Detailed Answer Key
N433 Exam 6 Practice Questions

1. The nurse is assessing a 7-year-old child at a pediatric clinic. The nurse notices that several developmental milestones have been missed or are late during previous visits. The parent states, “I know she is a little slow, but she will catch up quickly.” Which action by the nurse is warranted?

   A. Explain to the parent that rapid development takes place in infancy and early childhood.

      Rationale: This is incorrect. Explaining the expected periods and time frames when development rapidly occurs is not beneficial to the parent.

   B. Suggest activities in the home that may improve mental and physical development.

      Rationale: This is incorrect. Suggesting home activities that improve mental and physical development may or may not be effective. Further assessment is needed to better define the findings.

   C. Recommend that the child be placed in special classes aimed at promoting development.

      Rationale: This is incorrect. It is premature for the nurse to recommend special classes for the child.

   D. Ask the parent detailed questions about the pregnancy, birth, and early childhood health.

      Rationale: This is correct. The nurse needs to further assess for possible contributing factors for the child’s developmental delays. Along with information about the pregnancy, birth, and early childhood health, the nurse will explore the family health history and home environment.

2. The nurse is assessing an 8-month-old infant during a routine well-baby visit. During the neurological assessment, which finding is a reason for concern?

   A. The infant starts to suck when the mouth is touched.

      Rationale: This is incorrect. The nurse is assessing for the presence of the sucking reflex, which disappears by the age of 10 to 12 months.

   B. Toes fan out when the sole of the food is stroked upward.

      Rationale: This is incorrect. The nurse is checking for the presence of the Babinski sign, which is elicited by stroking the sole of the foot upward, causing the toes to fan out. The sign should disappear between 9 and 12 months of age.

   C. Placing a small object in the palm inconsistently elicits a grasp.

      Rationale: This is correct. The nurse is checking the presence of a palmer grasp reflex, which should weaken by 3 months and completely disappear by 6 months of age. The ability to elicit an inconsistent grasp at 8 months is a reason for concern.

   D. A light puff of air in the face causes the eyes to close.

      Rationale: This is incorrect. At birth, one permanent reflex is the blinking (glabellar) reflex. The reflex is elicited when a light puff of air hits the face.

3. The nurse is providing discharge instructions for a father whose child had a ventriculoperitoneal shunt. Which statement by the parent indicates that teaching was effective?

   A. "I will let my child resume swimming in 3 days."

      Rationale: This is incorrect. The child should not bathe, soak in water, or swim until approved by the surgeon.

   B. "I'm so happy that my child wouldn't need any more shunt surgeries."

      Rationale: This is incorrect. As the child grows, shunt revisions are often needed, until approximately 80% of the adult height has been reached.

   C. "I will observe my child for seizures, headache, fever, and vomiting."

      Rationale: This is correct. Parents should be taught to monitor for shunt infection and malfunction such as fever, lethargy, headache, vomiting, and seizures.

   D. "I like that these sutures dissolve in 3 days."

      Rationale: This is incorrect. The sutures will be removed by the surgeon in 7 to 14 days after the surgery.

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4. The nurse in the newborn nursery is providing care for a neonate with an open spinal cord defect. The neonate will be transported to a pediatric surgery hospital as soon as possible. Which description of the nurse's care of the neonate is correct?

   A. Using aseptic technique, place a sterile plastic bag around the defect and loosely tie it closed.

      Rationale: This is incorrect. A sterile bag is not placed around the defect and loosely tied closed.

   B. Place the newborn prone on a loose diaper and cover the defect with a second saline-moistened diaper.

      Rationale: This is incorrect. The nurse will use aseptic technique; the defect is not covered by a second saline moistened diaper, which can be clean but is not likely to be sterile.

   C. Position the newborn on the side with a moistened dressing on the defect; wrap the defect and the newborn in a blanket.

      Rationale: This is incorrect. The defect must remain as sterile as possible and the neonate is positioned to prevent any pressure on the defect. A side-lying position is not used, and the defect and neonate are not wrapped in a blanket. Body heat will be preserved by placing the newborn in a warmer.

   D. Cover the defect with a sterile dressing moistened with warm sterile normal saline, using aseptic technique.

      Rationale: This is correct. The nurse must exercise caution to keep the defect covered and protected until surgical correction can occur. Using aseptic technique, the nurse should cover the defect with a sterile dressing moistened with warm sterile normal saline. The neonate will be positioned prone and lying on an open diaper.

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5. The nurse is providing care for a pediatric patient who received a concussion while playing football. The patient had

brief loss of consciousness and now reports a headache with a pain level of 6 on a 0 to 10 scale. The patient states, “My team plays again in five days and I should be better.” Which information is vital for the patient and parents to understand?

A. A realistic time frame regarding complete recovery

Rationale: This is incorrect. The nurse needs to inform the patient and parents that full recovery from a concussion may take days, weeks, or months. This information is important, but it is not considered vital.

B. Type of equipment to prevent a second head injury

Rationale: This is incorrect. Information about the type of equipment needed to avoid a second head injury is important; however, it is not vital.

C. The risk of acquiring second impact syndrome

Rationale: This is correct. There is risk for a lethal condition known as second impact syndrome, in which the brain swells rapidly and the person succumbs quickly if a second concussion occurs before the first concussion has resolved. The patient’s remark makes this information vitally important.

D. The potential for long-term headaches

Rationale: This is incorrect. Head injuries may or may not cause long-term headaches.

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6. The nurse in the emergency department of a pediatric hospital is providing care for a toddler with a sudden high fever. The parent states, “She has been grumpy all day, and I thought she just needed a nap.” Which finding does the nurse recognize as an indication of an **immediate** medical emergency?

A. The toddler keeps their eyes closed or covered at all times.

Rationale: This is incorrect. Meningitis should always be suspected in acutely ill infants and children with fever and lethargy until proven otherwise; photophobia is a positive sign for meningitis. Meningitis can be a life-threatening infection and must be treated as a medical emergency; however, there is another finding that is more serious.

B. The nurse elicits a positive Brudzinski’s sign.

Rationale: This is incorrect. Brudzinski’s sign is positive for meningitis when flexion of the neck causes involuntary flexion of the knee and hip; however, there is another finding that is more serious.

C. A scattered purpuric rash is found on the skin.

Rationale: This is correct. The scenario describes the existence of a specific bacterial infection such as Neisseria meningitides. This infection results in a purpuric rash, often combined with sepsis. Death can occur in hours after the rash appears. This finding is an immediate medical emergency.

D. The toddler cries when head and neck are moved.

Rationale: This is incorrect. Meningitis is commonly associated with a stiff neck; crying when the head and neck is moved is indicative of pain. There is a finding that is even more serious.

7. A parent brings an adolescent who is 16 years of age to the pediatric clinic because the patient is experiencing unusual sensations in the feet. The nurse learns the patient was diagnosed with type 1 diabetes mellitus as a toddler; glucose levels have always been erratic and difficult to control. Which assessment findings does the nurse expect based on the health history? **Select all that apply.**

   Answers cannot be displayed for this alternate item format.

   Rationale: Feedback1.This is correct. The nurse is likely to suspect neuropathy, which is a condition of peripheral nerve damage resulting from a metabolic or endocrine disorder such as diabetes. The inability to distinguish between a sharp or blunt sensation on the sole of the foot supports the nurse's suspicion. 2.This is incorrect. The nurse does not expect to find feet that are warm to the touch, and capillary refill to be normal with suspected diabetic neuropathy. Compromised circulation is most likely. 3.This is correct. When neuropathy of the feet is present, balance can be adversely affected by pain, tingling, and loss of sensation. This finding supports the nurse's suspicions.4.This is incorrect. Smooth toenails and nail beds that are pink in color indicate good circulation. 5.This is correct. The presence of neuropathy in the lower extremities can be manifested by weakness.

8. The nurse is reviewing the chart of an adolescent who is 17 years of age with a diagnosis acute kidney disease. Which dietary order is the nurse expecting to find in the electronic health record?

   A. Low-protein diet

      Rationale: This is correct. In AKI, there is a decrease in the glomerular filtration rate (GFR). A diet high in protein can cause proteinuria and electrolyte imbalance. Therefore, a low-protein diet is recommended.

   B. High-calorie diet

      Rationale: This is incorrect. The daily caloric intake is based on the patient's weight in kilogram calorie intake is based on weight.

   C. High-oxalate diet

      Rationale: This is incorrect. A high-oxalate diet will increase the risk of nephrolithiasis.

   D. Ketogenic diet

      Rationale: This is incorrect. A ketogenic diet increases the risk of nephrolithiasis.

9. A 6-year-old patient is brought to the pediatrician's office with symptoms of feeling ill, periorbital edema, weight gain, and anorexia. The nurse suspects nephrotic syndrome. Which laboratory value confirms the nurse's suspicion?

   A. Serum sodium of 138 mEq/L

      Rationale: This is incorrect. The patient with nephrotic syndrome occasionally exhibits hyponatremia; the presented value is within normal limits.

   B. Serum potassium of 4.5 mEq/L

      Rationale:

This is incorrect. Serum potassium is not usually affected by nephrotic syndrome; the presented value is within normal limits.

C. A high level of protein in the urine

Rationale: This is correct. Nephrotic syndrome manifests with massive proteinuria (greater than 50 mg/kg/day).

D. Low serum levels of high-density lipoprotein (HDL) and low-density lipoproteins (LDLs)

Rationale: This is incorrect. Serum cholesterol and LDLs are grossly increased with nephrotic syndrome; the values should not be low.

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10. The pediatric nurse receives a medical prescription to obtain a urine sample for culture from an infant 6 months of age diagnosed with an urinary tract infection (UTI). By which method will the nurse collect the sample?

A. Applying clean-catch techniques

Rationale: This is incorrect. In pediatrics, using clean-catch techniques to obtain a sterile urine sample for culture is likely to work only if the patient is toilet trained.

B. Attaching an external urine bag

Rationale: This is incorrect. A bag urine specimen is not an appropriate collection method for culture because of multiple opportunity for contamination of the specimen.

C. Catching urine in a sterile diaper

Rationale: This is incorrect. The diaper may be sterile, but contamination of the infant's skin is still possible. The method is not supported or suggested.

D. Performing urinary catheterization

Rationale: This is correct. Urine cultures should be obtained by catheterization or suprapubic tap to decrease secondary contamination of the urine specimen.

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11. The nurse is providing care for a 7-year-old child whose admitting diagnosis is poststreptococcal glomerulonephritis. The nurse expects which care to be prescribed for the child?

A. Hemodialysis

Rationale: This is incorrect. Hemodialysis is emergency care in the presence of renal failure. There is no information to support this procedure.

B. Nifedipine orally

Rationale: This is incorrect. Nifedipine is prescribed as part of the emergency care for hypertension related to the diagnosis. There is no information to support this action.

C. Increase fluids

Rationale:

This is incorrect. When the child is admitted for poststreptococcal glomerulonephritis, the nurse expects an order for strict I&O monitoring. Fluid restrictions are most commonly prescribed.

D. Antibiotic therapy

Rationale: This is correct. The nurse will expect that antibiotic therapy will be prescribed to eradicate the offending organism if present. A common cause of poststreptococcal glomerulonephritis is either a missed strep diagnosis or uncompleted antibiotic therapy.

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12. The nurse in a pediatric clinic is gathering information from the parent of a toddler who has anorexia, generalized edema, and joint pain following a bout with strep throat. Which question(s) will **most** likely give the nurse information for a specific condition?

A. “What behavior did you see to indicate joint pain?”

Rationale: This is incorrect. The question about the parent-recognized joint pain does not provide information specific to a condition.

B. “When and where did you first notice swelling?”

Rationale: This is incorrect. Asking specifically about the time line for the existing edema does not provide information specific to a condition.

C. “Is the child urinating, and what color is the urine?”

Rationale: This is correct. The nurse may suspect a kidney disorder from the presenting symptoms and recent health history. The question about urination and the appearance of the urine will give the nurse information to validate a specific condition, which is acute postinfectious glomerulonephritis. The urine will appear tea-colored, cola-colored, or bright red.

D. “How were you managing the symptoms at home?”

Rationale: This is incorrect. It is not incorrect to ask how symptoms were being managed at home; however, this question does not provide information about a specific condition.

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13. The nurse is providing care for a 3-year-old toddler admitted with a diagnosis of nephrotic syndrome related to a recent upper respiratory infection. In preparation for discharge, which teaching does the nurse provide for the parents? **Select all that apply.**

Answers cannot be displayed for this alternate item format.

Rationale: Feedback1.This is incorrect. Infection is the most common complication, followed by thromboembolism. Broad-spectrum antibiotics should be initiated when an infection is suspected. Antibiotics are not given prophylactically. 2.This is correct. The parents need to know that edema is gravity dependent and occurs gradually; therefore, the parents need to check the feet and lower legs for swelling. 3.This is correct. Because increase in weight is a sign of fluid retention, the parents are taught weight should be taken at the same time each day, on the same scale, unclothed.4.This is incorrect. The nurse should teach the importance of encouraging ambulation and physical activity to prevent stasis complications.5.This is correct. Compliance with nutrition requirements and fluid restriction is important with a toddler with nephrotic syndrome. The nurse provides written materials to make sure that the correct dietary and fluid intake is maintained.

14. A parent brings a 15-year-old adolescent to the emergency department because of severe lower abdominal pain, with nausea and vomiting. Physical examination reveals a swollen scrotum and tenderness of one testicle. Which additional assessment finding supports the possibility of testicular torsion?

A. The symptoms have been intermittent since the patient's birth.

Rationale: This is incorrect. Peak incidence is in boys 12 to 18 years old; it is a smaller group in neonatal period. Torsion is corrected regardless of the age when it is first diagnosed.

B. The testis lies horizontally and there is a reactive hydrocele.

Rationale: This is correct. Along with being tender and swollen, the testis may lie horizontally and may have a reactive hydrocele.

C. The unaffected testicle is lifted higher in the scrotal sac.

Rationale: This is incorrect. With scrotal edema, the affected testis is tender, swollen, and slightly elevated. The unaffected testis is not elevated.

D. The symptoms are intermittent and resolve suddenly.

Rationale: This is incorrect. Intermittent torsion can present with intermittent sharp pain and swelling, then rapid resolution; however, there is no information in the scenario that validates the patient having prior experience with the condition.

15. The nurse is preparing to teach a class about genetics at a workshop for nurses. The nurse will remind the attending nurses that genes are responsible for determining our physical attributes and biological functions. Which other function will the nurse accredit to genes?

A. Organizing the chromosomes and the genetic code

Rationale: This is incorrect. The cell nucleus houses the chromosomes, the highly organized structures that contain the genetic code, DNA. Genes are not involved in organizing chromosomes and the genetic code.

B. Maintaining cell cytoplasm for the preservation of cell organelles

Rationale: This is incorrect. The cell is composed of a central enclosed core (nucleus) and the outer area (cytoplasm), which contains fluid and other cell organelles. The genes do not have a role in maintaining the cytoplasm for any purpose.

C. Ensuring the development of all the different types of body cells

Rationale: This is incorrect. Humans are composed of almost a trillion cells of different types, each of which derives from a single cell. This single cell then differentiates, or develops, into highly specific cell types. The genes do not play a role in cell differentiation.

D. Producing products necessary for the organism's function

Rationale: This is correct. Under the direction of genes, the cell cytoplasm makes products necessary for the organism's functions, such as growth, release of energy, and elimination of waste products at the cellular level.

16. The school nurse is answering questions about anatomy and physiology in a middle-school science class. One student asks, “How does our body become either a girl or a boy?” Which answer will the nurse provide?

A. “Girls are born more frequently because the mother’s sex chromosome is bigger.”

Rationale: This is incorrect. The female sex chromosome is larger, but the sex of a baby is actually determined by the male.

B. “Fathers always give a male chromosome, and the mother can give one of either sex.”

Rationale: This is incorrect. The female always gives an X chromosome (XX), and the male (XY) will give either an X chromosome (XX = female) or a Y chromosome (XY = male).

C. “Depending on the sex chromosome from the father, the baby will be a boy or a girl.”

Rationale: This is correct. The male, with two different sex chromosomes, always determines the sex of the child.

D. “There is no single chromosome that makes the sex determination; it’s by chance.”

Rationale: This is incorrect. The sex of a child is not determined by chance; XX for female and XY for male offspring.

17. The nurse is counseling a couple who has a neonate exhibiting the manifestations of trisomy 21. This is the couple’s first child, and they have no identifiable risks. Which explanation does the nurse provide to the parents?

A. Advanced maternal age will cause an alteration in an oocyte before reproduction.

Rationale: This is incorrect. Advanced maternal age can cause an alteration in an oocyte before reproduction; however, the scenario states no identifiable risks were associated with the parents.

B. An exposure to a highly contagious viral infection is responsible for the defect.

Rationale: This is incorrect. No information in the scenario identifies an exposure to a highly contagious viral infection.

C. Errors or abnormalities in a child can occur at any time during the process of fetal development.

Rationale: This is correct. Errors or abnormalities can occur at any time during the process of fetal development, from meiosis, to mitotic division after fertilization, to cell differentiation, and organ formation and development.

D. Fertilization is likely to have occurred with an immature spermatocyte from the male.

Rationale: This is incorrect. Spermatocytes are immature sperm cells that are not capable of fertilization.

18. The nurse shares genetic information with the parents of a 12-year-old female with a lack of pubertal development. The child is missing an X chromosome and is diagnosed with Turner’s syndrome. Which information will the nurse

provide regarding secondary sexual characteristics?

A. Estrogen therapy will reverse infertility.

Rationale: This is incorrect. Girls with Turner syndrome are missing an entire X chromosome, because the father did not contribute any sex chromosome. The female offspring will be infertile; no treatment is available for the infertility.

B. Offspring will be positive for Turner's syndrome.

Rationale: This is incorrect. The female with Turner syndrome will not be able to produce offspring.

C. Height and weight will remain within normal parameters.

Rationale: This is incorrect. Height and weight are usually within normal parameters at birth, and then deceleration of height velocity occurs.

D. Estrogen supplementation will prompt development.

Rationale: This is correct. Lack of pubertal development can be treated with estrogen supplementation so that girls can develop secondary sexual characteristics; however, they will remain infertile.

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19. The nurse is providing care for a father and son who were injured in an all-terrain vehicle (ATV; off-roading) accident. The 5-year-old child has a torus fracture in the forearm. The father has a fractured clavicle. The parent asks about healing time. Which information should the nurse share with the parent?

A. The healing time for both will be about the same.

Rationale: This is incorrect. The nurse would communicate that children's bones tend to heal faster than adult bones.

B. Children require a shorter immobilization time and will heal faster.

Rationale: This is correct. A child's bones tend to heal faster than adults. The immobilization times are shorter as well. This is appropriate information to share with the parent.

C. Adults require a shorter immobilization time and will heal faster.

Rationale: This is incorrect. The nurse would communicate that immobilization times are shorter in children than in adults.

D. Clavicle fractures heal faster than arm fractures.

Rationale: This is incorrect. This statement is incorrect. The nurse would communicate that bones tend to heal faster in children than in adults and that immobilization times are shorter in children as well.

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20. The nurse is caring for a child who reports having pain in the ankle after "twisting" it during play. Which would be the **most** appropriate follow-up assessment to this report?

A. Color and temperature of the skin around the ankle

Rationale:

This is incorrect. Color and temperature informs about the perfusion around the area.

B. The patient's gait and range-of-motion of all extremities

Rationale: This is incorrect. Gait and range of motion of all extremities informs about all areas rather than focus on the injured joint. Pain will affect a patient's gait.

C. Swelling and deformity of the ankle joint

Rationale: This is correct. Swelling and deformity will inform about injury to the joint.

D. Palpation of the joints proximal to the ankle

Rationale: This is incorrect. Palpation of the proximal joints will not inform about the injured area.

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21. The nurse is caring for a child in the emergency department. The child's arm is abnormally positioned, and the child is holding the arm near that area and is crying with pain. The child's parents explain that the child fell off the bicycle when riding on the streets of the subdivision. Which is the **priority** care to provide to the child?

A. Apply ice to the painful area.

Rationale: This is incorrect. Ice application is the third-level priority in care of emergent musculoskeletal injuries.

B. Elevate the child's arm.

Rationale: This is incorrect. Elevating the extremity is the last-level priority in care of emergent musculoskeletal injuries.

C. Encourage the child to rest.

Rationale: This is incorrect. Rest is the second-level priority in care of emergent musculoskeletal injuries.

D. Protect the child from further injury.

Rationale: This is correct. Protecting the patient from further injury is the priority care during emergent care of musculoskeletal injuries.

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22. The parent of a 3-month-old returns for a visit with the health-care provider who is caring for the infant's hip dysplasia. However, the nurse notes that on arrival, the infant is not wearing the prescribed Pavlick harness. The parent indicates they removed the harness, believing the infant was uncomfortable. Which is the **best** response by the nurse?

A. Inform the parent how to check for capillary refill in the toes.

Rationale: This is correct. This is done when the child is wearing the harness.

B. Assess the infant for trauma or swelling to the lower extremities.

Rationale: This is incorrect. Assessing for trauma or injury does not address the need to wear the harness as prescribed.

C. Report the findings to the health-care provider before entering the examination room.

Rationale: This is incorrect. The nurse is responsible to teach about care of the patient and has the responsibility to teach the parent rather than report to the health-care provider.

D. Ask the parent to demonstrate how to place the Pavlick harness.

Rationale: This is incorrect. This allows the nurse to determine whether the patient's parent can effectively apply the harness and assess what teaching needs completed to promote proper treatment.

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23. The parent of a 6-week-old patient calls the health-care provider's office and reports the infant is irritable, running a fever, holds his hip in an "unusual" position, and was recently given antibiotics for an ear infection. Which response by the nurse is **most** appropriate?

A. "Administer acetaminophen every 4 hours for the fever and call back if he still has a fever in 24 hours."

Rationale: This is incorrect. This only addresses the fever, which is not the complete health picture.

B. "This can easily be managed at home and will most likely resolve on its own."

Rationale: This is incorrect. This condition should be evaluated and likely requires hospital management.

C. "The antibiotics need more time to work. Finish the antibiotics prescribed and call back if the symptoms continue."

Rationale: This is incorrect. Finishing the antibiotics does not address the symptoms described by the parent. The antibiotics will treat the ear infection but are not adequate to treat the full condition.

D. "You need to take him to the walk-in clinic or emergency room for evaluation."

Rationale: This is correct. The infant is demonstrating symptoms of possible septic arthritis of the hip and needs immediate evaluation for the possible condition.

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24. A 12-year-old girl is noted to have a C-shaped lateral spinal curvature. Which condition is the girl **most** likely experiencing?

A. Internal femoral torsion

Rationale: This is incorrect. Internal femoral torsion causes laxity in the ligaments, and the child usually chooses the "W" sitting position.

B. Hip dysplasia

Rationale: This is incorrect. Hip dysplasia presents with limited hip abduction, asymmetrical thigh skinfolds, a positive Barlow test, and Galeazzi signs.

C. Clubfoot

Rationale: This is incorrect. Clubfoot is the inward turning of either one or both feet. The calf often looks smaller as well as the foot may be smaller than usual.

D. Scoliosis

Rationale: This is correct. Scoliosis, in this age group, often presents with a C- or S-shaped lateral spinal curvature.

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25. The nurse is caring for a 13-year-old patient diagnosed with adolescent idiopathic scoliosis. The curve in her back was treated by spinal fusion with rod insertion. Which is the **priority** nursing intervention in the postoperative period?

A. Promote adequate oral fluid intake.

Rationale: This is incorrect. While adequate intake is important to reduce the risk of dehydration, it is not the priority in this list.

B. Keep oxygen saturation within normal limits.

Rationale: This is correct. Oxygen saturation is the priority in this list. It is the ability to maintain an open airway and breathe effectively (ABCs) that makes this the priority.

C. Ensure placement of indwelling urinary catheter.

Rationale: This is incorrect. Placement of the indwelling urinary catheter is related to the ability to excrete waste during the immediate postoperative period, which is not a priority over oxygenation.

D. Maintain a straight back, no bending.

Rationale: This is incorrect. Maintaining a straight back, no bending, relates to the integrity of the surgical intervention and healing needed. Although important, another intervention is a higher priority.

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26. Which of the following nursing actions should the nurse plan to take postoperatively?**For each potential nursing action, click to specify if the potential action is essential, nonessential, or contraindicated for the infant.**

Answers cannot be displayed for this alternate item format.

Rationale: **Keep the head of bed elevated 60° to 90° for 48 hr is contraindicated.** The infant should be in a flat or nearly flat position during the immediate postoperative period to prevent rapid drainage of the intracranial fluid. **Apply a pressure dressing over the shunt valve is contraindicated.** Pressure on the shunt can cause the valve to open and lead to excessive rapid drainage of intracranial fluid. **Assess for unilateral pupil dilation is essential.** Increased intercranial pressure can cause pupil dilation on the side of the head in which the pressure is elevated. **Measure head circumference daily is essential.** An infant's head circumference can change due to the amount of intracranial pressure that exists. **Monitor for abdominal distention is essential.** Drainage of intracranial fluid into the peritoneal cavity can lead to the development of peritonitis or a postoperative ileus. **Perform clean intermittent catheterization every 4 hr is nonessential.** This procedure is for infants and children who have a myelomeningocele and a neurogenic bladder. **Test drainage from incision site for the presence of glucose is essential.** The presence of glucose in drainage can indicate the presence of cerebral spinal fluid.

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27. **Drag words from the choices below to fill in each blank in the following sentence.**

Answers cannot be displayed for this alternate item format.

Rationale: **Apply lotion to infant's shoulders after bathing is incorrect.** Lotion or powders should not be used on the skin beneath the harness because they can cause irritation to the skin and lead to skin breakdown. **Always place the diaper under the straps is correct.** Placing the diaper under the straps prevent the straps from becoming wet or soiled which would increase the risk of skin irritation. **Remove the Pavlik harness when infant is breastfeeding is incorrect.** There is no need to remove harness for breastfeeding. The harness is prescribed by the provider to be worn as much as possible except for baths. The harness permits easy access for parents to hold and provide care for the infant. The more frequently the harness is removed, the less likely the harness will be effective in correcting the DDH. **Adjust the length of the harness straps as needed at home is incorrect.** The parent should not adjust the harness straps. The harness may need to be refitted as the infant grows and gains weight or if skin breakdown is noted. The parent should be instructed to contact provider if this occurs. The parent should be instructed to reapply the harness correctly and to examine the skin beneath the harness for any areas of breakdown. **Gently massage intact skin under the straps once a day is correct.** The parent should be instructed to massage intact skin under the straps once a day to promote circulation to the area and prevent skin breakdown.

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28. **Drag 1 condition and 1 client finding to fill in each blank in the following sentence.**

Answers cannot be displayed for this alternate item format.

Rationale: **ConditionSeizure is correct.** The client has a history of a seizure disorder (tonic-clonic) and a recent change in their anti-epileptic medication. In addition, the guardian reports recent increase in the frequency of seizures. The risk of seizure activity is high and should be immediately addressed. **Pneumonia is incorrect.** Pneumonia is an acute condition, that is manifested by a cough, fever, and an increased WBC count. This child's EMR shows the child is afebrile, and their WBC is within expected reference range. The cough has been occurring for over 1 month and manifestations are consistent with mild exercise induced asthma.**Liver failure is incorrect.** The child's liver enzymes were all within the expected reference range and the nurse's note indicates no concerning abdominal findings during their assessment.**Steven's-Johnson Syndrome (SJS) is incorrect.** This child does not have any manifestations of such as fever, extensive necrosis, and epidermal detachment of their skin, or involvement of the mucous membranes. The skin rash described in the nurse's note is similar to the manifestations of eczema which is a chronic skin disorder. **Pneumothorax is incorrect.** The child does not have any manifestations of a pneumothorax. The breath sounds are being transmitted bilaterally and the child's SaO2 is within an expected range. Respiratory effort is easy and regular. **FindingPhenytoin level is correct.** Their current phenytoin level is below therapeutic level. This puts the child at risk for seizures. **Cough is incorrect.** They have a history of mild exercise induced asthma, their SaO2 is within an expected range and there are no current signs of respiratory distress. **Liver enzymes are incorrect.** The child's liver enzymes are all within the expected range. **Skin rash is incorrect.** The skin rash described in the nurse's note is similar to the manifestations of eczema which is a chronic disorder. **Breath sound is incorrect.** A slight end expiratory wheeze that is heard bilaterally is a finding associated with mild asthma. The child does not have any manifestations of respiratory distress that would increase their risk of respiratory failure.

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29. 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: The nurse should initiate IV hydration and prepare the child for hemodialysis because they are most likely experiencing hemolytic uremic syndrome. The patient’s blood pressure and weight should be monitored because weight is the best indicator of fluid balance and hemolytic uremic syndrome can cause hypertension.

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30. 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: This infant most likely has had a tonic-clonic seizure. The nurse should initiate seizure precautions to ensure the infant's safety. Because the infant is at risk for aspiration, they need to be NPO until they are awake and alert. The nurse should monitor for any changes in the infant's level of consciousness and assess their motor ability and note any weakness.
