and heat.

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8. A school nurse is assessing an adolescent who reports feeling shaky and is having difficulty speaking and concentrating on the questions the nurse is asking. The nurse checks the adolescent's blood glucose level and identifies a value of 55 mg/dL. Which of the following findings should the nurse expect?

A. Dry, flushed skin

Rationale: A blood glucose level of 55 mg/dL is below the expected reference range and an adolescent with this blood glucose level is likely to be diaphoretic and have pale skin.

B. Deep, rapid respirations

Rationale: A blood glucose level of 55 mg/dL is below the expected reference range and an adolescent with this blood glucose level is likely to have shallow or normal respirations. An adolescent who has a blood glucose level above the expected reference range is likely to have deep, rapid respirations, known as Kussmaul respirations.

C. Tachycardia

Rationale: A blood glucose level of 55 mg/dL is below the expected reference range and an adolescent with this blood glucose level is likely to have tachycardia due to increased circulating catecholamines and increased adrenergic activity.

D. Polyuria

Rationale: A blood glucose level of 55 mg/dL is below the expected reference range and an adolescent with this blood glucose level is likely to a normal urine output. An adolescent who has a blood glucose level above the expected reference range is likely to have polyuria as the body responds to the increased glucose in the blood.

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9. A nurse is assessing a school-age child whose blood glucose level is 280 mg/dL. Which of the following findings should the nurse expect?

A. Lethargy

Rationale: A blood glucose of 280 mg/dL is above the expected reference range indicating hyperglycemia. The nurse should expect the child to appear lethargic, leading to a decreased level of consciousness and confusion.

B. Pallor

Rationale: The nurse should expect a child who has a blood glucose level below the expected reference range to have pallor and sweating. This child is more likely to have flushed, dry skin and mucous membranes.

C. Tremors

Rationale: The nurse should expect a child who has a blood glucose level below the expected reference range to have tremors, leading to hyperreflexia and possibly seizures. This child is more likely to have diminished deep tendon reflexes.

D. Shallow respirations

Rationale: The nurse should expect a child who has a blood glucose level below the expected reference range to have shallow or normal respirations. This child is more likely to have deep rapid

respirations.

10. The nurse in a pediatrician's office is assessing a 9-year-old male patient who is being monitored for the possible diagnosis of hypopituitarism. Which assessment finding does the nurse recognize specifically as an indication of growth hormone (GH) deficiency?

A. High weight-to-height ratio

Rationale: This is incorrect. Hypopituitarism can result in a high weight-to-height ratio; however, the finding alone can be caused by other conditions as well.

B. Large hands and feet for body size

Rationale: This is incorrect. Large hands and feet when compared with the body size is most likely associated with hyperpituitarism after closure of the epiphyseal disks.

C. Severe aching in knees and ankles

Rationale: This is incorrect. A side effect of GH replacement therapy can be joint aches primarily in the knees, ankles, and wrists.

D. Height increase of 1.75 inches in 12 months

Rationale: This is correct. A cardinal sign of hypopituitarism is delayed growth of less than 2 inches (3 to 4 cm) per year.

11. The nurse is planning a teaching session for a 10-year-old patient and the patient's parents. The patient is newly diagnosed with type 1 diabetes mellitus. Which is the most important topic for the nurse to cover?

A. Methods for preventing hypoglycemia during exercise

Rationale: This is incorrect. The patient and parents need to understand the actions that are necessary for preventing hypoglycemia during exercise. Teaching will include eating an extra complex carbohydrate and protein serving at least 30 minutes to 1 hour before engaging in exercise or sports. Another topic is most important.

B. The purpose of setting up a dietary consult for the patient

Rationale: This is incorrect. The patient and parents should have a dietary consult so that the patient can be placed on a diabetic diet or be taught to count carbohydrate exchanges and adjust insulin requirements based on dietary intake. This an important action, but one other is more important.

C. All procedures involved in insulin administration

Rationale: This is correct. Because the patient is insulin dependent, insulin management is crucial and procedures for insulin administration are vital; this is the most important topic for the nurse to present in patient and parent teaching.

D. Instructions for blood glucose and urine ketone testing

Rationale:

This is incorrect. The second most important teaching for the nurse to present is the methods by which the patient and parents will monitor the patient's blood glucose levels and test for the presence of urine ketones.

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12. A 10-year-old patient is diagnosed with type 2 diabetes mellitus. Which medical history finding will help the nurse identify alternative interventions for managing the patient's condition?

A. The patient is black.

Rationale: This is incorrect. Certain race/ethnicity groups such as black, Latino, Asian American, American Indian, and Pacific Islanders have a higher risk for type 2 diabetes mellitus. However, there is no alternative intervention that will diminish this risk.

B. The patient has a body mass index (BMI) that is greater than the 85th percentile for age and weight.

Rationale: This is correct. A BMI greater than the 85th percentile for age and weight is an indication of childhood obesity, which is a major contributor to the increasing numbers of type 2 diabetes mellitus in children. The alternative intervention the nurse will recommend is increased exercise and a decrease in sedentary lifestyle.

C. The patient's mother had gestational diabetes during her pregnancy.

Rationale: This is incorrect. Maternal history of gestational diabetes or diabetes during pregnancy puts the child at higher risk for type 2 diabetes mellitus. However, there is no alternative intervention that will diminish this risk.

D. The patient's extended family exhibits a high incidence of diabetes.

Rationale: This is incorrect. A family history of type 2 diabetes mellitus places the child at a greater risk for the condition. The nurse may or may not be able to suggest alternative interventions that will diminish this risk.

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13. The pediatric nurse is preparing a community education program for parents and children who have endocrine disorders. With which normal regulatory functions does the nurse begin the presentation before covering endocrine disorders? **Select all that apply.**

Answers cannot be displayed for this alternate item format.

Rationale: Feedback1.This is correct. The endocrine system regulates growth and development.2.This is correct. The endocrine system regulates sexual development.3.This is correct. The endocrine system regulates energy use and storage. 4.This is correct. The endocrine system regulates an individual's response to stress.5.This is correct. The endocrine system regulates the levels of glucose, fluid, and sodium in the blood.

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14. Complete the diagram by dragging from the choices below to specify what condition the client is most likely experiencing, 2 actions the nurse should take to address that condition, and 2 parameters the nurse should monitor to assess the client's progress.

Answers cannot be displayed for this alternate item format.

Rationale: Complete the diagram by dragging from the choices below to specify what condition the client is most likely experiencing, 2 actions the nurse should take to address that condition, and 2 The nurse should prepare the infant for an abdominal ultrasound and insert a nasogastric tube. The infant is most likely experiencing pyloric stenosis indicated by vomiting after feeding and the olive-sized mass in the right upper quadrant near the umbilicus. An abdominal ultrasound is used to confirm this condition and the nasogastric tube will be used to decompress the stomach prior to surgery. Prior to surgery, the nurse should monitor the infant's electrolyte values and intake and output because the infant is at risk for developing metabolic alkalosis related to the vomiting. After surgery the nurse should monitor the infant's intake and output to evaluate hydration status. the nurse should monitor to assess the client's progress.

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15. The pediatric nurse in a clinic is mentoring a newly hired nurse who has no experience in pediatrics. The new nurse is performing a physical assessment on an infant who is 1 month of age. Which observation will prompt the nurse to discuss assessment skills with the new nurse?

A. The new nurse states, "How can I hear bowel sounds when he cries?"

Rationale: This is correct. The new nurse needs to know that auscultation of the abdomen of an infant is performed prior to percussion and palpation in order to keep the infant quiet for auscultation.

B. The new nurse keeps the sleeping infant covered for parts of the assessment.

Rationale: This is incorrect. When the infant is sleeping, the new nurse is correct in keeping the infant partially covered for parts of the assessment. Auscultation of the abdomen can be performed while the infant is partially covered.

C. The new nurse performs all observations before physical assessment.

Rationale: This is incorrect. The new nurse is correct to perform all inspection assessment before any physical assessment.

D. The new nurse informs the attending parent about the assessment actions.

Rationale: This is incorrect. The new nurse is correct in informing the parent about the assessment actions.

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16. A parent brings an 18-month-old toddler to the pediatric emergency department for abdominal pain and stool mixed with blood and mucus. The pain is recurring three to four times an hour. Which intervention will the nurse initiate **first**?

A. Assess laboratory results.

Rationale: This is incorrect. The nurse strongly suspects intussusception because of the passage of stool mixed with blood and mucus. The nurse does assess laboratory results; however, this is not the nurse's first intervention.

B. Initiate intravenous access.

Rationale: This is correct. The nurse recognizes the existence of an emergency based on the toddler's

presenting symptoms. The nurse will first initiate intravenous access in order to have a route established for medications and/or emergency interventions.

C. Maintain strict intake and output.

Rationale: This is incorrect. The initial action by the nurse does not involve maintaining a strict intake and output.

D. Prepare for ultrasound studies.

Rationale: This is incorrect. Once the toddler has an established IV, the nurse will initiate other interventions, such as preparations for ultrasound studies.

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17. The nurse in a pediatric clinic is assessing an infant 2 months of age. The parent states, “He always spits up, but it has become so much worse. Vomit goes everywhere.” Which additional assessment will help the nurse identify a possible diagnosis for the infant?

A. A hard mass is palpated in the mid-epigastrium.

Rationale: This is correct. Vomiting after eating that grows worse and evolves into projectile vomiting are signs of pyloric stenosis. If the nurse palpates the infant’s mid-epigastrium and finds a pyloric mass, it is likely indicative of pyloric stenosis. This finding is called the olive sign.

B. Vomiting occurs both before and after eating.

Rationale: This is incorrect. With pyloric stenosis, vomiting always occurs after eating.

C. Weight is normal even with frequent vomiting.

Rationale: This is incorrect. When an infant has pyloric stenosis, there is poor weight gain.

D. Normal skin turgor is noted over the sternum.

Rationale: This is incorrect. A serious manifestation of pyloric stenosis is the development of dehydration and a decrease in serum chloride.

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18. The nurse in a pediatric clinic is working with a preschool patient and a parent about managing the child’s functional constipation. Which is the **most** important information for the nurse to share?

A. The child is allowed to select a reward for having a bowel movement.

Rationale: This is incorrect. Rewards are great motivators for young children; however, the parent sets the award. Reward should be a privilege such as extra TV or video game time; no food awards should be given. This is important information but not the most important.

B. The child is informed of the treatments for constipation and/or impaction.

Rationale: This is incorrect. Informing the child of the treatments for constipation and/or impaction will instill fear in the child and may compound the problem.

C. Parental action is required for the onset of vomiting or severe abdominal pain.

Rationale:

This is correct. The nurse needs to inform the parent of what actions to take if the child starts to vomit or has severe abdominal pain. Because the symptoms are indicative of a medical emergency, the caregiver should take the child to a medical facility for immediate evaluation.

D. The parents expect the child to sit on the toilet for a period of time each day.

Rationale: This is incorrect. The nurse needs to provide information applicable to behavior modification. The child's condition is likely to improve with regular times for stooling, usually after meals, and sitting on the toilet for 5 to 10 minutes. However, this is not the most important information for the nurse to provide.

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19. The nurse is informing a new mother of the concern about her newborn who is 36 hours old and has not passed any meconium. The nurse shares a suspicion of Hirschsprung's disease. The mother asks the nurse multiple questions about the condition. Which information will the nurse provide?

A. Retained meconium is a source of severe infection in newborns.

Rationale: This is incorrect. Retained meconium is not a source of severe infections in newborns. The inability to pass the meconium is the concern.

B. A positive diagnosis indicates the newborn is terminally ill.

Rationale: This is incorrect. Hirschsprung's disease, in itself, is not considered a terminal disease.

C. The absence of nerves in the colon also indicates mobility issues.

Rationale: This is incorrect. The physical manifestation of Hirschsprung's disease is an absence of nerves in the bottom segment of the colon, which causes an intestinal blockage.

D. The condition is congenital and causes blockage of the intestines.

Rationale: This is correct. Hirschsprung's disease is a congenital condition that causes blockage of the intestine because of a lack of nerves in the bottom segment of the colon. These nerves normally allow the muscles in the wall of the bowel to contract and move digested material toward the anus to be eliminated.

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20. The nurse is performing an abdominal examination on a preschool-age child. When palpating the abdomen, which action will the nurse take? **Select all that apply.**

Answers cannot be displayed for this alternate item format.

Rationale: Feedback1.This is incorrect. During abdominal palpation, the child should be supine, with the arms at their side and the knees flexed.2.This is correct. Allowing the child to place their hand on the nurse's makes the child feel as if they have some control over the examination.3.This is correct. The nurse will use light palpation to decrease pain. 4.This is correct. When palpating the abdomen, the nurse will place their entire palm on the patient's abdomen. When possible, nurses should warm their hands beforehand. 5.This is correct. The nurse will check for a hernia as part of the abdominal examination.
