

Chapter 1

1. When integrating the principles of family-centered care into the birthing process, the nurse would base care upon which belief?
 - A. Birth is viewed as a medical event.
 - B. Families are unable to make informed choices due to stress.
 - C. Birth results in changes in relationships.
 - D. Families require little information to make appropriate decisions for care.

Answer: C

Rationale: Family-centered care is based on the following principles: Birth affects the entire family, and relationships will change; birth is viewed as a normal, healthy event in the life of the family; and families are capable of making decisions about their own care if given adequate information and professional support.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Integrated Process: Caring

Reference: p. 7

2. The nurse is working with a group of community health members to develop a plan to address the special health needs of women. The group would design educational programs to address which **priority** condition?

- A. Smoking
- B. Heart disease
- C. Diabetes
- D. Cancer

Answer: B

Rationale: The group needs to address cardiovascular disease, the number one cause of death in women regardless of racial or ethnic group. Smoking is related to heart disease and the development of cancer. However, heart disease and cancer can occur in any woman regardless of her smoking history. Cancer is the second leading cause of death, with women having a one in three lifetime risk of developing cancer. Diabetes is another important health condition that can affect women. However, it is not the major health problem that heart disease is.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 12

3. A nurse is conducting an orientation program for a group of newly hired nurses. As part of the program, the nurse is reviewing the issue of informed consent. The nurse determines that the teaching was effective when the group identifies which situation as a violation of informed consent?
- A. Performing a procedure on a 15-year-old without parental consent
 - B. Serving as a witness to the signature process on an operative permit
 - C. Asking whether the client understands what she is signing following receiving education
 - D. Getting verbal consent over the phone for an emergency procedure from the spouse of a unconscious woman

Answer: A

Rationale: In most states, only clients over the age of 18 can legally provide consent for health care. Serving as a witness to the signature process, asking whether the client understands what she is signing, and getting verbal consent over the phone for emergency procedures are all key to informed consent and are not violations.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Analyze

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 45

4. A pregnant woman is to undergo an invasive procedure to evaluate the status of her fetus. To ensure informed consent, which action would be the **priority** responsibility of the nurse providing care to this woman?
- A. Asking relevant questions to determine the client's understanding
 - B. Providing a detailed description of the risks and benefits of the procedure
 - C. Explaining the exact steps that will occur during the procedure
 - D. Offering suggestions for alternative options for treatment

Answer: A

Rationale: The nurse's responsibilities related to informed consent include: Ensuring the consent form is completed with signatures from the client; serving as a witness to the signature process; and determining whether the client understands what she is signing by asking her pertinent questions. The physician, advanced practice nurse, or midwife is responsible for informing the client about the procedure and obtaining consent by providing a detailed description of the procedure or treatment, its potential risks and benefits, and alternative methods available.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 45

5. A 9-month-old with glaucoma requires surgery. The infant's parents are divorced. To obtain informed consent, which action would be **most** appropriate?

- A. Contacting the father for informed consent
- B. Obtaining informed consent from the mother
- C. Seeking a court ruling on the course of care
- D. Determining sole or joint custody by the parents

Answer: D

Rationale: The most appropriate action would be to determine legal custody by court decree. If the parents have joint custody, then either parent may give consent, but it is always best to have consent given by both parents. The parent with only physical custody may give consent for emergency care. The last resort is getting a court ruling; usually this is not necessary unless the parents disagree about the care of the child.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 47

6. Which statement made by a nursing student would **best** indicate that her education on family-centered care was fully understood?

- A. "Childbirth affects the entire family, and relationships will change."
- B. "Families are usually not capable of making health care decisions for themselves, especially in stressful situations."
- C. "Mothers are the only family member affected by childbirth."
- D. "Since childbirth is a medical procedure, it may affect everyone."

Answer: A

Rationale: Childbirth affects the entire family, and relationships will change.

Childbirth is viewed as a normal life event, not a medical procedure. Families are very capable of making health care decisions about their own care with proper information and support.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Integrated Process: Nursing Process

Reference: p. 15

7. Which aspect of client wellness has **not** been a focus of health during the 21st century ?

- A. Disease prevention
- B. Health promotion
- C. Wellness
- D. Analysis of morbidity and mortality

Answer: D

Rationale: The focus on health has shifted to disease prevention, health promotion, and wellness. In the last century, much of the focus was on analyzing morbidity and mortality rates.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: , p. Health Status of Women and Children

8. A nurse is planning a continuum of care for a client during pregnancy, labor, and childbirth. What is the **most** important factor in enhancing the birthing experience?
- A. Adhering to strict specific routines
 - B. Involving a pediatric physician
 - C. Educating the client about the importance of a support person
 - D. Assigning several nurses as a support team

Answer: C

Rationale: Educating the client about the importance of a support person during labor and delivery has been shown to improve and enhance the birthing experience.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 5-7

9. The nurse is administering a number of therapeutic interventions for neonates, infants, and children on the pediatric unit. Which intervention contributes to an increase in chronic illness seen in early childhood?

- A. Administering antibiotics to prevent lethal infections
- B. Vaccinating children to prevent childhood diseases
- C. Using mechanical ventilation for premature infants
- D. Using corticosteroids as a treatment for asthma

Answer: C

Rationale: Using mechanical ventilation and medications to foster lung development in premature infants increases their survival rate. Yet the infants who survive are often faced with myriad chronic illnesses. Administering antibiotics to prevent lethal

infections, vaccinating children to prevent childhood diseases, and using corticosteroids as a treatment for asthma may cause side effects, but do not contribute to chronic illness in children.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 5-7

10. The nurse is reviewing a copy of the U.S. Surgeon General's Report, Healthy People 2020. Which nursing action **best** reflects the nurse fostering this health care agenda?

- A. The nurse signs up for classes to obtain an advanced degree in nursing.
- B. The nurse volunteers at a local health care clinic providing free vaccinations for low-income populations.
- C. The nurse performs an in-service on basic hospital equipment for student nurses.
- D. The nurse compiles nursing articles on evidence-based practices in nursing to present at a hospital training seminar.

Answer: B

Rationale: Healthy People 2020 is a comprehensive health promotion and disease prevention agenda that is working toward improving the quantity and quality of life for all Americans. Overarching goals are to eliminate preventable disease, disability, injury, and premature death; achieve health equity, eliminate disparities, and improve the health of all groups; create physical and social environments that promote good health; and promote healthy development and behaviors across every stage of life. Volunteering at a local health care clinic directly reflects the goal of improving the health of all groups of people. Signing up for classes, performing in-services on equipment, and compiling nursing articles on evidence-based practices in nursing are all worthwhile activities that foster health care delivery, but are not as directly linked to the agenda of promoting health in the community.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 9

11. When assessing a family for barriers to health care, the nurse documents the psychosocial barriers. What is an example of this type of health care deficit?

- A. Academic difficulties
- B. Respiratory illness
- C. Poor sanitation
- D. Inherited diseases

Answer: A

Rationale: Environmental and psychosocial factors are now an identified area of concern in children. They include academic differences, complex psychiatric disorders, self-harm and harm to others, use of firearms, hostility at school, substance use disorder, HIV/AIDS, and adverse effects of the media. Respiratory illness and inherited diseases are health problems, and poor sanitation is an environmental factor.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Understand

Client Needs: Psychosocial Integrity

Integrated Process: Nursing Process

Reference: p. 13

12. When integrating the principles of family-centered care, the nurse would include which concept?

- A. Parents want nurses to make decisions about their child's treatment.
- B. Families are unable to make informed choices.
- C. People have taken increased responsibility for their own health.
- D. Families require little information to make appropriate decisions.

Answer: C

Rationale: Due to the influence of managed care, the focus on prevention, better education, and technological advances, people have taken increased responsibility for their own health. Parents now want information about their child's illness, to participate in making decisions about treatment, and to accompany their children to all health care situations.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 15

13. The nurse is caring for a 2-week-old girl with a metabolic disorder. Which activity would deviate from the characteristics of family-centered care?

- A. Softening unpleasant information or prognoses
- B. Evaluating and changing the nursing plan of care
- C. Collaborating with the child and family as equals
- D. Showing respect for the family's beliefs and wishes

Answer: A

Rationale: Family-centered care requires that the nurse provide open and honest information to the child and family. It is inappropriate to soften unpleasant information or prognoses. Evaluating and changing the nursing plan of care to fit

the needs of the child and family, collaborating with them as equals, and showing respect for their beliefs and wishes are guidelines for family-centered care.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Understand

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Teaching/Learning

Reference: p. 39

14. The nurse is caring for a 14-year-old girl with multiple health problems. Which activity would **best** reflect evidence-based practice by the nurse?

- A. Following blood pressure monitoring recommendations
- B. Determining how often the vital signs are monitored
- C. Using hospital protocol for ordering diagnostic tests
- D. Deciding the prescribed medication dose

Answer: A

Rationale: Using hospital protocol for ordering a diagnostic test, determining how often the vital signs are monitored, and deciding the medication dose ordered would be the health care provider's responsibility. However, following blood pressure monitoring recommendations would be part of evidence-based practice reflected in the nursing care delivered.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 13

15. The nurse is functioning in the primary role to care for a 12-year-old boy with metastatic cancer in the liver. Which activity is typical of advocacy?

- A. Instructing parents about proper home care
- B. Educating the family about choices they have
- C. Telling parents about clinical guidelines
- D. Teaching the family about types of cancers

Answer: B

Rationale: Educating the family about choices they have regarding therapies for the cancer in the child's liver is an example of advocacy, in which the nurse advances the interests of the child and family by informing them of options and assisting them to make informed decisions. Telling parents about proper home care, clinical guidelines, and the types of cancers are all done in the primary role of educator.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Understand

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Caring

Reference: p. 14

16. The nurse is caring for a 14-year-old boy with a growth hormone deficiency.

Which action **best** reflects using the nursing process to provide quality care to children and their families?

- A. Reviewing the effectiveness of interventions
- B. Questioning the facility standards for care
- C. Earning continuing education credits
- D. Ensuring reasonable costs for care provided

Answer: A

Rationale: The nursing process is used to care for the child and family during health promotion, maintenance, restoration, and rehabilitation. It is a problem-solving method based on the scientific method that allows nursing care to be planned and implemented in a thorough, organized manner to ensure quality and consistency of care. The nursing process is applicable to all health care settings and consists of five steps: assessment, nursing diagnosis, outcome identification and planning, implementation, and outcome evaluation. Reviewing the effectiveness of interventions is related to outcome evaluation in the nursing process. Even though the three remaining answer options are valuable in ensuring quality of care in health care facilities, they do not involve the direct care of the child and family using the nursing process.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 4

17. A preschool child is scheduled to undergo a diagnostic test. Which action by the nurse would violate a child's bill of health care rights?

- A. Arranging for her mother to be with her
- B. Telling the child the test will not hurt
- C. Assuring the child that the test will be done quickly
- D. Introducing the child to the lab technicians

Answer: B

Rationale: Telling the child the test will not hurt lacks veracity. It is not a lie, but it does not honor the child's right to be educated honestly about his or her health care. Arranging for the mother to be with the child, assuring the child that the test will be done quickly, and introducing the child to the lab technicians are actions that honor the child's bill of health care rights.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Understand

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 49

18. The pediatric nurse knows that the children being treated are considered minors. Which statement accurately describes the regulations related to consent for medical treatment?

A. Children older than age 16 can provide their own consent for, or refusal of, medical procedures.

B. A guardian

ad litem may be appointed by the parents to serve to protect the child's best interests.

C. Parents ultimately are the decision makers regarding medical treatment for their children younger than the age of 18.

D. When divorce occurs, the parent with whom the child is living on a daily basis will be granted custody of the child.

Answer: C

Rationale: Parents ultimately are the decision makers for their children. Generally, only persons over the age of majority (18 years of age) can legally provide consent for health care. Minors (children younger than 18 years of age) generally require adult guardians to act on their behalf. Biological or adoptive parents are usually considered to be the child's legal guardian. When divorce occurs, one or both parents may be granted custody of the child. In certain cases (such as child violence or neglect, or during foster care), a guardian *ad litem* may be appointed by the courts. This person generally serves to protect the child's best interests.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Understand

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 45-46

19. The nurse is caring for a 12-year-old child hospitalized for internal injuries following a motor vehicle accident. For which medical treatment would the nurse ensure that an informed consent is completed beyond the one signed at admission?

A. Diagnostic imaging

B. Cardiac monitoring

C. Blood testing

D. Spinal tap

Answer: D

Rationale: Most care given in a health care setting is covered by the initial consent for treatment signed when the child becomes a client at that office or clinic or by the consent to treatment signed upon admission to the hospital or other inpatient facility. Certain procedures, however, require a specific process of informed

consent, including major and minor surgery; invasive procedures such as lumbar puncture or bone marrow aspiration; treatments placing the child at higher risk, such as chemotherapy or radiation therapy; procedures or treatments involving research; photography involving children; and applying restraints to children.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Understand

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 45-46

20. A child needs a consent form signed for a minor surgical procedure. Which statement accurately describes the responsibilities of the health care providers when obtaining the consent?

- A. The physician is responsible for ensuring that the consent form is completed with signatures from the parents or legal guardians.
- B. The physician is responsible for serving as a witness to the signature process.
- C. The nurse is responsible for informing the child and family about the procedure and obtaining consent.
- D. The nurse is responsible for determining that the parents or legal guardians understand what they are signing by asking them pertinent questions.

Answer: D

Rationale: The nurse's responsibility related to informed consent includes the following: determining that the parents or legal guardians understand what they are signing by asking them pertinent questions, ensuring that the consent form is completed with signatures from the parents or legal guardians, and serving as a witness to the signature process. The physician or advanced practitioner providing or performing the treatment and/or procedure is responsible for informing the child and family about the procedure and obtaining consent by providing a detailed description of the procedure or treatment, the potential risks and benefits, and alternative methods available.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Understand

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 46

21. The nurse is caring for a child brought to the emergency department by a babysitter. The child needs an emergency appendectomy and the parents cannot be contacted. What would be the nurse's **best** response to this situation?

- A. Have the babysitter sign the consent form even if she does not have signed papers to do so.
- B. Have the primary care physician for the child sign the consent form.
- C. Document failed attempts to obtain consent to allow emergency care.
- D. Delay medical care until the child's next of kin can be contacted.

Answer: C

Rationale: Health care providers can provide emergency treatment to a child without consent if they have made reasonable attempts to contact the child's parent or legal guardian (American Academy of Pediatrics, Committee on Pediatric Emergency Medicine, 2007). If the parent is not available, then the person in charge may give consent for emergency treatment if that person has a signed form from the parent or legal guardian allowing him or her to do so. During an emergency situation, a verbal consent via the telephone may be obtained. In urgent or emergent situations, appropriate medical care never should be delayed or withheld due to an inability to obtain consent.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 46

22. The nurse knows that the emancipated minor is considered to have the legal capacity of an adult and may make his or her own health care decisions. Which child would potentially be considered an emancipated minor?

- A. A minor with financial independence who is living with his parents
- B. A minor who is pregnant
- C. A child older than 13 years of age who asks for emancipation
- D. A minor who puts his or her medical decisions in writing

Answer: B

Rationale: Emancipation may be considered in any of the following situations, depending on the state's laws: membership in a branch of the armed services, marriage, court-determined emancipation, financial independence and living apart from parents, college attendance, pregnancy, mother younger than 18 years of age, and a runaway.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 46

23. After describing the procedure and medical necessity, the nurse asks a 14-year-old child to assent to a skin graft. Which statement accurately describes the requirements for this type of assent?

- A. The age of assent occurs at 12 years old.
- B. It is not necessary to obtain assent from a minor for a procedure.
- C. A minor can dissent to a procedure but his or her wishes are not binding.

D. In some cases, such as cases of significant morbidity or mortality, dissent may need to be overridden.

Answer: D

Rationale: Assent means agreeing to something. In pediatric health care, the term assent refers to the child's participation in the decision-making process about health care (McCullough & Stein, 2009). In some cases, such as cases of significant morbidity or mortality, dissent may need to be overridden. The age of assent depends on the child's developmental level, maturity, and psychological state. The converse of assent, dissent (disagreeing with the treatment plan), when given by an adolescent 13 to 17 years of age, is considered binding in some states.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Understand

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 47

24. The family is the basic unit of society. Which statement correctly illustrates the importance of this concept related to how society functions?

- A. Healthy, well-functioning families provide members of all ages with fulfilling, supporting relationships.
- B. The family serves as a place that encourages members to autonomously function in pursuit of personal pleasures.
- C. Society functions best when families determine how they will interface with others without having to deal with the overall consequences.
- D. Work is an important part of family function but is not necessary for success if one member can fulfill multiple roles.

Answer: A

Rationale: The family is the basic unit of society. In order for this to work well, members of the family must work together. Families make a central contribution to enhance the quality of our society. Families must consider how their actions will impact others, and one member cannot fulfill all roles within the family.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 15

25. A nursing group is examining their hospital's maternal outcomes for the previous 5 years. Which identified factors have contributed to the decline in the maternal mortality rate? Select all that apply.

- A. Increased participation of women in prenatal care
- B. Use of ultrasound to detect disorders

- C. Increased use of anesthesia with birth
- D. Closer monitoring for complications associated with hypertension of pregnancy
- E. Better management of hemorrhage and infection

Answer: A, B, D, E

Rationale: The following factors have contributed to the decline in the maternal mortality rate: increased participation of women in prenatal care; greater detection of disorders such as ectopic pregnancy or placenta previa; prevention of related complications through the use of ultrasound; increased control of complications associated with hypertension of pregnancy; and decreased use of anesthesia with birth.

Question format: Multiple Select

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 9

26. The nurse is working with a group of community health members to develop a plan to address the special health needs of women. Which educational program would the group **most** likely identify as the priority?

- A. risk reduction strategies for diabetes
- B. methods for smoking cessation
- C. ways to adopt a heart-healthy lifestyle
- D. importance of cancer screening and early detection

Answer: C

Rationale: The group needs to address cardiovascular disease, the number one cause of death in women regardless of racial or ethnic group. Thus, education for adopting a heart-healthy lifestyle would be the priority. Smoking is related to heart disease and the development of cancer. However, heart disease and cancer can occur in any woman regardless of her smoking history. Cancer is the second leading cause of death, with women having a one in three lifetime risk of developing cancer. Diabetes is another important health condition that can affect women. However, it is not the major health problem that heart disease is, and thus educational programs focusing on smoking cessation, cancer screening and early detection, and diabetes risk reduction would be lesser priorities.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 12-13

27. A perinatal nurse is interviewing a group of women in the community about health care services. Assessment of these services reveals that many of them are

being underutilized. Which statement from the women would assist the nurse in identifying potential reasons for this underutilization? Select all that apply.

- A. "The services are hard to get to by public transportation."
- B. "The clinic is only open during the morning hours."
- C. "The staff seems to look down on us when we do come in."
- D. "There are staff there that can speak our language."
- E. "You need insurance to go to the clinic."

Answer: A, B, C, E

Rationale: Access to care can be jeopardized by lower incomes and greater responsibilities when juggling work and family. Lack of finances or transportation, geographic misdistribution of health care providers, no babysitters, language or cultural barriers, distrust of health care providers, inconvenient clinic hours, and the poor attitudes of health care workers often discourage clients from seeking health care. Having staff that speak the language of the client population would be helpful in encouraging clients to use the services.

Question format: Multiple Select

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 14

28. A nurse is preparing a class discussion on cardiovascular disease in women. When discussing the priority risk factors for this disease, which would the nurse **least** likely include? Select all that apply.

- A. Menopause
- B. Diabetes diagnosis
- C. Weight cycling
- D. Gender
- E. Age

Answer: D, E

Rationale: CVD is the leading cause of death in women. Risk factors of CVD differ between men and women with menopause, diabetes, and repeated weight losses and gains increasing the risk for coronary morbidity and mortality in women. Yo-yo dieting or yo-yo effect, also known as weight cycling is a major risk factor. Gender and age are not major risk factors and should not be considered in this list.

Question format: Multiple Select

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 12

29. A nurse is preparing a class discussion on the clinical manifestations of a heart attack observed in women. Which symptoms would the nurse include as key assessment data? Select all that apply.

- A. syncope
- B. unusual fatigue
- C. sleep disturbances
- D. arm pain
- E. extreme hunger

Answer: B, C, D

Rationale: Nurses need to go beyond the obvious crushing chest pain textbook symptom that indicates heart attack in men. Clinical manifestations of a heart attack observed in women include nausea, dizziness, irregular heartbeat, unusual fatigue, sleep disturbances, indigestion, anxiety, shortness of breath, pain or discomfort in one or both arms, and weakness.

Question format: Multiple Select

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 12

30. A nurse is preparing a breast cancer presentation for a health forum. Which fact would the nurse expect to address in this presentation?

- A. Breast cancer is more advanced in Black women when found.
- B. Black women have the BRCA1 and BRCA2 gene.
- C. More Hispanic women smoke, which increases their risk.
- D. White women respond better to breast cancer treatment.

Answer: A

Rationale: White women get breast cancer at a higher rate than Black women; however, Black women are more likely to die because they get breast cancer before 40 years of age, cancer is more advanced when found, and survival at every cancer stage is worse among Black women. Black women are not at greater risk due to the BRCA1 or BRCA2 genes that cause breast cancer. There is no evidence that Hispanic women smoke more, placing them at risk. White women do not respond better to cancer treatment.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 12

31. A nurse is making a presentation at a parenting class dealing with divorce. A participant asks the nurse, "How should a parent handle telling the children about a divorce?" Which statements are the **most** helpful? Select all that apply.

- A. "Tell your children about the divorce and the reasons for it."
- B. "Reassure your children that the divorce is not their fault."
- C. "Make sure your children are aware of the potential financial issues."
- D. "Let them know they can decide how the future family will look."
- E. "Inform them in advance of someone moving out of the family home."
- F. "Routines, rules, and discipline can be minimized until a later time."

Answer: A, B, E

Rationale: Rules for divorcing parents suggest to tell the children about the divorce and the reasons for the divorce in terms that they can understand; reassure the children that the divorce is not their fault; inform the children about the family structure after the divorce; inform them in advance of any changes in the household (i.e., someone moving out); do not discuss money or finances with your children; and maintain rules and routines.

Question format: Multiple Select

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 17-18

32. A nurse is preparing for a presentation on parenting at a local school. Which information would the nurse include when describing the results of an authoritarian parent? Select all that apply.

- A. The child will have lower self-esteem.
- B. The child will have increased feeling of security.
- C. Children will have higher achievements.
- D. An increase in aggression may be a result.
- E. The child will have increased social skills.
- F. There is a greater childhood happiness.

Answer: A, D

Rationale: This parenting style is associated with negative effects on self-esteem, happiness and social skills, increased aggression, and defiance. The child will not feel more secure as the parent is always in control. It will not result in higher achievements or an increase in social skills.

Question format: Multiple Select

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 21

33. Parents who recently experienced the death of their unborn child ask the nurse, "What is a fetal death?" What is the nurse's **best** response?

- A. "Fetal deaths occur later in pregnancy after 20 weeks' gestation."
- B. "It refers to the intrauterine fetal death at any time during pregnancy."
- C. "Fetal deaths occur earlier in pregnancy before 20 weeks' gestation."
- D. "Fetal death occurs only at the birth of the newborn."

Answer: B

Rationale: Fetal death refers to the spontaneous intrauterine death of a fetus at any time during pregnancy. Fetal deaths later in pregnancy (after 20 weeks of gestation) are referred to as stillbirths, and deaths earlier than 20 weeks are referred to as a miscarriage.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Integrated Process: Teaching/Learning

Reference: p. 10

34. Which factors are causes of the high infant mortality rate? Select all that apply.

- A. postmaturity
- B. low birth weight
- C. sudden infant death syndrome
- D. cardiac complications
- E. viral infections
- F. necrotizing enterocolitis

Answer: B, C, F

Rationale: The main causes of early infant death in the United States include problems occurring at birth or shortly thereafter, such as prematurity, low birth weight, congenital and chromosomal anomalies, sudden infant death syndrome, respiratory distress syndrome, unintentional injuries, bacterial sepsis, and necrotizing enterocolitis.

Question format: Multiple Select

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Remember

Client Needs: Psychosocial Integrity

Integrated Process: Nursing Process

Reference: p. 10

35. A nurse is preparing for a health promotion presentation for new mothers.

Which topics would be appropriate for the nurse to include in the presentation?

Select all that apply.

- A. Breastfeeding encouragement
- B. Proper infant sleep position
- C. Infants in smoke-free environments

- D. How to swaddle their infants
- E. How to bed share with their infants

Answer: A, B, C

Rationale: Health promotion strategies can significantly improve an infant's health and chances of survival. Breastfeeding has been shown to reduce rates of infection in infants and to improve their long-term health. Emphasizing the importance of placing an infant on his or her back to sleep will reduce the incidence of sudden infant death syndrome (SIDS). Parents/partners should not share a bed with an infant younger than 12 weeks old and should avoid exposing the infant to tobacco smoke. Encouraging mothers to join support groups to prevent postpartum depression will improve the health of both mothers and their infants. Swaddling an infant and bed sharing is discouraged due to SIDS.

Question format: Multiple Select

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 11

36. A client asks the nurse about her potential risk factors for breast cancer. Which risks would be important for the nurse to include in the response? Select all that apply.

- A. Oral contraceptive use
- B. Age when children were born
- C. Irregularities in menstruation
- D. Smoking
- E. Obesity

Answer: A, C, E

Rationale: A positive family history of breast cancer, aging, and irregularities in the menstrual cycle at an early age are major risk factors for breast cancer. Other risk factors include excess weight or obesity, not having children, oral contraceptive use, excessive alcohol consumption, a high-fat diet, sedentary lifestyle, and long-term use of hormones. Smoking is not a major risk factor for breast cancer, although it is considered. The age of the mother when children are born is not a risk factor.

Question format: Multiple Select

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 12-13

37. A public health nurse is preparing a presentation for a parenting class with the focus on childhood discipline. Which principles of childhood discipline would the nurse expect to emphasize? Select all that apply.

- A. The use of punishment will reduce or eliminate undesirable behaviors.
- B. Discipline methods should ensure the preservation of the child's self-esteem.
- C. Time-out technique for discipline is no longer acceptable.
- D. Positive reinforcement will increase desirable behaviors.
- E. Maintain a positive, supportive, nurturing parent-child relationship.

Answer: B, D, E

Rationale: Discipline should focus on the development of the child while ensuring to preserve the child's self-esteem and dignity. The American Academy of Pediatrics suggests three strategies for effective discipline: maintaining a positive, supportive, nurturing caregiver-child relationship; using positive reinforcement to increase desirable behaviors; and removing positive reinforcements or using punishment to reduce or eliminate undesirable behaviors. When using time-out, use 1 minute per year of the child's age (a 3-year-old would have time-out for 3 minutes). Do not exceed 5 minutes.

Question format: Multiple Select

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 22

38. When teaching a parenting class on childhood discipline, the nurse is asked by a parent, "How long do I place my child in time-out?" How should the nurse **best** respond?

- A. "Use the amount of time it takes to elicit a behavior change."
- B. "Use 1 minute per year of age, but do not exceed 5 minutes."
- C. "Use as much time as is needed to control the behavior."
- D. "Use 1 minute per year of the child's age as needed."

Answer: B

Rationale: Another form of discipline is extinction, which focuses on reducing or eliminating the positive reinforcement for inappropriate behavior. Examples are "time-out." When using time-out, use 1 minute per year of the child's age (a 3-year-old would have time-out for 3 minutes). Do not exceed 5 minutes.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 22

39. After teaching a group of parents on childhood discipline, the nurse understands that which statement, made by a parent, demonstrates an understanding of spanking as a form of discipline?

- A. "When responding to inappropriate behavior it is OK to lightly spank."
- B. "Use a combination of spanking along with other methods of discipline."
- C. "Use spanking as a last resort when time-out has failed."
- D. "Use methods other than spanking to respond to inappropriate behavior."

Answer: D

Rationale: Some research says spanking provides children with a model of aggressive behavior as a solution for conflict, is associated with increased aggression in children, and can lead to an altered parent-child relationship. Because of the negative consequences of spanking, and because it has been shown to be no more effective than other methods for managing inappropriate behavior, it is recommended that parents use methods other than spanking to respond to inappropriate behavior.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 22

40. A public health nurse visits the home of a young toddler. What aspect of the home environment would the nurse expect to address with the parents?

- A. The presence of power cords plugged into capped outlets
- B. Cartoons playing on a television in the child's room
- C. The family dog is present in the house during the visit
- D. The presence of pots on the stove with handles pointing toward back

Answer: B

Rationale: The nurse is encouraged to ask questions regarding the amount of recreational screen time and if the child has a television or Internet-connected device in his or her bedroom. The American Academy of Pediatrics discourages any screen media before the age of 2. The nurse would question why the TV is being used in the child's room. The family dog may be a threat to observe during the visit, but having a TV in the child's room indicates that it is being exposed to earlier than advised screen time. Pot handles are in the appropriate position. Cords are plugged into capped outlets, which is safe.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 26

41. The nurse notes that an older adult client receives only one visitor and asks the client if family members could be called. The client states, "I consider her to be all of my family." What would the nurse consider in responding to the client?
- A. The nurse could encourage the client to reconnect with other family members.
 - B. The client defines who is and who is not part of the family without undue influence.
 - C. The nurse realizes individuals exist without a family and do not often adopt substitutes.
 - D. Family is more important to those individuals with a large number of family members.

Answer: B

Rationale: It is important for nurses to remain neutral to all they hear and see in order to enhance trust and maintain open communication lines with all family members. Nurses need to remember that clients are experts of their own health and can define their own family.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Reference: p. 15

42. The nurse working in a maternity clinic suspects that a client and her children are in a violent relationship. While waiting for test results, the nurse decides to teach the client about intimate partner violence. What would be the **best** rationale for the nurse's decision?

- A. The nurse knows that the woman may be weak and controlled by her partner.
- B. The nurse has a legal responsibility to protect clients.
- C. The nurse understands there is an ethical responsibility to protect clients.
- D. The nurse knows that children exposed to family violence are likely to be victims of abuse.

Answer: D

Rationale: Children exposed to family violence are more likely to be physically, sexually, or emotionally abused themselves. Children have died from family violence and neglect when no one has intervened on their behalf. Children who are exposed to stressors such as family violence or who are victims of childhood violence or neglect are at high risk for short- and long-term problems. Witnessing and being exposed to violence in childhood results in a higher tolerance, and greater use, of violence as an adult. The nurse may feel an ethical responsibility towards clients, but the nurse does not have a legal responsibility to protect clients. Women being the weaker sex is a myth.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Integrated Process: Nursing Process

Reference: p. 29

43. A public health nurse is developing programs to educate parents on infant mortality. Which complications would the nurse include in the education? Select all that apply.

- A. Tricuspid atresia
- B. 39-week gestation birth
- C. 3.6 kg birth weight
- D. Anencephalus
- E. Spina bifida

Answer: A, D, E

Rationale: The main causes of early infant death in this country include problems occurring at birth or shortly thereafter. These include prematurity, low birth weight, congenital anomalies, sudden infant death syndrome (SIDS), and respiratory distress syndrome. A pregnancy at 39 weeks would be considered a term pregnancy. A birth weight of 3.6 kg would be considered appropriate.

Question format: Multiple Select

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 10

44. The pediatric nurse would be participating in the role of advocate when completing which action?

- A. Instructing parents on the side effects of vaccinations they are requesting for their child
- B. Contributing input on a task force with the aim to reduce the rate of mortality of infants and children
- C. Teaching parents to keep their prescribed medication safely out of reach of children
- D. Explaining to parents the reason for each medication their child was recently prescribed

Answer: B

Rationale: The role of advocacy is being fulfilled when the nurse works to safeguard and advance the interest of children and infants through many means, including contributing to the learning and application of a task force aimed at reducing infant and children mortality. The actions of instructing about side effects, explaining the purposes of medications, and teaching about medication safety would fall under the role of educator.

Question format: Multiple Choice

Chapter 1: Perspectives on Maternal and Child Health Care

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Caring

Reference: p. 50

Chapter 2

1. The nurse is providing care to a pregnant woman who speaks a different language from that of the nurse. When communicating with this client, the nurse demonstrates **best** practice by which action?
 - A. speaking to the client in a loud voice at a slow pace
 - B. standing close to the client while using a strong emphatic tone
 - C. having a family member communicate the information to the client
 - D. arranging for an interpreter to be present during any communication

Answer: D

Rationale: The nurse should arrange for an interpreter when communicating with a client who speaks another language. Speaking loudly, standing close to the client, and speaking emphatically would be of little benefit if the client does not understand the spoken language. Additionally, it can be interpreted as threatening to the client. Having a family member communicate the information to the client is inappropriate, violates client confidentiality (if the client has not given permission for that member to have the information), and does not ensure that the client will receive the correct information.

Question format: Multiple Choice

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Reference: p. 65

2. The nurse is caring for a 2-week-old newborn girl with a metabolic disorder. Which activity would deviate from the characteristics of family-centered care?
 - A. softening unpleasant information or prognoses
 - B. evaluating and changing the nursing plan of care
 - C. collaborating with the child and family as equals
 - D. showing respect for the family's beliefs and wishes

Answer: A

Rationale: Family-centered care requires that the nurse provide open and honest information to the child and family. It is inappropriate to soften unpleasant information or prognoses. Evaluating and changing the nursing plan of care to fit the needs of the child and family, collaborating with them as equals, and showing respect for their beliefs and wishes are guidelines for family-centered care.

Question format: Multiple Choice

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Understand

Client Needs: Psychosocial Integrity

Integrated Process: Nursing Process

Reference: p. 62-63

3. The nurse is providing home care for a 6-year-old girl with multiple medical challenges. Which activity would be considered the tertiary level of prevention?

- A. arranging for a physical therapy session
- B. teaching parents to administer albuterol
- C. reminding parent to give a full course of antibiotics
- D. giving a DTaP vaccination at the proper interval

Answer: A

Rationale: The tertiary level of prevention involves restorative, rehabilitative, or quality of life care such as arranging for a physical therapy session. Teaching parents to administer albuterol and reminding a parent to give the full course of antibiotics as prescribed are part of the secondary level of prevention, which focuses on diagnosis and treatment of illness. Giving a DTaP vaccination at the proper interval is an example of the primary level of prevention, which centers on health promotion and illness prevention.

Question format: Multiple Choice

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 72

4. A pregnant client tells her nurse that she is interested in arranging a home birth. After educating the client on the advantages and disadvantages of a home birth, which statement would indicate that the client understood the information?

- A. "I like having the privacy, but it might be too expensive for me to set up in my home."
- B. "I want to have more control, but I am concerned if an emergency would arise."
- C. "It is safer because I will have a midwife."
- D. "The midwife is trained to resolve any emergency, and she can bring any pain meds."

Answer: B

Rationale: Home births have many advantages, such as having more control over the birth, being the least expensive option, creating a good relationship with a midwife, and having more flexibility in the comfort of your home. However, the limited availability of pain medication and danger to the mother and baby if an emergency arises are two of the main disadvantages.

Question format: Multiple Choice

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 84-85

5. A nurse is reading a journal article about the changes in health care delivery and funding that have occurred over the years. Which factor would the nurse expect to find as a current trend in maternal and child health care settings?

- A. increase in ambulatory care
- B. decrease in family poverty level
- C. increase in hospitalization of children
- D. decrease in managed care

Answer: A

Rationale: The health care system has moved from reactive treatment strategies in hospitals to a proactive approach in the community, resulting in an increased emphasis on health promotion and illness prevention in the community through the use of community-based settings such as ambulatory care. Poverty levels have not decreased, and the hospitalization of children has not increased. Case management also is a primary focus of care.

Question format: Multiple Choice

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Remember

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 79

6. The nurse would recommend the use of which supplement as a primary prevention strategy to prevent neural tube defects in the future offspring of pregnant women?

- A. calcium
- B. folic acid
- C. vitamin C
- D. iron

Answer: B

Rationale: Prevention of neural tube defects in the offspring of pregnant women via the use of folic acid is an example of a primary prevention strategy. Calcium, vitamin C, and iron have no effect on the prevention of neural tube defects.

Question format: Multiple Choice

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 72

7. Which action would the nurse include in a primary prevention program in the community to help reduce the incidence of HIV infection?

- A. Provide treatment for clients who test positive for HIV.
- B. Monitor viral load counts periodically.
- C. Educate clients on how to practice safe sex.
- D. Offer testing for clients who practice unsafe sex.

Answer: C

Rationale: Primary prevention involves preventing disease before it occurs. Therefore, educating clients about safe sex practices would be an example of a primary prevention strategy. Providing treatment for clients who test positive for HIV, monitoring viral loads periodically, and offering testing for clients practicing unprotected sex are examples of secondary preventive strategies, which focus on early detection and treatment of adverse health conditions.

Question format: Multiple Choice

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 71-72

8. The nurse is preparing the discharge plan for a woman whose newborn requires ventilatory support at home. Which action by the nurse would be **most** appropriate to do when assuming the role of discharge planner?

- A. Confer with the client's parents.
- B. Teach new self-care skills to the client.
- C. Determine if there is a need for back-up power.
- D. Discuss coverage with the insurance company.

Answer: C

Rationale: The nurse should establish if there is a need for back-up power during discharge planning. Conferring with a woman's parents and dealing with insurance companies are case management activities. Teaching self-care skills are activities associated with the nurse as an educator.

Question format: Multiple Choice

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 71

9. A nurse working in the community is involved in providing primary prevention. Which intervention would be **most** appropriate to implement?

- A. teaching parents of toddlers about ways to prevent poisoning
- B. working with women who are victims of domestic violence
- C. working with clients at an HIV clinic to provide nutritional and CAM therapies
- D. teaching hypertensive clients to monitor blood pressure

Answer: A

Rationale: Primary prevention involves preventing a disease or condition before it occurs, such as teaching parents of toddlers about poisoning prevention. Working with women who are victims of domestic violence, clients at an HIV clinic, or hypertensive clients are all examples of tertiary prevention, which is designed to reduce or limit the progression of a disease or condition.

Question format: Multiple Choice

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 71-72

10. A nurse is preparing an in-service program for a group of newly hired nurses about trends in care for pregnant women. When describing events of the past decade, the nurse would state that the average length of stay in the hospital for vaginal births is:

- A. 24 to 48 hours or less.
- B. 72 to 96 hours or less.
- C. 48 to 72 hours or less.
- D. 96 to 120 hours or less.

Answer: A

Rationale: Hospital stays for vaginal births have averaged 24 to 48 hours or less during the past decade and 72 to 96 hours or less for cesarean births.

Question format: Multiple Choice

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 85

11. A nurse is teaching a local women's group about women's health care and changes that have occurred. When describing women's health care today, which statement would the nurse likely include?

- A. Women spend 50 cents of every dollar spent on health care.
- B. Women make almost 80% of all health care decisions.
- C. Women are still the minority in the United States.
- D. Men use more health services than women.

Answer: B

Rationale: Women make almost 80% of all health care decisions (those related to caregiver, mother, client); they represent the majority of the population; they spend 66 cents of every health care dollar; and they use more health services than men, with 7 of every 10 most frequently performed surgeries being specific to women.

Question format: Multiple Choice

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 87

12. A nurse is educating a client about a care plan. Which question would be appropriate to assess whether the client is learning?

- A. "Did you graduate from high school, and how many years of schooling did you have?"
- B. "Do you have someone in your family who would understand this information?"
- C. "Many people have trouble remembering information; is this a problem for you?"
- D. Would you prefer that the primary care provider give you more detailed medical information?"

Answer: C

Rationale: It is appropriate to ask the client if the client will have trouble remembering the information. Many clients have this problem. It removes any judgment or stereotypes regarding education level, ability to understand, or learning skills. Avoid giving information that uses a lot of medical language or jargon, and use a simple, conversational style.

Question format: Multiple Choice

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Teaching/Learning

Reference: p. 69-70

13. A nurse is working at a community prenatal drop-in clinic. Which actions **best** reflect the principles of family nursing within this clinic? Select all that apply.

- A. The clients and their families are assessed for adherence to federal health guidelines.
- B. Health promotion education activities are planned for the clients and their families.
- C. The clients and their families are included in all decision-making collaborations.
- D. The nurse would seek other health care provider input to plan care.
- E. The client is viewed as the ultimate decision maker.

Answer: B, C, D

Rationale: When implementing family-centered care, nurses seek other caregiver input. These suggestions and advice are incorporated into the client's plan of care as the nurse counsels and teaches the family appropriate health care interventions. Health promotion activities are offered to the client and family. The nurses partner with various experts to provide high-quality and cost-effective care. One expert partnership that nurses can make is with the client's family. The client and family are the health care decision makers.

Question format: Multiple Select

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning
Reference: p. 63

14. The nurse is preparing for a public health campaign with a focus on current trends with family-centered care. What information would the nurse include in the presentation? Select all that apply.
- A. Family-centered care requires sensitivity to the client's and family's beliefs.
 - B. The family should be assessed according to the relative importance of each member.
 - C. Family-centered care promotes greater family decision-making abilities.
 - D. The client's family is considered in health care to be an expert partnership.
 - E. Family members should be addressed individually before being addressed collectively.

Answer: A, C, D

Rationale: Family-centered care above all requires sensitivity to the client's and family's beliefs. This involves listening to the family's needs and a shift of the nurse's authoritarian role to the family to empower them to make their own decisions within the context of a supportive environment. One expert partnership that nurses can make is with the client's family. The philosophy of family-centered care recognizes the family as the constant.

Question format: Multiple Select

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 62-63

15. A nurse on a pediatric unit is asked by the mother of a young postoperative child, "What does atraumatic care mean?" Which responses by the nurse would be appropriate? Select all that apply.

- A. "Care on this unit attends to the distress experienced by children and their families."
- B. "Care that is provided minimizes the hospitalization stress."
- C. "Your child's care will prevent anxiety-provoking behaviors from occurring."
- D. "Attention will be paid to decreasing or preventing separation anxiety."
- E. "An early discharge will be planned so care can be given in the home."

Answer: A, B, D

Rationale: Atraumatic care refers to the delivery of care that minimizes or eliminates the psychological and physical distress experienced by children and their families in the health care system. The key principles of atraumatic care include preventing or minimizing physical stressors, preventing or minimizing separation of the child from the family, and promoting a sense of control for family. Nurses must be alert for any situation that has the potential for causing distress and should be able to identify potential stressors. Nurses should minimize separation anxiety of the child from the family and should decrease the child's exposure to stressful situations in order to prevent or minimize pain and injury.

Question format: Multiple Select

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 64

16. The nurse would include which principle(s) of adult learner-centered care when preparing to teach a female client about medication compliance? Select all that apply.

- A. Client teaching may include the strategy of role playing.
- B. Client teaching strategies should focus on a lecture style.
- C. Adults learn best when they realize there is gap in their knowledge base.
- D. The best time for adults to learn is when it meets an immediate need for them.
- E. Client teaching should focus on the content not the process.

Answer: A, C, D

Rationale: Teaching adults needs to focus more on the process than on the content. Adults are self-directed and value independence and want to learn on their own terms. Teaching strategies that include such concepts as role playing, demonstration, and self-evaluation are most helpful. Adults learn best when they perceive there is a gap in their knowledge base and want information to fill the gap. Adults learn best at a time when learning meets an immediate need. Adults value past experiences and beliefs.

Question format: Multiple Select

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 67

17. A nurse educator is preparing a lecture for a group of students about the possible client indicators of poor health literacy. Which student statements would indicate that teaching was successful? Select all that apply.

- A. "Clients will have difficulty filling out registration forms."
- B. "They frequently have missed appointments."
- C. "There is a pattern of lack of follow-up with treatment."
- D. "Clients will report not be able to hear."
- E. "There is a pattern of history of medication errors."
- F. "Clients will ask many questions about their health situation."

Answer: A, B, C, E

Rationale: Red flags that might indicate poor literacy skills include: difficulty filling out registration forms; frequently missed appointments; noncompliance and lack of follow-up with treatment regimens; history of medication errors; and avoiding asking questions for fear of looking "stupid." Reports of an inability to hear may be due to something else, like true hearing loss.

Question format: Multiple Select

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 68

18. A nurse is preparing to teach insulin administration to a newly diagnosed diabetic adolescent and the adolescent's family. Which strategies would the nurse use to assist the client's learning? Select all that apply.

- A. Go slow and repeat information often.
- B. Use plain nonmedical language to explain procedures.
- C. Deliver the material in an educational lecture format.
- D. Teach the prioritized information.
- E. Use the accurate medical terms in the presentation.

Answer: A, B, D

Rationale: Techniques that can help improve learning include: slow down and repeat information often; repeat important information at least four or five times; speak in conversational style using plain, nonmedical language; group information and teach it in small amounts using logical steps; and prioritize information first. Teach using an interactive, "hands-on" approach.

Question format: Multiple Select

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 69

19. A public health nurse is preparing to visit the home of teenage parents with a new infant.

Which action would be the **priority**?

- A. Determine the family's willingness for home visits.
- B. Prepare a schedule of follow-up visits.
- C. Review previous home visits to validate interventions.
- D. Review the family record to assess if the visit is necessary.

Answer: C

Rationale: It is essential to review previous interventions to eliminate unsuccessful ones.

Checking with previous home visit narratives will validate interventions. It would be necessary to communicate with previous nurses to ask questions and clarify. The other actions would not be the priority.

Question format: Multiple Choice

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Analyze

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 81

20. A nurse is preparing to visit the home of a two-day postpartum client and her infant. Which assessments would the nurse expect to prioritize during the home visit? Select all that apply.

- A. a postpartum assessment
- B. assessment of the family members' well-being
- C. newborn nutritional assessment
- D. routine newborn exam
- E. socioeconomic family assessment
- F. community day care assessment

Answer: A, B, C, D

Rationale: Postpartum care in the home environment usually includes monitoring the physical and emotional well-being of the family members; identifying potential or developing complications for the mother and newborn; newborn feeding; and instruction on pelvic floor exercises, nutrition, and self-hygiene care.

Question format: Multiple Select

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 70

21. A nurse working in the neonatal intensive care unit assists a family during the discharge of the premature newborn. What would the nurse prioritize in assessing the family's preparedness to care for the newborn? Select all that apply.

- A. The family's knowledge of newborn care
- B. The mother's and the family's concerns
- C. The family's available support system
- D. The availability of day care by the family's home
- E. The family's health insurance benefit program

Answer: A, B, C

Rationale: The nurse should assess the family's knowledge of positioning and handling of their infant, nutrition, hygiene, elimination, growth and development, immunizations needed, and recognition of illnesses. The nurse should identify knowledge deficiencies so that they can be addressed in the nurse's teaching plan. Targeting the mother's areas of concern will help the nurse focus on needed education. The nurse should also assess physical and emotional support for the new mother by asking questions about the availability of support.

Question format: Multiple Select

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 86

22. After teaching a group of nursing students about family-centered care, which statement made by the students would **best** indicate that the teaching was successful?

- A. "Family-centered care recognizes the health of the client."
- B. "Family-centered care is a component of health care."
- C. "Family-centered care recognizes the concept of family as the constant."
- D. "Family-centered care is one part of a system."

Answer: C

Rationale: Family-centered care recognizes the concept of the family as the constant. The health and functioning ability of the family influences and impacts the health of the client and other members of the family. It recognizes the client and the family as the source of control and a full partner in their care.

Question format: Multiple Choice

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Integrated Process: Teaching/Learning

Reference: p. 62

23. An oncology nurse is preparing a plan of care for a young father newly diagnosed with lung cancer. What action would be the nurse's **priority**?

- A. Complete the application for emergency financial assistance.
- B. Suggest that community members be sought to assist with child care.
- C. Recommend that the father join a community cancer support group.
- D. Teach the family how to navigate the health care system.

Answer: D

Rationale: Family-centered care refers to the collaborative partnership among the individual, family, and caregivers to determine the plan of care, gather information, offer support, and formulate plans for health care. It is generally understood to be an approach in which clients and their families are considered integral components of the health care decision making and delivery processes. The other options do not include the family in the process.

Question format: Multiple Choice

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Analyze

Client Needs: Safe, Effective Care Environment: Management of Care

24. A nurse is providing preoperative instructions to a client undergoing an emergency cesarean birth. Which actions follow appropriate communication guidelines? Select all that apply.

- A. During the instructions, the nurse uses open-ended questions.
- B. The conversation is redirected while maintaining its focus.

- C. The client's feelings are addressed.
- D. The nurse does not acknowledge the emotions in the situation.
- E. The family's words are used to describe the necessary information.
- F. Only the correct medical terms are used when explaining the cesarean birth.

Answer: A, B, C, E

Rationale: Good verbal communication skills are necessary. General guidelines for appropriate verbal communication include the following: Use open-ended questions that do not restrict the clients' answers; redirect the conversation to maintain focus; use reflection to clarify the parents' feelings; paraphrase the child's or parent's feelings to demonstrate empathy; acknowledge emotion; and demonstrate active listening by using the child's or family's own words.

Question format: Multiple Select

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Understand

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Teaching/Learning

Reference: p. 64

25. The public health nurse is preparing a presentation for an adolescent group with the focus being on primary prevention topics. Which topics would the nurse include? Select all that apply.
- A. Nutrition guidelines
 - B. Hygiene practices
 - C. Sun protection routine
 - D. Smoking cessation programs
 - E. Sexually transmitted infections

Answer: A, B, C

Rationale: The concept of primary prevention involves preventing the disease or condition before it occurs through health promotion activities, environmental protection, and specific protection against disease or injury. Its focus is on health promotion to reduce the person's vulnerability to any illness by strengthening the person's capacity to withstand physical, emotional, and environmental stressors. Secondary prevention is the early detection and treatment of adverse health conditions from smoking or STIs.

Question format: Multiple Select

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 71

26. The nurse is teaching a family about the benefits of circumcising their male neonate. The parents decline this procedure. How does this decision reflect the use of the family-centered approach by the nurse?

- A. It empowers the family to make their own decision.

- B. It applies the ethical principle of beneficence.
- C. Education about circumcision is provided to both parents.
- D. Evidence-based research is presented to the parents about circumcision.

Answer: A

Rationale: Family-centered care empowers the family to make their own decisions regarding care. The power of control becomes the family's, not the nurse's. This decision also takes into consideration the family's beliefs and culture. Beneficence is the act of being kind or helping someone. This term does not apply to this situation. Evidence-based information about circumcision may have been used for teaching, but allowing the family empowerment to make decisions about their health care exemplifies the family-centered approach.

Question format: Multiple Choice

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 62

27. The nurse is obtaining a health history from a parent who has brought the infant to the clinic for a well-baby check-up. Which statement by the nurse indicates the **most** appropriate way to demonstrate empathy for the parent's concerns?

- A. "I am sure you must be very tired with your baby wanting to nurse every two hours during the night."
- B. "Your concerns about your infant's growth are valid but your infant is growing well."
- C. "I believe I heard you say your infant is not doing well. Can you explain why you feel this way?"
- D. "Is there any other reason you brought your infant to the clinic today other than immunizations?"

Answer: A

Rationale: The way to demonstrate empathy through verbal communication is by paraphrasing the client's expressed feelings. This demonstrates the nurse heard what the client said and is being empathetic to the situation. Telling the parent not to worry about the infant's growth is a nontherapeutic and it also belittles the parent's concern. Asking the parent to explain one's feelings is using reflection to clarify the parent's feelings. Asking the parent why he or she brought the infant to clinic is a use of an open-ended question, which allows the parent to expand on the original statement.

Question format: Multiple Choice

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Integrated Process: Communication and Documentation

Reference: p. 62-63

28. The nurse needs to provide discharge education to a family to whom English is a second language and who will need to provide several skills daily for their child who has been diagnosed with a chronic illness. What is the **best** way for the nurse to provide this teaching?

- A. Provide teaching in short sessions
- B. Provide printed material with images of the skills
- C. Utilize videos of the skills to demonstrate
- D. Provide written materials in both English and the first language

Answer: A

Rationale: The most important element when teaching this family will be to break the teaching into short sessions so the family is not overwhelmed with the information and can better comprehend the content. Adding video and written material is a good idea, but these should be provided after the teaching is completed and the parents have returned demonstrations of the skill. The written and visual resources will be good for the family when they have returned home and need further clarification or additional understanding.

Question format: Multiple Choice

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 65

29. A hospital nurse is considering changing roles to become a home health nurse. What skill(s) will be important for this nurse to possess to be successful in the new role? Select all that apply.

- A. Be able to work with less structure
- B. Have good assessment skills
- C. Be knowledgeable about community resources
- D. Have good critical thinking skills
- E. Understand that not all environments will be desirable

Answer: A, B, D, E

Rationale: The nurse providing home health care must understand that decisions will need to be made for care at the point of care. That means the nurse must have very good assessment and communication skills. The home health nurse also performs care that has to be individualized for the client and the environment. Thus, critical thinking skills are essential. Equipment may not be available, so the nurse can improvise with what is available. The home health nurse must also understand that not every home the nurse visits will be a desirable environment. The nurse must make decisions based on safety for the client and the nurse. In the hospital setting, the nurse deals primarily with individual clients and has the advantage of having members of the health care team readily available. Hospitals tend to function with structure. Having structure is not always the case in the home environment. The nurse must be able to adapt to the immediate needs of the client in the situation. In the home setting, the nurse would not only be working with the client, but with the entire family. This role will require taking into consideration family issues, culture, and environmental threats. The new home health nurse would learn about

community resources. This knowledge could be acquired over time and is not required to start in the new role.

Question format: Multiple Select

Chapter 2: Family-Centered Community-Based Care

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 80

Chapter 3

1. When describing the menstrual cycle to a group of young women, the nurse explains that estrogen levels are highest during which phase of the endometrial cycle?
- A. menstrual
 - B. proliferative
 - C. secretory
 - D. ischemic

Answer: B

Rationale: Estrogen levels are the highest during the proliferative phase of the endometrial cycle, when the endometrial glands enlarge in response to increasing amounts of estrogen. Progesterone is the predominant hormone of the secretory phase. Levels of estrogen and progesterone drop sharply during the ischemic phase and fall during the menstrual phase.

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Reference: p. 104

2. After teaching a group of adolescent girls about female reproductive development, the nurse determines that teaching was successful when the girls state that menarche is defined as a woman's first:
- A. sexual experience.
 - B. full hormonal cycle.
 - C. menstrual period.
 - D. sign of breast development.

Answer: C

Rationale: Menarche is defined as the establishment of menstruation. It does not refer to the woman's first sexual experience, full hormonal cycle, or sign of breast development.

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 104

3. A client with a 28-day cycle reports that she ovulated on May 10. When would the nurse expect the client's **next** menses to begin?
- A. May 24
 - B. May 26
 - C. May 30

D. June 1

Answer: A

Rationale: For a woman with a 28-day cycle, ovulation typically occurs on day 14. Therefore, her next menses would begin 14 days later, on May 24.

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 102

4. The nurse is assessing a 13-year-old girl. Which event would the nurse expect to have occurred **first**?

- A. evidence of pubic hair
- B. development of breast buds
- C. onset of menses
- D. growth spurt

Answer: B

Rationale: Pubertal events preceding the first menses have an orderly progression beginning with the development of breast buds, followed by the appearance of pubic hair, then axillary hair, then a growth spurt. Menses typically occurs about 2 years after the start of breast development.

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 104

5. The nurse is preparing an outline for a class on the physiology of the male sexual response. Which event would the nurse identify as occurring **first**?

- A. sperm emission
- B. penile vasodilation
- C. psychological release
- D. ejaculation

Answer: B

Rationale: With sexual stimulation, the arteries leading to the penis dilate and increase blood flow into erectile tissue. Blood accumulates, causing the penis to swell and elongate. Sperm emission (movement of sperm from the testes and fluid from the accessory glands) occurs with orgasm. Orgasm results in a pleasurable feeling of physiologic and psychological release.

Ejaculation results in the discharge of semen from the urethra.

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 109

6. A woman comes to the clinic reporting that she has little sexual desire. As part of the client's evaluation, the nurse would anticipate the need to evaluate which hormone level?

- A. progesterone
- B. estrogen
- C. gonadotropin-releasing hormone
- D. testosterone

Answer: D

Rationale: Testosterone is thought to be the hormone of sexual desire in women. Thus, an evaluation of this level would be done. Progesterone is often called the hormone of pregnancy because of its calming effect (reduction in uterine contractions) on the uterus, allowing pregnancy to be maintained. Estrogen is the predominant hormone at the end of the follicular phase. Gonadotropin-releasing hormone induces the release of FSH and LH to assist with ovulation.

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 101

7. A school nurse who is teaching a health course at the local high school is presenting information on human development and sexuality. When talking about the role of hormones in sexual development, which hormone does the nurse teach the class is the **most** important for developing and maintaining the female reproductive organs?

- A. estrogen
- B. progesterone
- C. androgens
- D. follicle-stimulating hormone

Answer: A

Rationale: Estrogens are responsible for developing and maintaining the female reproductive organs. Progesterone is the most important hormone for conditioning the endometrium in preparation for implantation of the fertilized ovum. Androgens, secreted by the ovaries in small amounts, are involved in the early development of the follicle and affect the female libido. Follicle-stimulating hormone is responsible for stimulating the ovaries to secrete estrogen.

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 105

8. After explaining the function of the seminal vesicles to a class, the instructor determines the need for additional teaching when the students identify which action as a function of the seminal vesicles?

- A. nourishes the sperm
- B. reduces sperm motility
- C. aids sperm to reach the ovum
- D. prevents sperm destruction by female antibodies

Answer: B

Rationale: The seminal vesicles are a pair of glands that produce fluid with various substances that function to (1) nourish sperm, (2) enhance sperm motility by enzymatically liquefying ejaculated semen (3) stimulate contraction of the uterus to help the sperm reach the ovum, and (4) resist sperm destruction by female antibodies.

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 108

9. The nurse is reviewing the process of oocyte maturation and ovulation with a client. What occurs during the follicular phase of the ovarian cycle that the nurse should include in the teaching session?

- A. Under the influence of follicle-stimulating hormone, several follicles begin to ripen, and the ovum within each begins to mature.
- B. The empty ruptured graafian follicle becomes the corpus luteum, and it begins to secrete progesterone and estrogen.
- C. About day 14, a surge of hormones cause the ovum to burst through the ovary.
- D. The uterus prepares for implantation of an ovum.

Answer: A

Rationale: The follicular phase lasts from about day 4 to about day 14. During this time, under the influence of follicle-stimulating hormone, several follicles begin to ripen and the ovum within each begins to mature. About day 14, a surge of hormones causes the ovum to burst through the ovary; this act is called ovulation. During the luteal phase, the empty, ruptured graafian follicle becomes the corpus luteum, and it begins to secrete progesterone and estrogen. The endometrium of the uterus has a similar cycle. It is called the uterine cycle or endometrial cycle. This process prepares the uterus for implantation of an ovum (egg).

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 102

10. The nurse is reviewing the process of egg maturation and ovulation with a client. What occurs during ovulation in the ovarian cycle that the nurse should include in the teaching session with the client?
- A. Under the influence of follicle-stimulating hormone, several follicles begin to ripen, and the ovum within each begins to mature.
 - B. The empty ruptured cavity in the ovary becomes the corpus luteum and begins to secrete progesterone and estrogen.
 - C. About day 14, a surge of hormones cause the ovum to burst through the ovary.
 - D. The uterus is prepared for implantation of an ovum.

Answer: C

Rationale: The follicular phase lasts from about day 4 to about day 14. During this time, under the influence of FSH, several follicles begin to ripen, and the ovum within each begins to mature. About day 14, a surge of hormones causes the ovum to burst through the ovary. This act is called ovulation. During the luteal phase, the empty, ruptured graafian follicle becomes the corpus luteum and begins to secrete progesterone and estrogen. The endometrium of the uterus has a similar cycle. It is called the uterine cycle or endometrial cycle. This process prepares the uterus for implantation of an ovum (egg).

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 103

11. A nurse is conducting a class for a group of teenage girls about female reproductive anatomy and physiology. Which structures would the nurse include as an external female reproductive organ? Select all that apply.

- A. mons pubis
- B. labia
- C. vagina
- D. clitoris
- E. uterus

Answer: A, B, D

Rationale: The external female reproductive organs collectively are called the vulva (which means "covering" in Latin). The vulva serves to protect the urethral and vaginal openings and is highly sensitive to touch to increase the female's pleasure during sexual arousal (Stables & Rankin, 2010). The structures that make up the vulva include the mons pubis, the labia majora and minora, the clitoris, the structures within the vestibule, and the perineum. The vagina and uterus are internal female reproductive organs.

Question format: Multiple Select

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 96

12. A woman comes to the clinic for an evaluation. During the visit, the woman tells the nurse that her menstrual cycles have become irregular. "I've also been waking up at night feeling really hot and sweating. The nurse interprets these findings as:

- A. menopause.
- B. perimenopause.
- C. climacteric.
- D. menarche.

Answer: B

Rationale: Perimenopause is the time period occurring 2 to 8 years prior to menopause during which women may experience physical changes associated with decreasing estrogen levels, which may include vasomotor symptoms of hot flashes, irregular menstrual cycles, sleep disruptions, forgetfulness, irritability, mood disturbances, decreased vaginal lubrication, night sweats, fatigue, vaginal atrophy, and depression (Burbos & Morris, 2011). Vasomotor symptoms (hot flushes and night sweats) are the most common complaints for which women seek treatment. Menopause or climacteric is defined as 1 year without a menstrual period. Menarche refers to the onset of the first menses.

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 106

13. A nurse is examining a female client and tests the client's vaginal pH. Which finding would the nurse interpret as normal?

- A. 4.5
- B. 7
- C. 8.5
- D. 10

Answer: A

Rationale: The vagina has an acidic environment; therefore, a pH of 4.5 would indicate an acidic environment. A pH of 7 is considered neutral; a pH above 7 is considered alkaline.

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 97-98

14. When describing the male sexual response to a group of students, the instructor determines that the teaching was successful when they identify emission as:

- A. semen forced through the urethra to the outside.

- B. movement of sperm from the testes and fluid into the urethras.
- C. dilation of the penile arteries with increased blood flow to the tissues.
- D. body's return to the physiologic nonstimulated state.

Answer: B

Rationale: Emission refers to the movement of sperm from the testes and fluids from the accessory glands into the urethra, where it is mixed to form semen. As the urethra fills with semen, the base of the erect penis contracts, thus increases pressure. This pressure forces the semen through the urethra to the outside (ejaculation). Dilation of the penile arteries with increased blood flow describes erection. The body's return to the physiologic nonstimulated state describes resolution.

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 109

15. A nurse is describing the structure and function of the reproductive system to an adolescent health class. How would the nurse describe the secretion of the seminal vesicles?

- A. mucus-like
- B. alkaline
- C. acidic
- D. semen

Answer: B

Rationale: The paired seminal vesicles secrete an alkaline fluid that contains fructose and prostaglandins. The fructose supplies energy to the sperm on its journey to meet the ovum, and the prostaglandins assist in sperm mobility. The Cowper's glands secrete a mucus-like fluid. The vagina is an acidic environment. Semen refers to the sperm-containing fluid.

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 108

16. A nurse is completing a continuing education program about the male and female reproductive organs. After reviewing the information, the nurse demonstrates understanding of the information by identifying which structures as male accessory organs? Select all that apply.

- A. testes
- B. vas deferens
- C. bulbourethral glands
- D. prostate gland
- E. penis

Answer: B, C, D

Rationale: The organs of the male reproductive system include the two testes (where sperm cells and testosterone are made), the penis, the scrotum, and the accessory organs (epididymis, vas deferens, seminal vesicles, ejaculatory duct, urethra, bulbourethral glands, and prostate gland).

Question format: Multiple Select

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 108

17. A woman is diagnosed with a vaginal infection. After teaching the client about measures to reduce her risk, the nurse determines that the client needs additional teaching when she states which factor as increasing her risk?

- A. antibiotic therapy
- B. menstruation
- C. douching
- D. use of feminine hygiene sprays

Answer: B

Rationale: The vagina has an acidic environment, which protects it against ascending infections. Antibiotic therapy, douching, perineal hygiene sprays, and deodorants upset the acid balance within the vaginal environment and can predispose women to infections. Menstruation is not considered a risk factor.

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 97-98

18. A nurse is describing the hormones involved in the menstrual cycle to a group of young adult women who are planning to get pregnant. The nurse determines the teaching was successful when the group identifies the follicle-stimulating hormone as being secreted by the:

- A. hypothalamus.
- B. anterior pituitary gland.
- C. ovaries.
- D. corpus lute.

Answer: B

Rationale: Follicle-stimulating hormone and luteinizing hormone are secreted by the anterior pituitary gland. The hypothalamus secretes gonadotropin-releasing hormone. The ovaries secrete estrogen. The corpus luteum secretes progesterone.

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 105

19. A nurse has been invited to be a guest speaker for a female high school health class about the menstrual cycle and reproduction. When describing the hormones involved in the menstrual cycle, a nurse identifies which hormone as responsible for initiating the cycle?

- A. estrogen
- B. luteinizing hormone
- C. progesterone
- D. prolactin

Answer: B

Rationale: With the initiation of the menstrual cycle, luteinizing hormone rises and stimulates the follicle to produce estrogen. As this hormone is produced by the follicle, estrogen levels rise, inhibiting the output of LH. Ovulation occurs after an LH surge damages the estrogen-producing cells leading to a decline in estrogen. The LH surge results in the corpus luteum, which produces estrogen and progesterone. These two levels rise, suppressing LH. Lack of LH promotes degeneration of the corpus luteum, which then leads to a decline in estrogen and progesterone. The decline of ovarian hormones ends their negative effect on the secretion of LH, which is then secreted and the menstrual cycle begins again. Prolactin is the hormone responsible for breast milk production.

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 103

20. After teaching a group of adolescents about female reproductive anatomy, the nurse determines that the teaching was successful when the adolescents identify which structure as the site of fertilization?

- A. vagina
- B. uterus
- C. fallopian tubes
- D. vestibule

Answer: C

Rationale: Fertilization occurs in the distal portion of the fallopian tubes. The lining of the uterus is shed with menstruation. The vagina connects the external genitalia to the uterus. The vestibule is an oval area enclosed by the labia minora laterally.

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 100

21. The nurse is assessing a 12-year-old girl who has had her first menses. When reviewing the client's history, which event would the nurse expect to have most likely occurred **last**?

- A. evidence of pubic hair
- B. breast bud development
- C. growth spurt
- D. onset of menses

Answer: D

Rationale: Pubertal events preceding the first menses have an orderly progression beginning with the development of breast buds, followed by the appearance of pubic hair, then axillary hair, then a growth spurt. Menses typically occurs about 2 years after the start of breast development.

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 104

22. After teaching a group of pregnant women about breastfeeding, the nurse determines that the teaching was successful when the group identifies which hormone as being inhibited during pregnancy but is important for the production of breast milk after birth?

- A. placental estrogen
- B. progesterone
- C. gonadotropin-releasing hormone
- D. prolactin

Answer: D

Rationale: Following birth and the expulsion of the placenta, levels of placental hormones (progesterone and lactogen) fall rapidly, and the action of prolactin (milk-producing hormone) is no longer inhibited. Prolactin stimulates the production of milk within a few days after birth. Placental estrogen and progesterone stimulate the development of the mammary glands during pregnancy. Gonadotropin-releasing hormone induces the release of follicle-stimulating hormone and luteinizing hormone to assist with ovulation.

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 100

23. A nurse is asked to be a guest speaker for a parents' meeting at the local middle school. Part of the presentation is to focus on the events girls will experience when going through puberty. Place the events in the order that the nurse would address them, from first to last. Use all options.

- A. Development of the breast

- B. Appearance of pubic hair
- C. Appearance of axillary hair
- D. Growth spurt
- E. Menstruation

Answer: A, B, C, D, E

Rationale: Pubertal events preceding the first menses have an orderly progression: thelarche, the development of breast buds; adrenarche, the appearance of pubic and then axillary hair followed by a growth spurt; and menarche (occurring about 2 years after the start of breast development).

Question format: Drag and Drop

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 104

24. When teaching a group of female adolescents about reproduction and reproductive organs, the nurse describes the vulva. Which structure(s) would the nurse identify as being included?

Select all that apply.

- A. Mons pubis
- B. Labia
- C. Clitoris
- D. Vagina
- E. Fallopian tubes

Answer: A, B, C

Rationale: The structures that make up the vulva include the mons pubis, the labia majora and minora, the clitoris and prepuce, the structures within the vestibule, and the perineum. The vagina and fallopian tubes are internal reproductive structures.

Question format: Multiple Select

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 96

25. A nurse is teaching a group of female adolescents and young adult females about the female sexual response. The nurse determines that the teaching was successful when the group identifies which structure as being most erotically sensitive?

- A. Labia minora
- B. Clitoris
- C. Mons pubis
- D. Prepuce

Answer: B

Rationale: The clitoris is sensitive to touch, stimulation, and temperature and can become erect. For its small size, 9 to 11 cm, it has a generous blood and nerve supply. There are more free nerve endings of sensory reception located on the clitoris than on any other part of the body, and it is therefore unsurprisingly the most erotically sensitive part of the genitalia for most females. Its function is sexual stimulation. The labia minora lubricate the vulva, swell in response to stimulation, and are highly sensitive. However, they are not the most sensitive. The mons pubis protects the symphysis pubis during sexual intercourse. The joining of the folds above the clitoris forms the prepuce, a hood-like covering over the clitoris.

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 97

26. A nurse is assessing a 49-year-old client who has come to the clinic for her annual physical exam. The client tells the nurse, "I usually sleep about 8 hours a night without any problems but there are some nights where I wake up drenched in perspiration. And some days I feel on edge for no apparent reason." Additional assessment reveals use of a vaginal lubricant during sexual intercourse. The client also reports occasional flatulence without constipation or bloating and continuation of her menstrual cycle every 32 days with a moderate flow. The nurse suspects that the client may be perimenopausal based on which finding(s)? Select all that apply.

- A. Reports of night sweats
- B. Unexplained irritability
- C. Use of vaginal lubrication
- D. Absence of bloating
- E. Expanded length of menstrual cycle

Answer: A, B, C

Rationale: During the perimenopausal years (2 to 8 years prior to menopause), women may experience physical changes associated with decreasing estrogen levels, which may include vasomotor symptoms of hot flashes, irregular menstrual cycles, sleep disruptions, forgetfulness, irritability, mood disturbances, decreased fertility, weight gain and bloating, changing bleeding patterns, headaches, decreased vaginal lubrication, night sweats, fatigue, vaginal atrophy, and depression.

Question format: Multiple Select

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 106

27. A nurse is conducting a health class about the reproductive system for a group of high school students. The nurse determines that the teaching was successful when the students identify which structure(s) as part of the external male reproductive system? Select all that apply.

- A. Penis
- B. Scrotum
- C. Prostate gland
- D. Vas deferens
- E. Seminal vesicles

Answer: A, B

Rationale: The penis and the scrotum form the external genitalia in the male. The prostate gland, vas deferens, and seminal vesicles are internal male genitalia.

Question format: Multiple Select

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 107

28. A nurse is preparing a presentation for a group of young adults about the sexual response cycle. Place the events in the sequence that they would occur. Use all options.

- A. Desire
- B. Excitement
- C. Plateau
- D. Orgasm
- E. Resolution

Answer: A, B, C, D, E

Rationale: The sexual response cycle for males and females is as follows: Desire, excitement, plateau, orgasm, and resolution.

Question format: Drag and Drop

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 101

29. A nurse is discussing the changes in the breast that occur after birth to a group of pregnant women. One woman says, "My friend who was breastfeeding told me that at first, her breast milk was dark yellow." Which response by the nurse would be appropriate?

- A. "That is called colostrum. It is rich in antibodies and proteins."
- B. "That was just fluid that normally collects to make your breasts get bigger."
- C. "Your friend probably had a mild infection in her milk ducts."
- D. "The fluid is yellow because of the anesthesia your friend received."

Answer: A

Rationale: Prolactin stimulates the production of milk within a few days after childbirth, but in the interim, dark yellow fluid called colostrum is secreted. Colostrum contains more minerals and protein but less sugar and fat than mature breast milk. Colostrum secretion may continue for approximately 1 week after child birth, with gradual conversion to mature milk. Colostrum is rich in maternal antibodies, especially immunoglobulin A (IgA), which offers protection for the newborn against enteric pathogens. Colostrum is not fluid that has collected during pregnancy that causes breasts to enlarge, not a sign of infection, or the result of anesthesia given.

Question format: Multiple Choice

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 100

30. A nurse is teaching a group of adolescent males about the male reproductive system. The nurse determines that the teaching was successful when the group identifies which activity(ies) as a function of the testes? Select all that apply.

- A. Sperm production
- B. Testosterone production
- C. Sperm transport
- D. Seminal fluid production
- E. Sperm nourishment

Answer: A, B

Rationale: The testes have two functions: producing sperm and synthesizing testosterone (the primary male sex hormone). Sperm is transported via the ductal system. Seminal fluid is produced by the seminal vesicles. The seminal vesicles and the prostate gland produce fluid that nourishes the sperm.

Question format: Multiple Select

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 107

31. A nurse is conducting a presentation for a group of young adults who are considering childbearing. As part of the class, the nurse describes semen as consisting of sperm and which substance(s)? Select all that apply.

- A. Prostatic fluid
- B. Seminal fluid
- C. Mucus from accessory glands
- D. Prostate-specific antigen

E. Colostrum

Answer: A, B, C

Rationale: During ejaculation, the ducts of the testes, epididymis, and vas deferens contract and cause expulsion of sperm into the urethra, where the sperm mixes with the seminal and prostatic fluids. These substances, together with mucus secreted by accessory glands, form the semen, which is discharged from the urethra. Prostate-specific antigen is a glycoprotein that thins semen. Colostrum is the dark yellow fluid that contains more minerals and protein but less sugar and fat than mature breast milk. It is secreted by women for the first few days after childbirth.

Question format: Multiple Select

Chapter 3: Anatomy and Physiology of the Reproductive System

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 109

Chapter 4

1. After discussing various methods of contraception with a client and her partner, the nurse determines that the teaching was successful when they identify which contraceptive method as providing protection against sexually transmitted infections (STIs)?

- A. oral contraceptives
- B. tubal ligation
- C. condoms
- D. intrauterine system

Answer: C

Rationale: Condoms are a barrier method of contraception. In addition to providing a physical barrier for sperm, they also protect against STIs. Oral contraceptives, tubal ligation, and intrauterine systems provide no protection against STIs.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 141

2. When discussing contraceptive options, the nurse would recommend which option as being the **most** reliable?

- A. coitus interruptus
- B. lactational amenorrheal method (LAM)
- C. natural family planning
- D. intrauterine system

Answer: D

Rationale: An intrauterine system is the most reliable method because users have to consciously discontinue using them to become pregnant rather than making a proactive decision to avoid conception. Coitus interruptus, LAM, and natural family planning are behavioral methods of contraception and require active participation of the couple to prevent pregnancy. These behavioral methods must be followed exactly as prescribed.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 148

3. A client comes to the clinic with abdominal pain. Based on her history the nurse suspects endometriosis. The nurse expects to prepare the client for which evaluatory method to confirm this suspicion?

- A. pelvic examination
- B. transvaginal ultrasound
- C. laparoscopy
- D. hysterosalpingogram

Answer: C

Rationale: The only certain method of diagnosing endometriosis is by seeing it. Therefore, the nurse would expect to prepare the client for a laparoscopy to confirm the diagnosis. A pelvic examination and transvaginal ultrasound are done to assess for endometriosis but do not confirm its presence. Hysterosalpingography aids in identifying tubal problems resulting in infertility.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 125

4. The nurse discusses various contraceptive methods with a client and her partner. Which method would the nurse explain as being available only by prescription?

- A. condom
- B. spermicide
- C. diaphragm
- D. basal body temperature

Answer: C

Rationale: The diaphragm is available only by prescription and must be professionally fitted by a health care provider. Condoms and spermicides are available over the counter. Basal body temperature requires the use of a special thermometer that is available over the counter.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Reference: p. 143

5. When developing a teaching plan for a couple who are considering contraception options, the nurse would include which statement?

- A. "You should select one that is considered to be 100% effective."
- B. "The best one is the one that is the least expensive and most convenient."
- C. "A good contraceptive doesn't require a primary care provider's prescription."
- D. "The best contraceptive is one that you will use correctly and consistently."

Answer: D

Rationale: For a contraceptive to be most effective, the client must be able to use it correctly and consistently. Even if a method is considered 100% effective, it is not the best choice if the couple

does not use it correctly or consistently. Cost is a consideration, but the least expensive method is not necessarily the best choice. The need for a prescription is not relevant to the couple's choice.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 152

6. Which measure would the nurse include in the teaching plan for a woman to reduce the risk of osteoporosis after menopause?

- A. taking vitamin supplements
- B. eating high-fiber, high-calorie foods
- C. restricting fluid to 1,000 mL daily
- D. participating in regular daily exercise

Answer: D

Rationale: Measures to reduce osteoporosis after menopause include daily weight-bearing exercise, increasing calcium and vitamin D intake, and avoiding smoking and excessive alcohol intake. General vitamin supplements may be helpful overall, but they are not specific to reducing the risk of osteoporosis. A diet high in calcium and vitamin D, not fiber and calories, would be appropriate. Restricting fluids would have no effect on preventing osteoporosis.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 162

7. When teaching a group of postmenopausal women about hot flashes and night sweats, the nurse would address which **primary** cause?

- A. poor dietary intake
- B. estrogen deficiency
- C. active lifestyle
- D. changes in vaginal pH

Answer: B

Rationale: Hot flashes and night sweats are classic signs of estrogen deficiency. They are unrelated to dietary intake or active lifestyle. Changes in vaginal pH are associated with genitourinary changes of menopause.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Reference: p. 160

8. A client states that she is to have a test to measure bone mass to help diagnose osteoporosis. The nurse would **most** likely plan to prepare the client for:

- A. DEXA scan.
- B. ultrasound.
- C. MRI.
- D. pelvic X-ray.

Answer: A

Rationale: Currently, no method exists for directly measuring bone mass. Instead, a bone mass density (BMD) measurement is used. BMD is a two-dimensional measurement of the average content of mineral in a section of bone. The client most likely will be having a DEXA scan, which is a screening test that calculates the mineral content of the bone at the spine and hip. Ultrasound, MRI, and a pelvic X-ray would be of little help in determining bone mass.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 162

9. The nurse is reviewing the medical records of several clients. Which client would the nurse expect to have an increased risk for developing osteoporosis?

- A. a Black woman
- B. a woman who plays tennis twice a week
- C. a thin woman with small bones
- D. a woman who drinks one cup of coffee a day

Answer: C

Rationale: A woman with a small frame and thin bones is at a higher risk for osteoporosis. White or Asian women, not Black women, are at higher risk for the condition. A woman who plays tennis twice a week is active and thus would be at low risk for osteoporosis. Women who ingest excessive amounts of caffeine are at increased risk.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 162

10. Which action would the nurse emphasize when teaching postmenopausal women about ways to reduce the risk of osteoporosis?

- A. swimming daily
- B. taking vitamin A
- C. using hormone replacements
- D. taking calcium supplements

Answer: D

Rationale: Osteoporosis is a condition in which bone mass declines to such an extent that fractures occur with minimal trauma. Increasing calcium and vitamin D intake is a major preventive measure. Other measures to reduce the risk include engaging in weightbearing exercise such as walking. Swimming, although a beneficial exercise, is not a weightbearing exercise. Taking vitamin A supplements would have no effect on preventing bone loss. Recent studies have shown that the overall health risks associated with hormone replacement therapy exceed the benefits, increasing the woman's risk for heart attacks, strokes, and breast cancer.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 162

11. Which finding would the nurse expect to find in a client with endometriosis?

- A. hot flashes
- B. dyspareunia
- C. fluid retention
- D. fever

Answer: B

Rationale: The client with endometriosis is often asymptomatic, but clinical manifestations include pain before and during menstrual periods (dyspareunia), pain during or after sexual intercourse, infertility, depression, fatigue, painful bowel movements, chronic pelvic pain, hypermenorrhea, pelvic adhesions, irregular and more frequent menses, and premenstrual spotting. Hot flashes may be associated with premenstrual syndrome or menopause. Fluid retention is associated with premenstrual syndrome. Fever would suggest an infection.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 125

12. After the nurse teaches a client about ways to reduce the symptoms of premenstrual syndrome, which client statement indicates a need for additional teaching?

- A. "I will make sure to take my estrogen supplements a week before my period."
- B. "I've signed up for an aerobic exercise class three times a week."
- C. "I'll cut down on the amount of coffee and colas I drink."
- D. "I quit smoking about a month ago, so that should help."

Answer: A

Rationale: Lifestyle changes such as exercising, avoiding caffeine, and smoking cessation are a key component for managing the signs and symptoms of premenstrual syndrome. Estrogen

supplements are not used. If medication is necessary, NSAIDs may be used for painful physical symptoms; spironolactone may help with bloating and water retention.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 123

13. A woman has opted to use the basal body temperature method for contraception. The nurse instructs the client that a rise in basal body temperature indicates which event?

- A. onset of menses
- B. ovulation
- C. pregnancy
- D. safe period for intercourse

Answer: B

Rationale: Basal body temperatures typically rise within a day or two after ovulation and remain elevated for approximately 2 weeks, at which point bleeding usually begins. Basal body temperature is not a means for determining pregnancy. Having intercourse while the temperature is elevated would increase the risk of pregnancy.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 139

14. A woman using the cervical mucus ovulation method of fertility awareness reports that her cervical mucus looks like egg whites. The nurse interprets this as which kind of mucus?

- A. spinnbarkeit mucus
- B. purulent mucus
- C. postovulatory mucus
- D. normal pre-ovulation mucus

Answer: A

Rationale: The client is describing spinnbarkeit mucus, the copious, clear, slippery, smooth, and stretchable mucus that occurs as ovulation approaches. Purulent mucus would be yellow or green and malodorous. Pre-ovulation mucus is clear but not as copious, slippery, and stretchable.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 139

15. A nurse is preparing a class for a group of women at a family planning clinic about contraceptives. When describing the health benefits of oral contraceptives, which benefits would the nurse include? Select all that apply.

- A. protection against pelvic inflammatory disease
- B. reduced risk for endometrial cancer
- C. decreased risk for depression
- D. reduced risk for migraine headaches
- E. improvement in acne

Answer: A, B, E

Rationale: The health benefits of oral contraceptives include protection against pelvic inflammatory disease, a reduced risk for endometrial cancer, and improvement in acne. Oral contraceptives are associated with an increased risk for depression and migraine headaches.

Question format: Multiple Select

Chapter 4: Common Reproductive Issues

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 145

16. A nurse manager in a family planning clinic is conducting an in-service presentation for the nursing staff on contraception. After teaching the group about the different methods for contraception, the manager determines that the teaching was successful when the group identifies which contraceptive methods as mechanical barrier methods? Select all that apply.

- A. condom
- B. cervical cap
- C. cervical sponge
- D. diaphragm
- E. vaginal ring

Answer: A, B, C, D

Rationale: Barrier methods include the condom, cervical cap, cervical sponge and diaphragm. The vaginal ring is considered a hormonal method of contraception.

Question format: Multiple Select

Chapter 4: Common Reproductive Issues

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 141

17. After teaching a group of students about premenstrual syndrome, the instructor determines that additional teaching is needed when the group identifies which finding as a prominent assessment finding?

- A. bloating
- B. tension
- C. dysphoria

D. weight loss

Answer: D

Rationale: Irritability, fatigue, bloating, tension, and dysphoria are the most prominent and consistently described manifestations of premenstrual syndrome. Weight gain, not weight loss, is associated with this disorder.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 122

18. A nurse is describing the criteria needed for the diagnosis of premenstrual dysphoric disorder (PMDD). Which would the nurse include as a mandatory requirement for the diagnosis?

- A. appetite changes
- B. sleep difficulties
- C. persistent anger
- D. chronic fatigue

Answer: C

Rationale: For the diagnosis of PMDD, the woman must exhibit one or more of the following: affective lability such as sadness, tearfulness, or irritability; anxiety and tension; persistent or marked anger or irritability; and depressed mood and feelings of hopelessness. Other symptoms, although not mandatory for the diagnosis, include increased or decreased appetite, sleep difficulties, chronic fatigue, headache, increased or decreased sexual desire, constipation or diarrhea, and breast swelling and tenderness.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 124

19. When reviewing the medical record of a client diagnosed with endometriosis, the nurse would identify which finding as a risk factor for this woman?

- A. low fat in the diet
- B. age of 14 years for menarche
- C. menstrual cycles of 24 days
- D. short menstrual flow

Answer: C

Rationale: Risk factors for developing endometriosis include increasing age, family history of endometriosis in a first-degree relative, short menstrual cycle (less than 28 days), long menstrual

flow (more than 1 week), high dietary fat consumption, young age at menarche (younger than age 12), and few (one or two) or no pregnancies.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 126

20. A client who has come to the clinic is diagnosed with endometriosis. What would the nurse expect the primary care provider to prescribe as a first-line treatment?

- A. progestins
- B. antiestrogens
- C. gonadotropin-releasing hormone analogues
- D. NSAIDs

Answer: D

Rationale: Although progestins, antiestrogens, and gonadotrophin-releasing analogues are used as treatment options for endometriosis, NSAIDS are considered the first-line treatment to reduce pain.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 126

21. A woman comes to the clinic because she has been unable to conceive. When reviewing the woman's history, the nurse would least likely identify which factor as a possible risk?

- A. age of 25 years
- B. history of smoking
- C. diabetes since age 15 years
- D. weight below standard for height and age

Answer: A

Rationale: Female risk factors for infertility include increased age older, smoking and alcohol consumption, history of chronic illness such as diabetes, and overweight or underweight, which can disrupt hormonal function.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 128

22. A couple comes to the clinic for a fertility evaluation. The male partner is to undergo a semen analysis. After teaching the partner about this test, which client statement indicates that the client has understood the instructions?

- A. "I need to bring the specimen to the lab the day after collecting it."
- B. "I will place the specimen in a special plastic bag to transport it."
- C. "I have to abstain from sexual activity for about 2 to 5 days before the sample."
- D. "I will withdraw before I ejaculate during sex to collect the specimen."

Answer: C

Rationale: Semen analysis is the most important indicator of male fertility. The man should abstain from sexual activity for 2 to 5 days before giving the sample. For a semen examination, the man is asked to produce a specimen by ejaculating into a specimen container and delivering it to the laboratory for analysis within 1 hour. When the specimen is brought to the laboratory, it is analyzed for volume, viscosity, number of sperm, sperm viability, motility, and sperm shape.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 131

23. A nurse is preparing a class for a group of young adult women about emergency contraceptives (ECs). What information would the nurse need to stress to the group? Select all that apply.

- A. ECs induce an abortion-like reaction.
- B. ECs provide some protection against STIs.
- C. ECs are birth control pills in higher, more frequent doses.
- D. ECs are not to be used in place of regular birth control.
- E. ECs provide little protection for future pregnancies.

Answer: C, D, E

Rationale: Important points to stress concerning ECs are that ECs do not offer any protection against STIs or future pregnancies; they should not be used in place of regular birth control, as they are less effective; they are regular birth control pills given at higher doses and more frequently; and they are contraindicated during pregnancy. Contrary to popular belief, ECs do not induce abortion and are not related to mifepristone or RU-486, the so-called abortion pill approved by the FDA in 2000.

Question format: Multiple Select

Chapter 4: Common Reproductive Issues

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 150

24. After assessing a woman who has come to the clinic, the nurse suspects that the woman is experiencing abnormal uterine bleeding. Which statement by the client would support the nurse's suspicions?

- A. "I've been having bleeding off and on that's irregular and sometimes heavy."
- B. "I get sharp pain in my lower abdomen usually starting soon after my period comes."
- C. "I get really irritable and moody about a week before my period."
- D. "My periods have been unusually long and heavy lately."

Answer: A

Rationale: Abnormal uterine bleeding is defined as irregular, abnormal bleeding that occurs with no identifiable anatomic pathology. It is frequently associated with anovulatory cycles, which are common for the first year after menarche and later in life as a woman approaches menopause. Pain occurring with menses refers to dysmenorrhea. Although mood swings may be associated with abnormal uterine bleeding, irritability and mood swings are more commonly associated with premenstrual syndrome. Unusually long and heavy periods reflect menorrhagia.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 120

25. The nurse discusses various contraceptive methods with a client and her partner. After the discussion, the nurse determines that the couple understood the information when they identify which method as being available only with a prescription?

- A. cervical cap
- B. cervical sponge
- C. condom
- D. spermicide

Answer: A

Rationale: The cervical cap is available only by prescription and must be fitted by a health care provider. The cervical sponge, condom, or spermicide do not require a prescription.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 143

26. A client is questioning the nurse about the various options for contraception. When explaining the implantable form, the nurse should point out it contains which form of contraception?

- A. progestin
- B. estrogen and progestin
- C. concentrated spermicide
- D. concentrated estrogen

Answer: A

Rationale: Implantable contraceptives deliver synthetic progestin that act by inhibiting ovulation and thickening cervical mucus so sperm cannot penetrate. Various options that combine estrogen and progestin include the transdermal patch and a vaginal estrogen/progestin (contraceptive) ring. Concentrated spermicide is inserted directly into the vagina. There are no concentrated estrogen products available for contraceptive measures.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Teaching/Learning

Reference: p. 148

27. The nurse is assessing the laboratory test results of a client with abnormal uterine bleeding (AUB). Which finding should the nurse **prioritize**?

- A. negative pregnancy test
- B. hemoglobin level of 10.1 g/dl (101 g/L)
- C. prothrombin time of 40 seconds
- D. serum cholesterol of 140 mg/dl (3.63 mmol/L)

Answer: B

Rationale: A hemoglobin level of 10.1 g/dl (101 g/L) suggests anemia, which might occur secondary to prolonged or heavy menses. A negative pregnancy test, prothrombin time of 40 seconds, and a serum cholesterol level of 140 mg/dl (3.63 mmol/L) are within normal parameters.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 120-121

28. A nurse is conducting a class for a group of young adult women interested in contraception. As part of the class, the nurse asks the group about their understanding about contraception and pregnancy. Which statement(s) would cause the nurse to address it as a misconception. Select all that apply.

- A. "If you douche after having sex, you will not get pregnant."
- B. "You cannot get pregnant if you have your menstrual period."
- C. "Birth control pills will not protect you against sexually transmitted infections."
- D. "Pregnancy cannot happen if my male partner pulls out before ejaculating."
- E. "I cannot get pregnant if I am breastfeeding."

Answer: A, B, D, E

Rationale: Common misconceptions include the following: Breastfeeding protects against pregnancy; pregnancy can be avoided if the male partner "pulls out" before he ejaculates; pregnancy cannot occur during menses; and douching after sex will prevent pregnancy. Taking birth control pills does not protect against sexually transmitted infections, thus the participants are correct in their understanding.

Question format: Multiple Select

Chapter 4: Common Reproductive Issues

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 156

29. A woman who is using an intrauterine system for contraception comes to the clinic. When assessing the woman, which finding(s) would alert the nurse to a possible complication? Select all that apply.

- A. Absence of pain with intercourse
- B. String length shorter than on initial visit
- C. Reports of abdominal pain
- D. Menstrual flow lighter and shorter
- E. Oral temperature of 101°F (38.3°C)

Answer: B, C, E

Rationale: Warnings for potential complications for intrauterine system users include: late period, pregnancy, or abnormal spotting or bleeding; abdominal pain or pain with intercourse; exposure to infection or abnormal vaginal discharge; not feeling well, fever or chills; and a string length that is shorter, longer or missing. Intrauterine systems make monthly periods lighter, shorter, and less painful.

Question format: Multiple Select

Chapter 4: Common Reproductive Issues

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 149

30. A woman is diagnosed with premenstrual dysphoric disorder. To address the woman's behavioral symptoms, which class of agents would the nurse anticipate needing to be addressed in the woman's teaching plan?

- A. Diuretics
- B. Nonsteroidal anti-inflammatory drugs (NSAIDs)
- C. Selective serotonin reuptake inhibitors (SSRIs)
- D. Vitamin supplements

Answer: C

Rationale: Although diuretics, NSAIDs, and vitamin supplements may be used as part of the treatment plan for premenstrual dysphoric disorder, SSRIs are commonly prescribed to address the behavioral and mood symptoms of this condition.

Question format: Multiple Choice

Chapter 4: Common Reproductive Issues

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Nursing Process

Reference: p. 123

Chapter 5

1. The nurse is developing a plan of care for a client who is receiving aggressive drug therapy for treatment of HIV. The goal of this therapy is to:
 - A. promote the progression of disease.
 - B. intervene in late-stage AIDS.
 - C. improve survival rates.
 - D. conduct additional drug research.

Answer: C

Rationale: Aggressive anti-retroviral therapy aims to reduce HIV morbidity and mortality, thereby improving survival rates. Drug therapy also aims to decrease the HIV viral load, restore the body's ability to fight off infection, and improve the quality of life. Drug therapy does not promote the progression of the disease. It is started at the time of the first infection, not in late-stage AIDS. Treatment advances have been based on research, but drug therapy is not prescribed to conduct additional research.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Understand

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Nursing Process

Reference: p. 197

2. A young adult woman who is HIV-positive is receiving anti-retroviral therapy (ART) and is having difficulty with adherence. To promote adherence, which area would be **most** important for the nurse to assess?
 - A. beliefs and education
 - B. financial situation and insurance
 - C. activity level and nutrition
 - D. family and living arrangements

Answer: A

Rationale: The most important area to assess initially would be the client's beliefs and knowledge about the disease and its treatment. A common barrier is a lack of understanding about the link between drug resistance and nonadherence. Once this area is assessed, the nurse can assess for other barriers, such as finances and insurance, nutrition and activity level, and family issues, including living arrangements (for example, the client may be afraid that his or her HIV status would be revealed if others see the client taking medication).

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 198

3. When developing a teaching plan for a community group about HIV infection, which group would the nurse identify being most vulnerable for HIV infection?

- A. Native American/First Nations people
- B. heterosexual women
- C. new health care workers
- D. Asian immigrants

Answer: B

Rationale: The number of women with HIV infection and AIDS has been increasing steadily worldwide. Today, women account for one in four (25%) new HIV infections in the United States. Women of color have been especially hard hit and represent the majority of women living with the disease and newly infected ones. African American women suffer disproportionately from the HIV/AIDS epidemic. New health care workers, Native American/First Nations members, and Asian immigrants are not among those considered at high risk.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 196

4. After teaching a group of adolescents about HIV, the nurse asks them to identify the primary means by which adolescents are exposed to the virus. The nurse determines that the teaching was successful when the group identifies which means of exposure?

- A. sexual intercourse
- B. sharing needles for IV drug use
- C. perinatal transmission
- D. blood transfusion

Answer: A

Rationale: HIV infections are increasing in adolescents and young adults aged 13 to 24 years predominantly transmitted by sexual intercourse. Millions of US adolescents between the ages of 10 and 19 are living with HIV, and many do not receive the care and support they need to stay in good health. This is particularly significant because the risk of HIV transmission increases substantially if either partner is infected with an STI. Sharing of needles, perinatal transmission, and blood transfusions are less often means of transmission in adolescents.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 196

5. The nurse reviews the CD4 cell count of a client who is HIV-positive. A result less than which count would indicate to the nurse that the client has AIDS?

- A. 1,000 cells/mm³
- B. 700 cells/mm³
- C. 450 cells/mm³
- D. 200 cells/mm³

Answer: D

Rationale: When the CD4 T-cell count reaches 200 or less, the person has reached the stage of AIDS per the CDC. A CD4 T-cell count between 450 and 1,200 is considered normal.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 196

6. When obtaining the health history from an adolescent client, which factor would lead the nurse to suspect that the client has an increased risk for sexually transmitted infections (STIs)?

- A. hive-like rash for the past 2 days
- B. five different sexual partners
- C. weight gain of 5 lb (2.3 kg) in 1 year
- D. clear vaginal discharge

Answer: B

Rationale: The number of sexual partners is a risk factor for the development of STIs. A rash could be related to numerous underlying conditions. A weight gain of 5 lb (2.3 kg) in 1 year is not a factor increasing one's risk for STIs. A change in the color of vaginal discharge such as yellow, milky, or curd-like, not clear, would suggest an STI.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 172

7. Assessment of a female client reveals a thick, white vaginal discharge. The client also reports intense itching and dyspareunia. Based on these findings, the nurse would suspect that the client has:

- A. trichomoniasis.
- B. bacterial vaginosis.
- C. candidiasis.

D. genital herpes simplex.

Answer: C

Rationale: A thick, white vaginal discharge accompanied by intense itching and dyspareunia suggest vulvovaginal candidiasis. Trichomoniasis is characterized by a heavy yellow, green, or gray frothy or bubbly discharge. Bacterial vaginosis is manifested by a thin, white homogenous vaginal discharge with a characteristic stale fish-like odor. Genital herpes simplex involves genital ulcers.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Remember

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 179

8. A client with trichomoniasis is to receive metronidazole. What should the nurse instruct the client to avoid while taking this drug?

- A. alcohol
- B. nicotine
- C. chocolate
- D. caffeine

Answer: A

Rationale: The client should be instructed to avoid consuming alcohol when taking metronidazole because severe nausea and vomiting could occur. There is no need to avoid nicotine, chocolate, or caffeine when taking metronidazole.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Teaching/Learning

Reference: p. 181

9. Which finding would the nurse expect in a client with bacterial vaginosis?

- A. vaginal pH of 3
- B. fish-like odor of discharge
- C. yellowish-green discharge
- D. cervical bleeding on contact

Answer: B

Rationale: Manifestations of bacterial vaginosis include a thin, white, homogenous vaginal discharge with a characteristic stale fishy odor, vaginal pH greater than 4.5, and clue cells on

wet-mount examination. A yellowish-green discharge with cervical bleeding on contact would be characteristic of trichomoniasis.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 182

10. A pregnant woman diagnosed with syphilis comes to the clinic for a visit. The nurse discusses the risk of transmitting the infection to her newborn, explaining that this infection is transmitted to the newborn through the:

- A. amniotic fluid.
- B. placenta.
- C. birth canal.
- D. breast milk.

Answer: B

Rationale: The syphilis spirochete can cross the placenta after 9 weeks gestation. It is not transmitted via amniotic fluid, passage through the birth canal, or breast milk.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 188

11. The nurse encourages a female client with human papillomavirus (HPV) to receive continued follow-up care because she is at risk for:

- A. infertility.
- B. dyspareunia.
- C. cervical cancer.
- D. dysmenorrhea.

Answer: C

Rationale: Clinical studies have confirmed that HPV is the cause of essentially all cases of cervical cancer. Therefore, the client needs continued follow-up for routine Papanicolaou testing. HPV is not associated with an increased risk for infertility, dyspareunia, or dysmenorrhea.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 191

12. Which instructions would the nurse include when teaching a woman with pediculosis pubis?
- A. "Take the antibiotic until you feel better."
 - B. "Wash your bed linens in bleach and cold water."
 - C. "Your partner doesn't need treatment at this time."
 - D. "Remove the nits with a fine-toothed comb."

Answer: D

Rationale: The nurse should instruct the client to remove the nits from the hair using a fine-toothed comb. Permethrin cream and lindane shampoo are used as treatment, not antibiotics. Bedding and clothing should be washed in hot water to decontaminate it. Sexual partners should also be treated, as well as family members who live in close contact with the infected person.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 195

13. A client with genital herpes simplex infection asks the nurse, "Will I ever be cured of this infection?" Which response by the nurse would be **most** appropriate?
- A. "There is a new vaccine available that prevents the infection from returning."
 - B. "All you need is a dose of penicillin and the infection will be gone."
 - C. "There is no cure, but drug therapy helps to reduce symptoms and recurrences."
 - D. "Once you have the infection, you develop an immunity to it."

Answer: C

Rationale: Genital herpes is a lifelong viral infection. No cure exists, but antiviral drug therapy helps to reduce or suppress symptoms, shedding, and recurrent episodes. A vaccine is available for HPV infection but not genital herpes. Penicillin is used to treat syphilis. No immunity develops after a genital herpes infection.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 186

14. A woman gives birth to a healthy newborn. As part of the newborn's care, the nurse instills erythromycin ophthalmic ointment as a preventive measure for which sexually transmitted infection (STI)?

- A. genital herpes
- B. hepatitis B
- C. syphilis

D. gonorrhea

Answer: D

Rationale: To prevent gonococcal ophthalmia neonatorum, erythromycin or tetracycline ophthalmic ointment is instilled into the eyes of all newborns. This action is required by law in most states. The ointment is not used to prevent conditions related to genital herpes, hepatitis B, or syphilis.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 184

15. While obtaining a health history from a male adolescent during a well checkup, the nurse assesses his sexual behavior and risk for sexually transmitted infections. Based on the information, the nurse plans to teach the adolescent about using a condom. What statement would the nurse include in the teaching plan?

- A. "You can reuse a condom if it's within 3 hours."
- B. "Store your condoms in your wallet so they are ready for use."
- C. "Put the condom on before engaging in any genital contact."
- D. "Use petroleum jelly with a latex condom for extra lubrication."

Answer: C

Rationale: When teaching an adolescent about condom use, the nurse should tell the adolescent to put the condom on before any genital contact. A new condom should be used with each act of sexual intercourse; a condom should never be reused. Condoms should be stored in a cool, dry place away from direct sunlight and never stored in wallets, automobiles, or anywhere they could be exposed to extreme temperatures. Only water-soluble lubricants should be used with latex condoms. Oil-based or petroleum-based lubricants can weaken latex condoms.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 199-200

16. A female adolescent is diagnosed with gonorrhea. When developing the plan of care for this adolescent, the nurse would expect that she would also receive treatment for:

- A. chlamydia.
- B. syphilis.
- C. genital herpes.
- D. trichomoniasis.

Answer: A

Rationale: Clients with gonorrhea usually receive treatment for chlamydia as well because they often are coinfected. Coinfection with syphilis, genital herpes, or trichomoniasis is uncommon.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 184

17. A client is admitted in the health care facility with pelvic inflammatory disease (PID). When reviewing the client's history, what would the nurse identify as a risk factor?

- A. gestational diabetes
- B. frequent douching
- C. genetic predisposition
- D. environmental exposure

Answer: B

Rationale: One of the risk factors associated with pelvic inflammatory disease is frequent douching. Women with gestational diabetes are at an increased risk for developing type 2 diabetes later in life. Genetic predisposition and environmental exposure are risk factors associated with breast cancer.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 190

18. A 40-year-old woman is being discharged from the walk-in health care clinic after a diagnosis of pelvic inflammatory disease. Which health teaching topic should the nurse address?

- A. symptoms of menopause
- B. pain control for endometriosis
- C. fertility issues
- D. sexually transmitted infections

Answer: D

Rationale: STIs are responsible for genital tract infections that may lead to later complications in women such as pelvic inflammatory disease (PID). The other topics do not relate to PID.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 189-190

19. A public health nurse is teaching a class on sexually transmitted infections (STIs). Which statements would the nurse include in the discussion? Select all that apply.

- A. "65 million people live with incurable STIs."
- B. "STIs are biologically sexist causing more complications among men."
- C. "After a single exposure, women are twice as likely as men to acquire a STI."
- D. "STIs contribute to cervical cancer."
- E. "STIs cannot be transmitted to the fetus or infant during childbirth."

Answer: A, C, D

Rationale: An estimated 65 million people live with an incurable STI. STIs are biologically sexist, presenting greater risk and causing more complications among women than among men. After only a single exposure, women are twice as likely as men to acquire infections. STIs may contribute to cervical cancer. Certain infections can be transmitted in utero to the fetus or during childbirth to the newborn.

Question format: Multiple Select

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 172

20. A pregnant woman is diagnosed with chlamydia and asks the nurse, "How will this infection affect my baby and pregnancy?" Which responses by the nurse are accurate? Select all that apply.

- A. "Your newborn can be infected during birth."
- B. "Your newborn may have eye infections from this infection."
- C. "Your membranes may rupture earlier than normal."
- D. "Your newborn is protected from this infection."
- E. "It will not have any effect on your pregnancy."

Answer: A, B, C

Rationale: STIs' effects on the fetus or newborn such as chlamydia include the newborn being infected during birth with eye infections (neonatal conjunctivitis), pneumonia, low birth weight, increased risk of premature rupture of the membranes (PROM), preterm birth, and stillbirth.

Question format: Multiple Select

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 183

21. The school public health nurse is teaching a high school class on sexually transmitted infections (STIs). The nurse would include what information in the presentation? Select all that apply.

- A. Fifteen- to twenty-four-year-olds represent almost half of all cases of new STIs.
- B. Two in five sexually active teen girls have an STI.
- C. Adolescent females make up more than three-quarters of HIV diagnoses.
- D. Teens who are sexually active experience high rates of STIs.
- E. All groups of teens are at the same risk.
- F. Adolescent males make up more than four-fifths of HIV diagnosis.

Answer: A, B, D, F

Rationale: Individuals aged 15 to 24 years represent almost half of all cases of new STIs acquired. Two in five sexually active teen girls have a STI. Adolescent males make up more than three-quarters of HIV diagnoses among 13- to 19-year-olds. In the United States, teens who are sexually active experience high rates of STIs, and some groups are at higher risk, including African American and Hispanic youths, youths living in poverty, and those with limited educational attainment.

Question format: Multiple Select

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 172

22. A sexual health public health nurse is presenting information on sexually transmitted infections (STIs) to adolescent girls and is asked, "Why are females more at risk for STIs?"

Which statements by the nurse would **best** answer this question? Select all that apply.

- A. "Teenage females have sex as they feel they have power to control the sex act."
- B. "Teenage females lack communication skills to negotiate for safer sex."
- C. "The teenage female anatomy is mature, leaving them more susceptible to STIs."
- D. "The female genital tract makes you more sensitive to specific STI organisms."
- E. "Teenage girls are more susceptible to STIs due to their genital anatomy."

Answer: B, D, E

Rationale: Female adolescents are more susceptible to STIs due to their anatomy. During adolescence and young adulthood, women's columnar epithelial cells are especially sensitive to invasion by sexually transmitted organisms, such as chlamydia and gonococci. Adolescent females may perceive that they have limited power over when and where intercourse occurs with their partners. They typically lack negotiating skills and self-confidence needed to successfully negotiate for safer sex practices and thus are exposed to STIs.

Question format: Multiple Select

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning
Reference: p. 172

23. The sexual health nurse is presenting to a group of adolescents the government initiative that proposes to reduce the numbers of adolescents with sexually transmitted infections (STIs). What is the name of this initiative?

- A. Health For All
- B. Healthy People 2030
- C. Onward to Health
- D. Healthy Communities 2030

Answer: B

Rationale: Healthy People 2030 proposes to reduce the proportion of adolescents and young adults with STIs. It also proposes to increase the proportion of sexually active persons aged 15 to 19 years who use condoms.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 173

24. A sex trade worker is seen at the sexual health clinic reporting dysuria, mucopurulent vaginal discharge with bleeding between periods, conjunctivitis, and a painful rectal area. What sexually transmitted infection would the nurse suspect?

- A. syphilis
- B. chlamydia
- C. genital herpes
- D. gonorrhea

Answer: B

Rationale: Chlamydial symptoms include dysuria, mucopurulent vaginal discharge, and dysfunctional uterine bleeding. It can cause inflammation of the rectum and conjunctiva. Syphilis starts with a chancre on vulva or vagina but can develop in other parts of the body. Secondary infection is maculopapular rash on hands and feet with a sore throat. Genital herpes symptoms include itching, tingling, and pain in genital area followed by small pustules and blister-like genital lesions. Gonorrhea vaginal discharge is yellowish color and very foul smelling.

Question format: Multiple Select

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 183

25. A client is to receive 3 million units of penicillin G intramuscular to treat gonorrhea. The drug is available in 1,500,000 units/mL. How many milliliters should the nurse administer? Record your answer using a whole number.

Answer: 2

Rationale: Formula of D/H X V $3,000,000 / 1,500,000 \times 1 \text{ mL} = 2 \text{ mL}$

Question format: Fill in the Blank

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Nursing Process

Reference: p. 188

26. What is the **most** important consideration for the nurse when communicating with an adolescent about sexually transmitted infections (STI)?

- A. Adjust information to the client's developmental level
- B. Use communication techniques that are direct and nonjudgmental
- C. Utilize audio and visual aids to reinforce teaching
- D. Design teaching for the best effect in the shortest time

Answer: B

Rationale: All of the answers are correct, but the most important consideration for a nurse communicating with an adolescent about STIs is to be direct and nonjudgmental. The style, content, and the message has to be aimed at the adolescent's developmental level. Any aids to help the adolescent learn should be used. The content should be designed to be delivered in the shortest amount of time because many clinics and health care provider offices are busy and do not lend themselves to long class times.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 173

27. A woman has been diagnosed with trichomoniasis and asks the nurse when it would be safe to resume sexual activity. How should the nurse respond?

- A. "After treatment you must be symptom free to resume sexual activity."
- B. "You may resume sexual activity after you and your partner have been treated."
- C. "You and your partner must wait 10 days after you complete your treatment regimen."
- D. "When you have taken your medication and no longer have any discharge, then sexual activity is fine."

Answer: A

Rationale: Trichomoniasis is the most prevalent nonviral sexually transmitted infection. It is treated with metronidazole, usually a single 2-gram dose. For treatment to be effective all sexual partners of the client need to be treated. Sexual activity can resume after the partners have been treated and both the woman and partner are symptom free. There is no timeline for this to occur and treatment will not be effective if both the woman and her partner are not treated. The infection will reoccur.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Teaching/Learning

Reference: p. 181

28. A woman has been prescribed doxycycline to treat a chlamydia infection. What instruction(s) should the nurse give this client? Select all that apply.

- A. "You must take all the 7 days of the medication."
- B. "You will need to be retested after you complete the medication."
- C. If the symptoms do not go away after the medication, you will need to return to the health care provider."
- D. "If you suspect you have another infection, you need to see the health care provider right away."
- E. "You will need to have a pregnancy test before starting the medication."

Answer: A, C, D

Rationale: Doxycycline belongs to the classification of tetracyclines. It is useful in the treatment of many types of infections and specifically chlamydia. The drug is given twice a day for 7 days. It is contraindicated with a known hypersensitivity to the drug. The medication may be taken during pregnancy. The client needs to be retested only if it is suspected or known the client did not complete the medication, if symptoms persist or if a reinfection is suspected. The client needs to return to the health care provider if treatment has been completed and symptoms persist. It is recommended for women to be screened annually for this infection.

Question format: Multiple Select

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Teaching/Learning

Reference: p. 183

29. A woman is diagnosed with gonorrhea. The client asks why she needs to take two medications. How should the nurse respond? Select all that apply.

- A. "The medicines are needed to kill the bacteria causing the infection."
- B. "The medications help prevent the spread of the bacteria to your female organs."
- C. "Taking two medications will cure the infection faster."
- D. "The bacteria causing the infection is very strong, so two medications are needed."
- E. "The medications will stop the bacteria before it can cause complications."

Answer: A, B, E

Rationale: The antibiotic treatment for gonorrhea is a dual therapy with azithromycin and ceftriaxone. Dual therapy is recommended to prevent drug resistance and it is also effective against chlamydia. If left untreated or not treated adequately, gonorrhea can cause infertility, pelvic inflammatory disease, and ectopic pregnancy. The medications can cure the infection and help prevent spread to the pelvic organs. Taking two medications does not kill the bacteria faster nor is the bacteria so strong two medications are needed.

Question format: Multiple Select

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Teaching/Learning

Reference: p. 184-185

30. A client has been diagnosed and treated for primary syphilis. What instruction should the nurse give this client about follow-up testing?

- A. "You will need to be retested again in 6 months."
- B. "You also will need to be tested for HIV in 6 months."
- C. "You do not need to be retested after treatment unless symptoms develop."
- D. "You need to retested if you have a new sexual partner."

Answer: A

Rationale: For the client treated for primary or secondary syphilis, retesting needs to occur at 6 months and at 12 months. If the client was treated for latent syphilis, then testing needs to be done at 6 months, 12 months, and 24 months. For latent syphilis, the testing also needs to include testing for HIV. The client does not need to be retested if there is a new sexual partner, but the client should be instructed in safer sex methods to prevent a sexually transmitted infection.

Question format: Multiple Choice

Chapter 5: Sexually Transmitted Infections

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Teaching/Learning

Reference: p. 188

Chapter 6

1. The nurse is developing the discharge plan for a woman who has had a left-sided radical mastectomy. The nurse is including instructions for ways to minimize lymphedema. Which statement by the client indicates the need for additional instruction?
 - A. "I need to wear gloves when doing any gardening."
 - B. "Any blood pressures need to be taken in my right arm."
 - C. "I should wear clothing with elasticized sleeves."
 - D. "I need to avoid driving to and from work every day."

Answer: C

Rationale: Lymphedema increases when there is obstruction to the lymph flow. Wearing clothing with elasticized sleeves would compress the extremity, possibly cause trauma, and obstruct the flow, thus increasing the woman's risk. Wearing gloves when gardening and using the unaffected arm for blood pressure readings help to reduce the risk of injury and subsequent lymphedema. Driving would have no effect on lymphedema.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 222

2. The nurse determines that a woman has implemented prescribed therapy for her fibrocystic breast disease when the client reports that she has eliminated which from her lifestyle?
 - A. caffeine
 - B. cigarettes
 - C. dairy products
 - D. sweets

Answer: A

Rationale: Caffeine is a stimulant and eliminating it will help reduce symptoms of fibrocystic breast disease. Cigarettes, dairy products, and sweets are not associated with symptoms of fibrocystic breast disease.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 208

3. A nurse has completed the assessment of a client. The nurse suspects that the client may have a malignant breast mass based on which finding?
 - A. painful lump

- B. absence of dimpling
- C. regularly shaped mass
- D. nipple retraction

Answer: D

Rationale: Malignant breast masses typically are difficult to palpate, painless, irregularly shaped, and immobile, with nipple retraction and skin dimpling.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 228

4. A woman who has undergone a right-sided modified-radical mastectomy returns from surgery. Which nursing intervention would be **most** appropriate for the nurse to include in the client's plan of care at this time?

- A. Ask the client how she feels about having her breast removed.
- B. Attach a sign above her bed to have BP, IV lines, and lab work in her right arm.
- C. Encourage her to turn, cough, and deep breathe at frequent intervals.
- D. Position her right arm below heart level.

Answer: C

Rationale: Upon return from surgery, the nurse should encourage the client to turn, cough, and deep breathe at frequent intervals, at least every 2 hours, to help expand collapsed alveoli, clear inhalation anesthetic agents from the body, and prevent postoperative atelectasis and pneumonia. Asking the client how she feels about her breast removal should be done at a later time, when she is more alert and oriented and has had time to think about what has happened. The sign should state that no BP, IV lines, and lab work should be done on the client's right arm. The right arm should be elevated on a pillow to promote lymph drainage.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 221

5. A 42-year-old woman is scheduled for a mammogram. Which statement would the nurse include when teaching the woman about the procedure?

- A. "The room will be darkened throughout the procedure."
- B. "Each breast will be firmly compressed between two plates."
- C. "Make sure to refrain from eating or drinking after midnight."
- D. "A dye will be injected to highlight the breast tissue and its ducts."

Answer: B

Rationale: A mammogram involves taking X-ray pictures of the breasts while they are compressed between two plastic plates. There is no need to darken the room or to refrain from eating or drinking after midnight. A ductography involves the injection of dye to highlight the breast ducts.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 217

6. During a clinical breast examination, the nurse palpates a well-defined, firm, mobile lump in a 60-year-old woman's left breast. The nurse notifies the primary care provider. What would the nurse anticipate the care provider to prescribe **next?**

- A. mammogram
- B. hormone receptor status
- C. fine-needle aspiration
- D. genetic testing for BRCA

Answer: A

Rationale: The characteristics of the palpated mass suggest that it is a benign mass, most likely a fibroadenoma. However, since other breast lesions have similar characteristics, the lump needs to be evaluated via mammography. Hormone receptor status is used to determine if a malignant mass is stimulated to grow by estrogen or progesterone. A fine-needle aspiration may be done later on if there is reason to suspect a malignancy. Genetic testing for the BRCA genes would be done to determine a woman's risk for breast cancer, but this would not be done next.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 217

7. A client with advanced breast cancer, who has had both chemotherapy and radiation therapy, is to start endocrine therapy. Which agent would the nurse expect the client to receive?

- A. trastuzumab
- B. tamoxifen
- C. cortisone
- D. estrogen

Answer: B

Rationale: The objective of endocrine therapy is to block or counter the effect of estrogen in the pathogenesis of cancer. The best-known agent is tamoxifen. Use of estrogens in postmenopausal women increases a woman's risk for breast cancer. In addition, estrogen is considered to play a major role in the development of breast cancer and as such would not be used. Cortisone is a steroid and would not be used. Trastuzumab is an immunotherapeutic agent.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 211

8. As part of discharge planning, the nurse refers a woman to Reach to Recovery. The nurse initiates this referral to facilitate which goal?

- A. help support women who have undergone mastectomies
- B. raise funds to support early breast cancer detection programs
- C. provide all supplies needed after breast surgery for no cost
- D. collect statistics for research for the American Cancer Society

Answer: A

Rationale: Reach for Recovery is an organization that gives women and their families opportunities to express their feelings, verbalize their fears, and get answers. Reach to Recovery volunteers provide living proof that people can survive breast cancer and lead productive lives. Reach to Recovery helps raise funds, provide supplies, and collect statistics, but these are not the program's primary purpose.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 221-222

9. A woman with breast cancer is undergoing chemotherapy. Which side effect would the nurse interpret as being **most** serious?

- A. vomiting
- B. hair loss
- C. fatigue
- D. myelosuppression

Answer: D

Rationale: Chemotherapy typically causes side effects of nausea, vomiting, hair loss, fatigue, and myelosuppression. Of these, myelosuppression would be the most serious because it increases the risk for infection, bleeding, and a reduced red blood cell count, which can lead to anemia.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 224

10. A woman comes to the clinic reporting a greenish-colored nipple discharge. On examination, the area below the areola is red and slightly swollen, with tortuous tubular swelling. The nurse interprets these findings as suggestive of which disorder?

- A. fibrocystic breast disorder
- B. intraductal papilloma
- C. duct ectasia
- D. fibroadenoma

Answer: C

Rationale: Duct ectasia is manifested by a greenish nipple discharge. Subareolar redness and swelling can be noted, along with tortuous tubular swellings beneath the areola. Fibrocystic breast disorder is characterized by lumpy, tender breasts with possible clear to yellow nipple discharge. Intraductal papilloma is manifested by a wart-like growth in the mammary ducts near the nipple that is soft, nontender, mobile, and poorly delineated. A serous, serosanguinous, or watery discharge from the nipple may occur. Fibroadenoma is characterized by a firm, rubbery, well-circumscribed, freely mobile mass, usually located in the upper outer quadrant of the breast.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 213

11. When performing a clinical breast examination, which would the nurse do **first**?

- A. Palpate the axillary area.
- B. Compress the nipple for a discharge.
- C. Palpate the breasts.
- D. Inspect the breasts.

Answer: D

Rationale: The first step in the clinical breast exam is to inspect the woman's breasts. The nurse then palpates the breasts, compresses the nipple to check for a discharge, and finally palpates the axillary area.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 225

12. After teaching a woman how to perform breast self-examination, which statement would indicate that the nurse's instructions were successful?

- A. "I should lie down with my arms at my side when looking at my breasts."
- B. "I should use the fingerpads of my three middle fingers to apply pressure to my breast."
- C. "I don't need to check under my arm on that side if my breast feels fine."
- D. "I need to work from left to right down my breast towards my ribs."

Answer: B

Rationale: When performing breast self-examination, the client should use the pads of the middle three fingers to palpate the breast. When performing the visual part of the procedure, the woman should look at her breasts with her arms up behind the head, with arms down at the sides, and while bending forward. When palpating the breast, the woman should check the breasts as well as the area between the breast and the axilla, the axilla itself, and the area above the breast up to the clavicle and across the shoulder. When palpating, the woman should use a spiral, pie wedge, or vertical strip approach.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 230

13. Evaluation of a woman with breast cancer reveals that her mass is approximately 1.25 inches in diameter. Three adjacent lymph nodes are positive. The nurse interprets this as indicating that the woman has which stage of breast cancer?

- A. 0
- B. I
- C. II
- D. III

Answer: C

Rationale: Stage II breast cancer is characterized by a tumor from 1 to 2 inches in diameter with spread to adjacent lymph nodes. Stage 0 cancer is an early stage in which the cancer is extremely localized. Stage I cancer involves a tumor that is localized and less than 1 inch in diameter. Stage III cancer involves a tumor that is 2 inches or larger with spread to other lymph nodes and tissues.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 215

14. A laboratory technician arrives to draw blood for a complete blood count (CBC) for a client who had a right-sided mastectomy 8 hours ago. The client has an intravenous line with fluid infusing in her left antecubital space. To obtain the blood specimen, the technician places a tourniquet on the client's right arm. Which action by the nurse would be **most** appropriate?

- A. Assist in holding the client's arm still.
- B. Suggest a finger stick be done on one of the client's left fingers.
- C. Tell the technician to obtain the blood sample from the client's left arm.
- D. Call the surgeon to perform a femoral puncture.

Answer: B

Rationale: The most appropriate action would be to suggest that a finger stick be done. The right arm cannot be used because the mastectomy was performed on that side. The left arm has an intravenous infusion, so obtaining blood from this arm would be inappropriate, most likely leading to inaccurate results. Holding the client's arm still is inappropriate because neither arm should be used. Less invasive options should be attempted first before considering a femoral puncture.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 221-222

15. The nurse is developing a plan of care for a woman with breast cancer who is scheduled to undergo breast-conserving surgery. The nurse interprets this as which procedure?

- A. removal of nipple and areolar area
- B. lump removal followed by radiation
- C. entire breast removal without lymph nodes
- D. axillary lymph node removal

Answer: B

Rationale: Breast-conserving surgery is the wide local excision (or lumpectomy) of the tumor along with a 1-cm margin of normal tissue. A lumpectomy is often used for early-stage localized tumors and is followed by radiation to eradicate residual microscopic cancer cells. A simple mastectomy is the removal of all breast tissue, the nipple, and the areola. The axillary nodes and pectoral muscles are spared. A modified radical mastectomy involves removal of breast tissue, the axillary nodes, and some chest muscles, but not the pectoralis major, thus avoiding a concave anterior chest.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 221

16. A woman diagnosed with breast cancer is to receive trastuzumab. What information would the nurse incorporate into the explanation about how this drug works?

- A. It blocks the effect of the HER-2/neu protein inhibiting the growth of cancer cells.
- B. The drug blocks the conversion of androgens to estrogens.
- C. It interferes with hormone receptors that allow estrogen to enter a cell.
- D. The drug ultimately attacks areas where micrometastasis has occurred.

Answer: A

Rationale: Trastuzumab is immunotherapy approved for breast cancer. Breast cancers that overexpress the protein HER-2/neu are associated with a more aggressive form of disease and a poorer prognosis. Trastuzumab target the HER2 pathway to inhibit the growth of cancer cells. The aromatase inhibitors work by inhibiting the conversion of androgens to estrogens. SERMs Interfere with the hormone receptors that allow estrogen to enter the cell and stimulate it to divide. The goal of any chemotherapeutic regimen is to perform a system sweep of the body to reduce the chances that distant tumors will grow or micrometastasis will occur.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 225

17. When describing programs for breast cancer screening, the nurse includes breast self-examination (BSE). Which statement **most** accurately reflects the current thinking about breast self-examination?

- A. BSE is essential for early breast cancer detection.
- B. A woman performing BSE has breast awareness.
- C. BSE plays a minimal role in detecting breast cancer.
- D. A clinical breast exam has replaced BSE.

Answer: B

Rationale: Breast self-examination (BSE) is a technique that enables a woman to detect any changes in her breasts. Breast self-exams, once thought essential for early breast cancer detection, are now considered optional. Instead, breast awareness is stressed. Breast awareness refers to a woman being familiar with the normal consistency of both breasts and the underlying tissue. This emphasis is now on awareness of breast changes, not just discovery of cancer. Research has shown that breast self-examination plays a small role in detecting breast cancer compared with self-awareness. However, doing breast self-examination is one way for a woman to know how her breasts normally feel so that she can notice any changes that do occur. Clinical breast examination has not replaced BSE.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 230

18. A breast biopsy indicates the presence of malignant cells, and the client is scheduled for a mastectomy. Which nursing diagnosis would the nurse most likely include in the client's preoperative plan of care as the **priority**?

- A. risk for deficient fluid volume
- B. activity intolerance
- C. disturbed body image
- D. impaired urinary elimination

Answer: C

Rationale: The diagnosis of breast cancer and subsequent removal of the breast via surgery can affect all aspects of life for the woman, but most significantly her body image due to the loss of a body part. Therefore, the most important nursing diagnosis would be disturbed body image. Deficient fluid volume, activity intolerance, and impaired urinary elimination are possible due to the effects of surgery, but these are not as important preoperatively as the client's body image.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Reference: p. 226-228

19. A nurse is conducting a class on breast cancer prevention. Which statement would the nurse include in the discussion?

- A. "Most often a lump is felt before it is seen."
- B. "Early breast cancer usually has some symptoms."
- C. "If the mass is not painful, it is usually benign."
- D. "If lump is palpable, it has been there for some time."

Answer: D

Rationale: Early breast cancer has no symptoms. If a lump can be palpated, the cancer has been there for quite some time. The earliest sign of breast cancer is often an abnormality seen on a screening mammogram before the woman or the health care professional feels it. A healthy, asymptomatic presentation is typical.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 225

20. A woman comes to the clinic and tells the nurse that she has read an article about certain foods that have anticancer properties and help boost the immune system. During the discussion, the nurse would expect the client to identify which foods? Select all that apply.

- A. garlic
- B. soybeans
- C. milk
- D. leeks
- E. flax seed

Answer: A, B, D, E

Rationale: Phytochemical-rich foods include green tea and herbal teas; garlic; whole grains and legumes; onions and leeks; soybeans and soy products; tomato products (cooked tomatoes); fruits (citrus, apricots, pumpkin, berries); green leafy vegetables (spinach, collards, romaine);

colorful vegetables (carrots, squash, tomatoes); cruciferous vegetables (broccoli, cabbage, cauliflower); and flax seeds.

Question format: Multiple Select

Chapter 6: Disorders of the Breasts

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 231

21. During a wellness visit to the clinic, a 30-year-old woman asks the nurse if there is anything she can do to reduce her risk for developing breast cancer. Which suggestions would be appropriate? Select all that apply.

- A. "Eat three servings of fruit daily."
- B. "Keep your weight gain under 11 pounds (5 kilograms)."
- C. "Eat at least seven portions of complex carbohydrates daily."
- D. "Limit your intake of refined sugar products."
- E. "Use salt liberally when cooking"

Answer: B, C, D

Rationale: The American Institute for Cancer Research (AICR), which conducts extensive research, made the following recommendations to reduce a woman's risk for developing breast cancer: engaging in daily moderate exercise and weekly vigorous physical activity; consuming at least five servings of fruits and vegetables daily; not smoking or using any tobacco products; keeping a maximum body mass index (BMI) of 25 and limiting weight gain to no more than 11 pounds (5 kilograms) since age 18; consuming seven or more daily portions of complex carbohydrates, such as whole grains and cereals; limiting intake of processed foods and refined sugar; restricting red meat intake to approximately 3 ounces (.08 kilograms) daily; limiting intake of fatty foods, particularly those of animal origin; and restricting intake of salted foods and use of salt in cooking.

Question format: Multiple Select

Chapter 6: Disorders of the Breasts

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 231

22. A nurse is conducting a refresher program for a group of nurses about chemotherapy used for breast cancer. After teaching the group about the different types of chemotherapeutic agents used to treat breast cancer, the nurse determines that the teaching was successful when the group identifies which agent as an example of an aromatase inhibitor? Select all that apply.

- A. tamoxifen
- B. letrozole
- C. raloxifene
- D. exemestane
- E. anastrozole

Answer: B, D, E

Rationale: Letrozole, exemestane, and anastrozole are examples of aromatase inhibitors. Examples of SERMs include tamoxifen and raloxifene.

Question format: Multiple Select

Chapter 6: Disorders of the Breasts

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 224-225

23. A woman comes to the clinic and asks the nurse about when she should have her first mammogram. The woman is at low risk and has no family history of breast cancer. Using the recommendations of the American Cancer Society, the nurse would suggest the woman have her first mammogram at which age?

- A. 30 years
- B. 35 years
- C. 40 years
- D. 45 years

Answer: C

Rationale: The American Cancer Society still recommends annual mammograms and clinical breast exams for women starting at age 40.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 217

24. A nurse is preparing a presentation for a group of community nurses about benign and malignant breast masses. The nurses demonstrate understanding when they identify which as an indication of a benign breast mass? Select all that apply.

- A. absence of pain
- B. unilateral location
- C. firm consistency
- D. absence of dimpling
- E. fixed to the chest wall

Answer: C, D

Rationale: Benign breast masses are typically painful, firm, and rubbery in consistency, often bilateral, no dimpling and mobile, without being affixed to the chest wall.

Question format: Multiple Select

Chapter 6: Disorders of the Breasts

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 225

25. A nurse is working with a woman who has been diagnosed with severe fibrocystic breast disease. After describing the medications that can be used as treatment, the nurse determines that additional teaching is needed when the client identifies which drug as being used?

- A. tamoxifen
- B. bromocriptine
- C. danazol
- D. penicillin

Answer: D

Rationale: Treatment of severe fibrocystic breast disease may include the use of tamoxifen, bromocriptine, or danazol. Penicillin would be used to treat an infection such as mastitis.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 208

26. A woman comes to the clinic. Assessment reveals a firm, rubbery, movable mass in the upper outer quadrant of the left breast. The edges of the mass are clearly delineated. The nurse interprets these findings as suggestive of which disorder?

- A. fibrocystic breast disorder
- B. duct ectasia
- C. intraductal papilloma
- D. fibroadenoma

Answer: D

Rationale: Fibroadenoma is characterized by a firm, rubbery, well-circumscribed, freely mobile mass, usually located in the upper outer quadrant of the breast. Duct ectasia occurs when the milk ducts become congested with secretions and debris, resulting in periductal inflammation. Periareolar infections consist of active inflammation around nondilated subareolar breast ducts—a condition termed periductal mastitis. Fibrocystic breast disorder is characterized by lumpy, tender breasts with possible clear to yellow nipple discharge. Intraductal papilloma is manifested by a wart-like growth in the mammary ducts near the nipple that is soft, nontender, mobile, and poorly delineated. A serous, serosanguinous, or watery discharge from the nipple may occur.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 211-212

27. A client with advanced breast cancer, who has had both chemotherapy and radiation therapy, is to start hormonal therapy using a selective estrogen receptor modulator (SERM). Which agent would the nurse expect the client to receive?

- A. tamoxifen
- B. letrozole
- C. exemestane
- D. cortisone

Answer: A

Rationale: Tamoxifen is an example of a SERM used as adjunctive treatment for breast cancer. Letrozole and exemestane are aromatase inhibitors used to treat advanced breast cancer. Cortisone is a steroid and would not be used.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 224

28. A woman who has undergone a right modified-radical mastectomy returns from surgery. The nurse would focus immediate interventions on which area as the **priority**?

- A. respiratory function
- B. body image
- C. lymphedema prevention
- D. incisional care

Answer: A

Rationale: Upon return from surgery, the nurse's priority would be on the client's respiratory function, encouraging the client to turn, cough, and deep breathe at frequent intervals, at least every 2 hours, to help expand collapsed alveoli, clear inhalation anesthetic agents from the body, and prevent postoperative atelectasis and pneumonia. Body image and prevention of lymphedema would be priorities later on in the client's course of care. The client will most likely have a surgical dressing in place that most likely would not be removed in the immediate postoperative period.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 229

29. A client is diagnosed with fibrocystic breast disease. After teaching the client about this condition, the nurse determines that the teaching was successful based on which client statement?

- A. "I need to cut out drinking coffee like I'm used to doing."
- B. "It's important that I stop smoking or my condition will get worse."
- C. "I guess I'll have to find a replacement for milk and cheese."
- D. "No more cookies and baked goods for me."

Answer: A

Rationale: Caffeine is a stimulant, and eliminating it will help reduce symptoms of fibrocystic breast disease. Thus cutting out coffee from the client's intake indicates understanding of the situation. Although smoking cessation is important for anyone, cigarettes, along with dairy products such as milk and cheese, and sweets, such as cookies and baked goods, are not associated with symptoms of fibrocystic breast disease.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 208

30. A laboratory technician arrives to draw blood for a complete blood count (CBC) for a client who had a left-sided mastectomy 8 hours ago. The client has an intravenous line with fluid infusing in her right antecubital space. The nurse enters the room and sees the technician beginning to place a tourniquet on the client's right arm. Which response by the nurse would be **most appropriate**?

- A. Stop the technician immediately.
- B. Have the technician come back later on.
- C. Notify the surgeon to obtain the specimen via a cut-down procedure.
- D. Tell the technician to obtain the specimen from the client's left arm.

Answer: A

Rationale: The nurse should immediately stop the technician from obtaining the specimen. The left arm cannot be used because the mastectomy was performed on that side. The right arm has an intravenous infusion, so obtaining blood from this arm would be inappropriate, most likely leading to inaccurate results. Telling the technician to come back later on does not address the situation at present. Notifying the surgeon may be appropriate, but a cut-down procedure is invasive, and other less invasive options should be attempted first before considering such a procedure.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 221-222

31. A client is being discharged after having a right-sided modified radical mastectomy. After teaching the client about ways to minimize lymphedema, the nurse determines that the teaching was successful based on which client statement?

- A. "I should use lotion on my hands after working in my garden."
- B. "I need to avoid wearing tops that have elastic in the sleeves."
- C. "I should have my blood pressure taken in my right arm."
- D. "I need to limit my driving to once a week."

Answer: B

Rationale: Lymphedema increases when there is obstruction to the lymph flow. Wearing clothing with elasticized sleeves would compress the extremity, possibly cause trauma, and obstruct the flow, thus increasing the woman's risk. However, wearing a well-fitted compression sleeve would promote drainage return. Wearing gloves when gardening and using the unaffected arm for blood pressure readings help to reduce the risk of injury and subsequent lymphedema. Driving would have no effect on lymphedema.

Question format: Multiple Choice

Chapter 6: Disorders of the Breasts

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 221

Chapter 7

1. A woman is admitted for repair of cystocele and rectocele. She has nine living children. In taking her health history, what would the nurse expect to find?
 - A. sporadic vaginal bleeding accompanied by chronic pelvic pain
 - B. heavy leukorrhea with vulvar pruritus
 - C. menstrual irregularities and hirsutism on the chin
 - D. stress incontinence with feeling of low abdominal pressure

Answer: D

Rationale: Cystocele and rectocele are examples of pelvic organ prolapse. Manifestations typically include stress incontinence and lower abdominal pressure or pain. Complaints of sporadic vaginal bleeding and chronic pelvic pain are associated with uterine fibroids. Leukorrhea and vulvar pruritus commonly are associated with an infection. Menstrual irregularities and hirsutism are associated with polycystic ovarian syndrome.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 240

2. To assist the woman in regaining control of the urinary sphincter after bladder surgery, the nurse should teach the client to perform which action?
 - A. Perform Kegel exercises daily.
 - B. Void every hour while awake.
 - C. Limit the intake of fluid.
 - D. Take a laxative every night.

Answer: A

Rationale: After bladder surgery, the client should perform Kegel exercises daily to strengthen the pelvic floor muscles. Bladder training with voiding every 3 to 5 hours helps to establish normal voiding intervals. Fluids should not be limited; however, the woman should avoid fluids that are irritants, such as caffeinated fluids, soda, and alcohol. Constipation is to be avoided, but a high-fiber diet rather than daily laxative use is recommended.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 240

3. When developing the plan of care for a woman who has had an abdominal hysterectomy, the nurse would identify which action as contraindicated?

- A. ambulating the client
- B. massaging the client's legs
- C. applying elasticized stockings
- D. encouraging range-of-motion exercises

Answer: B

Rationale: After an abdominal hysterectomy, massaging the client's legs would be contraindicated because the woman is at risk for venous stasis, thrombophlebitis, and thromboembolism. Ambulation, elasticized stockings, and range-of-motion exercises would be appropriate to reduce the woman's risk for thrombophlebitis.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 252

4. A nurse is conducting a presentation for a local women's group about pelvic floor disorders. Which instruction would the nurse include about preventing pelvic support disorders?
- A. performing Kegel isometric exercises
 - B. consuming low-fiber diets
 - C. using hormone replacement
 - D. voiding every 2 hours

Answer: A

Rationale: Kegel exercises are an effective preventive measure for pelvic support disorders. They may limit the progression of a mild prolapse and alleviate mild prolapse symptoms. High-fiber rather than low-fiber diets are appropriate to reduce straining associated with constipation. Hormone replacement therapy must be highly individualized and is not an appropriate option for every woman. Normal voiding patterns typically are every 3 to 5 hours. Too frequent or too infrequent voiding can lead to problems.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 240

5. A client is diagnosed with an enterocoele. The nurse interprets this condition as:
- A. protrusion of the posterior bladder wall downward through the anterior vaginal wall.
 - B. sagging of the rectum with pressure exerted against the posterior vaginal wall.
 - C. bulging of the small intestine through the posterior vaginal wall.
 - D. descent of the uterus through the pelvic floor into the vagina.

Answer: C

Rationale: An enterocele occurs when the small intestine bulges through the posterior vaginal wall, especially when straining. A cystocele is a protrusion of the posterior bladder wall downward through the anterior vaginal wall. A rectocele occurs when the rectum sags and pushes against or into the posterior vaginal wall. Uterine prolapse occurs when the uterus descends through the pelvic floor and into the vaginal canal.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 238

6. A woman is scheduled for an anterior and posterior colporrhaphy as treatment for a cystocele. When the nurse is explaining this treatment to the client, which description would be **most** appropriate to include?

- A. "This procedure helps to tighten the vaginal wall in the front and back so that your bladder and urethra are in the proper position."
- B. "Your uterus will be removed through your vagina, helping to relieve the organ that is putting the pressure on your bladder."
- C. "This is a series of exercises that you will learn to do so that you can strengthen your bladder muscles."
- D. "These are plastic devices that your primary care provider will insert into your vagina to provide support to the uterus and keep it in the proper position."

Answer: A

Rationale: An anterior and posterior colporrhaphy tightens the anterior and posterior vaginal wall, and the supportive tissue between the vagina and bladder is folded and sutured to bring the bladder and urethra into proper position. Removal of the uterus through the vagina refers to a vaginal hysterectomy. Exercises to strengthen the bladder muscles are called Kegel exercises. Plastic devices inserted to provide support are called pessaries.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 242

7. A client is diagnosed with uterine fibroids. When reviewing the client's health history, the nurse would identify which finding as associated with the client's condition?

- A. diarrhea
- B. chronic pelvic pain
- C. amenorrhea
- D. upper back pain

Answer: B

Rationale: Findings associated with uterine fibroids include chronic pelvic pain, constipation, dysmenorrhea, and lower back pain.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 249

8. A client with polycystic ovarian syndrome (PCOS) is receiving oral contraceptives as part of her treatment plan. When discussing this treatment with the client, the nurse would discuss which rationale for this therapy?

- A. restore menstrual regularity
- B. induce ovulation
- C. improve insulin uptake
- D. alleviate hirsutism

Answer: A

Rationale: Oral contraceptives are used as treatment for PCOS to restore menstrual irregularities and treat acne. Ovulation induction agents such as clomiphene are used to induce ovulation.

Metformin is used to improve insulin uptake. Mechanical hair removal methods are used to treat hirsutism.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 255

9. When teaching a woman how to perform Kegel exercises, the client asks what muscles are being helped with these exercises. The nurse would include reference to which muscles in the response?

- A. gluteus
- B. lower abdominal
- C. pelvic floor
- D. diaphragmatic

Answer: C

Rationale: Kegel exercises strengthen the pelvic floor muscles to support the inner organs and prevent further prolapse. They have no effect on the gluteal, lower abdominal, or diaphragmatic muscles.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 240

10. A postmenopausal woman with uterine prolapse is being fitted with a pessary. The nurse would be **most** alert for which side effect?

- A. increased vaginal discharge
- B. urinary tract infection
- C. vaginitis
- D. vaginal ulceration

Answer: D

Rationale: Use of a pessary can lead to pressure necrosis. Postmenopausal women with thin vaginal mucosa are highly susceptible to vaginal ulceration. Increased vaginal discharge, urinary tract infections, and vaginitis are possible side effects that could be seen in any woman fitted with a pessary.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 242

11. When preparing the discharge teaching plan for the woman who had surgery to correct pelvic organ prolapse, which information would the nurse include?

- A. care of the indwelling catheter at home
- B. emphasis on coughing to prevent complications
- C. return to usual activity level in a few days
- D. daily douching with dilute vinegar solution

Answer: A

Rationale: Following surgery to repair a pelvic organ prolapse, the nurse would teach the woman about caring for the indwelling catheter, which will remain in place for approximately 1 week. Activities that increase intra-abdominal pressure, such as straining, sneezing, or coughing, should be avoided. The woman also should avoid heavy lifting or straining for several weeks. Pelvic rest is prescribed until the operative area is healed in 6 weeks. Douching is indicated if the woman had a pessary inserted, not surgery.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 245

12. A woman with polycystic ovary syndrome tells the nurse, "I hate this disease. Just look at me! I have no hair on the front of my head, but I've got hair on my chin and upper lip. I don't feel like a woman anymore." Further assessment reveals breast atrophy and increased muscle mass. Which nursing diagnosis would the nurse identify as the **priority**?

- A. situational low self-esteem related to masculinization effects of the disease

- B. social isolation related to feelings about appearance
- C. risk for suicide related to effects of condition and fluctuating hormone levels
- D. ineffective peripheral tissue perfusion related to effects of disease on vasculature

Answer: A

Rationale: The woman is verbalizing how she sees herself in light of the manifestations of PCOS. She is exhibiting a negative self-image. Therefore, the nursing diagnosis of situational low self-esteem would be a priority. There is no information about the woman's participation in social activities. Her statements do not reflect that she might hurt herself. PCOS is associated with long-term health problems, but this is not evidenced by the scenario.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Reference: p. 254

13. After teaching a local woman's group about incontinence, the nurse determines that the teaching was successful when the group identifies which characteristic of stress incontinence?
- A. feeling a strong need to void
 - B. passing a large amount of urine
 - C. developing most often in women in their 30s
 - D. sneezing as an initiating stimulus

Answer: D

Rationale: Stress incontinence is characterized by the involuntary passage of a small amount of urine in response to an increase in intra-abdominal pressure, such as with sneezing, coughing, laughing, or physical exertion. It develops commonly in women in their 40s and 50s due to the weakening of the muscles and the ligaments in the pelvis after birth.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Remember

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Teaching/Learning

Reference: p. 246

14. After teaching a woman with pelvic organ prolapse about dietary and lifestyle measures, which statement would indicate the need for additional teaching?
- A. "If I wear a girdle, it will help support the muscles in the area."
 - B. "I should take up jogging to make sure I exercise enough."
 - C. "I will try to drink at least 64 oz of fluid each day."
 - D. "I need to increase the amount of fiber I eat every day."

Answer: B

Rationale: High-impact aerobics, jogging, or jumping repeatedly should be avoided to reduce the risk of increasing intra-abdominal pressure. Wearing a girdle or abdominal support helps to support the muscles surrounding the pelvic organs. The woman should consume at least eight 8-oz glasses of fluid daily and replace refined low-fiber foods with high-fiber foods.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 244

15. A nurse is conducting an in-service program for a group of staff nurses working at the women's health center. After teaching the group about genital fistulas, the nurse determines that the teaching was successful when the group identifies which as a major cause of genital fistulas?

- A. radiation therapy
- B. congenital anomaly
- C. female genital cutting
- D. Bartholin's gland abscess

Answer: C

Rationale: Although genital fistulas may be due to radiation therapy, congenital anomaly, or Bartholin's gland abscess, the majority of fistulas are caused by obstetric trauma and female genital cutting.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 254

16. A nurse is providing care to a female client receiving treatment for a Bartholin cyst. The client has had a small loop of plastic tubing secured in place to allow for drainage. The nurse instructs the client that she will have a follow-up appointment for removal of the plastic tubing at which time?

- A. 1 week
- B. 2 weeks
- C. 3 weeks
- D. 4 weeks

Answer: C

Rationale: The follow-up visit for removal of the plastic tubing is in approximately 3 weeks. After the Word catheter is inserted, the balloon tip is inflated, and it is left in place for 4 to 6 weeks.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential
Reference: p. 253

17. After undergoing diagnostic testing, a woman is diagnosed with a corpus luteum cyst. The nurse anticipates that the woman will require:

- A. biopsy.
- B. no treatment.
- C. oral contraceptives.
- D. metformin.

Answer: B

Rationale: Corpus luteum cysts form when the corpus luteum becomes cystic or hemorrhagic and fails to degenerate after 14 days. Typically these cysts appear after ovulation and resolve without intervention. Biopsy would be indicated if a malignancy was suspected. Oral contraceptives and metformin would be used to treat polycystic ovarian syndrome.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 254

18. A nurse is assessing a female client and suspects that the client may have endometrial polyps based on which clinical manifestation?

- A. bleeding after intercourse
- B. vaginal discharge
- C. bleeding between menses
- D. irregular, acyclic bleeding

Answer: D

Rationale: The most common clinical manifestation of endometrial polyps is irregular, acyclic uterine bleeding. Cervical and endocervical polyps are often asymptomatic, but they can produce mild symptoms such as abnormal vaginal bleeding (after intercourse or douching, between menses) or discharge.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 249

19. A nurse is conducting an in-service program for a group of staff nurses. After teaching the group about ovarian cysts, the nurse determines that the teaching was successful when the group identifies which type of cyst as being associated with hydatidiform mole?

- A. theca-lutein cyst
- B. corpus luteum cyst

- C. follicular cyst
- D. polycystic ovarian syndrome

Answer: A

Rationale: Although rare, theca-lutein cysts, which develop from prolonged abnormally high levels of human chorionic gonadotropin, are associated with hydatidiform mole, choriocarcinoma, polycystic ovarian syndrome, and clomiphene therapy. Corpus luteum cysts form when the corpus luteum becomes cystic or hemorrhagic and fails to degenerate after 14 days. Follicular cysts are caused by the failure of the ovarian follicle to rupture at the time of ovulation. Both types typically require no treatment. Polycystic ovarian syndrome (PCOS) involves the presence of multiple inactive follicle cysts within the ovary that interfere with ovarian function.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 254

20. A nurse is reading a journal article about care of the woman with pelvic organ prolapse. The nurse would expect to find information related to which disorder? Select all that apply.

- A. rectocele
- B. fecal incontinence
- C. cystocele
- D. urinary incontinence
- E. enterocele

Answer: A, C, E

Rationale: The four most common types of pelvic or genital prolapse are cystocele, rectocele, enterocele, and uterine prolapse. Urinary and fecal incontinence along with pelvic organ and genital prolapse are classified as pelvic support disorders.

Question format: Multiple Select

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 238

21. A nurse is reviewing the medical record of a client. Which finding would lead the nurse to suspect that the client is experiencing polycystic ovarian syndrome? Select all that apply.

- A. decreased androgen levels
- B. elevated blood insulin levels
- C. anovulation
- D. waist circumference of 32 inches
- E. triglyceride level of 175 mg/dL
- F. high-density lipoprotein level of 40 mg/dL

Answer: B, C, E

Rationale: Polycystic ovarian syndrome is a multifaceted disorder, and central to its pathogenesis are hyperandrogenemia and hyperinsulinemia. PCOS is associated with obesity, hyperinsulinemia, elevated luteinizing hormone levels (linked to ovulation), elevated androgen levels (virilization), hirsutism (male-pattern hair growth), follicular atresia (ovarian growth failure), ovarian growth and cyst formation, anovulation (failure to ovulate), infertility, type 2 diabetes, sleep apnea, amenorrhea (absence of menstruation or irregular periods) and metabolic syndrome, which is characterized by abdominal obesity (waist circumference >35 in.), dyslipidemia (triglyceride level >150 mg/dL, high-density lipoprotein cholesterol [HDL-C] level <50 mg/dL), elevated blood pressure, a pro-inflammatory state characterized by an elevated C-reactive protein level, and a prothrombotic state characterized by elevated PAI-1 and fibrinogen levels.

Question format: Multiple Select

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 255

22. A group of nurses are preparing a presentation about reproductive tract polyps for a local women's group. Which information would the nurses include in the presentation?

- A. Polyps are rarely the result of an infection.
- B. Endocervical polyps commonly appear after menarche.
- C. Cervical polyps are more common than endocervical polyps.
- D. Endocervical polyps are most common in women in their 50s.

Answer: D

Rationale: Endometrial polyps are solitary, and they rarely occur in women younger than 20 years of age. The incidence of these polyps rises steadily with increasing age, peaks in the fifth decade of life, and gradually declines after menopause. The exact cause of polyps is unknown, but they are frequently the result of infection. Cervical polyps often appear after menarche.

Endocervical polyps are more common than cervical polyps and are commonly found in multiparous women ages 40 to 60.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 248

23. A nurse is teaching a client how to perform Kegel exercises. Which directives would the nurse include? Select all that apply.

- A. "Squeeze your rectal muscles as if you are trying to avoid passing flatus."
- B. "Tighten your pubococcygeal muscles for a count of 10."
- C. "Contract and relax your pubococcygeal muscles rapidly 10 times."
- D. "Try bearing down for about 10 seconds for no more than 5 times."

E. "Do these exercises at least 5 times every hour."

Answer: A, C

Rationale: To perform Kegel exercises, the nurse would tell the client to squeeze the muscles in her rectum as if she is trying to prevent passing flatus. Then the nurse would tell the client to stop and start urinary flow to help identify the pubococcygeus muscle. Once this is accomplished, the nurse would tell the client to tighten the pubococcygeus muscle for a count of 3, and then relax it. Next the nurse would tell the woman to contract and relax the pubococcygeus muscle rapidly 10 times and try to bring up the entire pelvic floor and bear down 10 times. Finally, the nurse would tell the client to repeat these exercises at least 5 times daily.

Question format: Multiple Select

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 244

24. A client is diagnosed with a leiomyoma. The client asks the nurse what this is. The nurse describes this as a:

- A. cyst.
- B. pelvic organ prolapse.
- C. fistula.
- D. fibroid.

Answer: D

Rationale: Leiomyomas are also called uterine fibroids. Cysts are fluid-filled sac-like structures. A fistula is an abnormal opening. Pelvic organ prolapse is an abnormal descent or herniation of the pelvic organs from their original attachment sites or their normal position in the pelvis.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 249

25. The nurse is caring for a client with polycystic ovarian syndrome (PCOS) who is receiving oral contraceptives as part of her treatment plan. The nurse teaches the client about the drug therapy and how it will help her. The nurse determines that the teaching was successful when the client states which reason for the drug?

- A. "It will help regulate my menstrual cycle."
- B. "It will help me to ovulate."
- C. "My body will be able to use insulin better."
- D. "It will help decrease my hair growth."

Answer: A

Rationale: Oral contraceptives are used as treatment for PCOS to restore menstrual irregularities and treat acne. Ovulation induction agents such as clomiphene are used to induce ovulation. Metformin is used to improve insulin uptake. Mechanical hair removal methods are used to treat hirsutism.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 255

26. A client is experiencing urinary incontinence. The nurse is teaching the client measures to regain control of the urinary sphincter. The nurse determines that the teaching was effective when the client states she will perform which action?

- A. Perform Kegel exercises daily.
- B. Urinate every hour while awake.
- C. Limit the intake of fluids.
- D. Use a laxative every night.

Answer: A

Rationale: The client should perform Kegel exercises daily to strengthen the pelvic floor muscles. Bladder training with voiding every 3 to 5 hours helps to establish normal voiding intervals. Fluids should not be limited; however, the woman should avoid fluids that are irritants, such as caffeinated fluids, soda, and alcohol. Constipation is to be avoided, but a high-fiber diet rather than daily laxative use is recommended.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 246

27. A nurse is reading a journal article about treatment options for fibroids. Which information would the nurse **most** likely find as a disadvantage associated with uterine artery embolization? Select all that apply.

- A. The procedure often causes pain.
- B. It can negatively affect fertility.
- C. The fibroids can regrow after the procedure.
- D. The procedure is noninvasive.
- E. Radiation and contrast dye are used.

Answer: A, B, E

Rationale: Uterine artery embolization is frequently painful, minimally invasive, and requires the use of radiation and contrast dye. In addition, although future fertility is possible, there is a possibility of a negative effect on fertility. Fibroids can regrow after treatment with hormones, a noninvasive treatment.

Question format: Multiple Select

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 251

28. A client comes to the clinic for an evaluation. After assessing the client, the nurse suspects that the client may be experiencing uterine prolapse. Which findings would the nurse report when notifying the primary care provider about the suspicion? Select all that apply.

- A. urge to defecate
- B. nocturnal urinary frequency
- C. abdominal pressure
- D. low back pain on sitting
- E. dyspareunia

Answer: A, B, C, E

Rationale: Symptoms associated with pelvic organ prolapse including urgency of defecation, diurnal and nocturnal frequency, abdominal pressure and pain, low back pain on standing for long periods and dyspareunia.

Question format: Multiple Select

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 240

29. A client is diagnosed with urinary incontinence. The nurse teaches the client about the condition and ways to manage it. The nurse determines that the teaching was successful based on which client statement?

- A. "I will limit my daily fluid intake to about 1.5 liters."
- B. "I can continue to drink coffee, but I must avoid drinking tea."
- C. "I can use a feminine deodorant spray to help control the odor."
- D. "I should perform Kegel exercises about once a week."

Answer: A

Rationale: The client with urinary incontinence must avoid drinking too much fluid, typically limiting fluid intake to about 1.5 liters/day. The client also should avoid caffeine which includes tea as well as coffee. The client should use a mild soap and water for perineal care. Feminine hygiene sprays are not indicated and can be irritating. Kegel exercises should be done at least 5 times each day.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 247-248

30. A woman diagnosed with uterine fibroids is scheduled for a myomectomy. After reviewing this procedure with the client, the nurse determines that the client understands this procedure based on which statement?

- A. "This will help to reduce the size of my fibroids."
- B. "I will have tiny particles put in to shrink the fibroids."
- C. "The fibroid will be removed but new ones may grow."
- D. "I will not be able to have any more children."

Answer: C

Rationale: A myomectomy involves removing the fibroid alone and leaves the healthy areas of the uterus intact to preserve fertility. Fertility is not jeopardized because this procedure leaves the uterine muscle walls intact. Myomectomy relieves symptoms but does not affect the underlying process; thus, fibroids grow back and further treatment will be needed in the future. Hormones are used to reduce the size of fibroids. Uterine artery embolization (UAE) is an option in which polyvinyl alcohol pellets are injected into selected blood vessels via a catheter to block circulation to the fibroid, causing it to shrink and producing symptom resolution. This procedure can affect fertility. A hysterectomy involves the removal of the uterus and loss of fertility.

Question format: Multiple Choice

Chapter 7: Benign Disorders of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Teaching/Learning

Reference: p. 251

Chapter 8

1. A 58-year-old client comes to the clinic for evaluation. After obtaining the client's history, the nurse suspects endometrial cancer. Which information would lead the nurse to this suspicion?
- A. use of oral contraceptives between ages 18 and 25
 - B. onset of painless, bright red postmenopausal bleeding
 - C. menopause occurring at age 46
 - D. use of intrauterine device for 3 years

Answer: B

Rationale: Any episode of bright red painless bleeding occurring after menopause needs to be investigated. Abnormal uterine bleeding in postmenopausal women should be regarded with suspicion. Oral contraceptive use is associated with cervical cancer. Late menopause (after age 52) is associated with endometrial cancer. Use of an intrauterine device is not associated with endometrial cancer.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 272

2. A woman is to have a Papanicolaou test. When teaching the woman about this test, the nurse would emphasize which instruction to the client?
- A. "Refrain from sexual intercourse for 1 week before the test."
 - B. "Wear cotton panties on the day of the test."
 - C. "Avoid taking any medications for 24 hours."
 - D. "Do not douche for 48 hours before the test."

Answer: D

Rationale: The nurse should instruct the woman not to douche for 48 hours before the test to prevent washing away cervical cells, which might be abnormal. Sexual intercourse should be avoided for 48 hours before the test. Wearing cotton panties is unrelated to preparation for a Papanicolaou test. Medications do not need to be withheld before the test.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 281

3. A woman comes to the clinic for a routine checkup. After obtaining the client's history, the nurse identifies that the client is at increased risk for cervical cancer based on her history of exposure to which virus?

- A. hepatitis
- B. human papillomavirus
- C. cytomegalovirus
- D. Epstein-Barr virus

Answer: B

Rationale: Human papillomavirus is a major causative factor for cervical cancer. Hepatitis, cytomegalovirus, and Epstein-Barr virus are not associated with the development of cervical cancer.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Understand

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 276

4. A client is scheduled to have a Papanicolaou test. After the nurse teaches the client about the Papanicolaou test, which client statement indicates successful teaching?
- A. "I need to douche the night before with a mild vinegar solution."
 - B. "I will take a bath first thing that morning to make sure I'm clean."
 - C. "I will not engage in sexual intercourse for 48 hours before the test."
 - D. "I will get a clean urine specimen when I first wake up the morning of the test."

Answer: C

Rationale: The woman should refrain from sexual intercourse for 48 hours before the test because sperm can obscure the specimen. Douching should be avoided for 48 hours before the test to prevent washing away cervical cells, which might be abnormal. Although a bath is an appropriate hygiene measure, it is not required before a Papanicolaou test. Collecting a urine specimen also is not necessary.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 281

5. Which finding obtained during a client history would the nurse identify as increasing a client's risk for ovarian cancer?
- A. multiple sexual partners
 - B. consumption of a high-fat diet
 - C. underweight
 - D. grand multiparity (more than five children)

Answer: B

Rationale: Risk factors for ovarian cancer include a high-fat diet, obesity, nulliparity, early menarche, late menopause, and increasing age. Having multiple sexual partners is a risk factor for cervical cancer.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 270

6. A client is scheduled for cryosurgery to remove some abnormal tissue on the cervix. The nurse teaches the client about this treatment, explaining that the tissue will be removed by which method?

- A. freezing
- B. cutting
- C. burning
- D. irradiating

Answer: A

Rationale: Cryosurgery destroys abnormal cervical tissue by freezing. Conization involves cutting out a cone-shaped section of tissue. Laser therapy destroys cervical tissue by using high-energy light to burn it off. Radiation therapy involves irradiating the tissue for destruction.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 278

7. Which statement **best** indicates that a client has taken self-care measures to reduce her risk for cervical cancer?

- A. "I've really cut down on the amount of caffeine I drink every day."
- B. "I've thrown out all my bubble baths and just use soap and water now."
- C. "Every time I have sexual intercourse, I douche."
- D. "My partner always uses a condom when we have sexual intercourse."

Answer: D

Rationale: Unprotected sexual intercourse is a risk factor for cervical cancer. Use of barrier methods of contraception such as condoms is a key measure for reducing the risk for cervical cancer. Cessation of smoking and drinking alcohol, not caffeine, also are effective measures for risk reduction. Eliminating irritants such as bubble baths is a general measure to reduce perineal irritation and urinary tract infections. Douching has no effect on risk reduction for cervical cancer.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 281

8. A client is suspected of having endometrial cancer. The nurse would **most** likely prepare the client for which procedure to confirm the diagnosis?

- A. transvaginal ultrasound
- B. colposcopy
- C. Papanicolaou test
- D. endometrial biopsy

Answer: D

Rationale: An endometrial biopsy is the procedure of choice to make the diagnosis of endometrial cancer. A transvaginal ultrasound may be used to evaluate the endometrial cavity and measure the endometrial thickness to detect endometrial hyperplasia, but it does not confirm the diagnosis. Colposcopy is used to diagnose cervical cancer. A Papanicolaou test screens for abnormal cervical cells.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 272

9. Which description would the nurse include when teaching a client about a scheduled colposcopy?

- A. "A gel will be applied to your abdomen and a microphone-like device will be moved over the area to identify problem areas."
- B. "A solution will be wiped on your cervix to identify any abnormal cells, which will be visualized with a magnifying instrument."
- C. "Scrapings of tissue will be obtained and placed on slides to be examined under the microscope."
- D. "After you receive anesthesia, a small device will be inserted into your abdomen near your belly button to obtain tissue samples."

Answer: B

Rationale: A colposcopy is a microscopic examination of the lower genital tract using a magnifying instrument. Use of a microphone-like device over the abdomen describes an ultrasound. Obtaining tissue scrapings that are examined under a microscope describes a Papanicolaou test. Insertion of a device under anesthesia near the umbilicus describes a biopsy obtained via laparoscopy.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 278

10. The nurse is preparing a presentation for a local women's group about methods to reduce the risk of reproductive tract cancers. Which action should the nurse include?
- A. blood pressure evaluation every 6 months
 - B. yearly Papanicolaou test starting at age 40
 - C. condom use with every sexual encounter
 - D. consumption of two to three glasses of red wine per day

Answer: C

Rationale: Staying healthy is a major way to reduce one's risk for cancer. Current recommendations include: using a condom with every sexual encounter; having blood pressure evaluated at least every 2 years; undergo a Papanicolaou test every 1 to 3 years, if sexually active, starting at age 21; and consuming alcohol in moderation (not more than one drink per day), if at all.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 264

11. The daughter of a woman who has been diagnosed with ovarian cancer asks the nurse about screening for this cancer. Which response by the nurse would be **most** appropriate?
- A. "Currently there is no reliable screening test for ovarian cancer."
 - B. "A Papanicolaou test is almost always helpful in identifying this type of cancer."
 - C. "There's a blood test for a marker, CA-125, that if elevated indicates cancer."
 - D. "A genetic test for two genes, if positive, will identify the ovarian cancer."

Answer: A

Rationale: Currently there are no adequate screening tests for ovarian cancer. A Papanicolaou test is used to screen for cervical cancer. The CA-125 marker may be elevated in women with ovarian cancer, but it is not specific for this cancer and may be elevated in other malignancies. Genetic testing via BRCA-1 and BRCA-2 provides information about a woman's risk but does not predict if the woman will develop cancer.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 268

12. After teaching a group of young women how to reduce their risk for ovarian cancer, the nurse determines that additional teaching is needed when the group identifies which element as a way to reduce risk?

- A. pregnancy
- B. use of oral contraceptives

- C. use of feminine hygiene sprays
- D. breastfeeding

Answer: C

Rationale: Risk reduction strategies include pregnancy, use of oral contraceptives, and breastfeeding. Women should avoid using talc and hygiene sprays on the genital area.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 270

13. A woman is diagnosed with adenocarcinoma of the endometrium in situ. The nurse interprets this as indicating which information about the cancer?

- A. spread to the uterine muscle wall
- B. found on the endometrial surface
- C. spread to the cervix
- D. invaded the bladder

Answer: B

Rationale: Carcinoma in situ is found only on the endometrial surface. In stage I, the cancer has spread to the uterine muscle wall. In stage II, it has spread to the cervix. In stage IV, it has invaded the bladder mucosa with distant metastases to the lungs, liver, and bone.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 272

14. When preparing a woman with suspected vulvar cancer for a biopsy, the nurse expects that the lesion would **most** likely be located at which area?

- A. labia majora
- B. labia minora
- C. clitoris
- D. prepuce

Answer: A

Rationale: The diagnosis of vulvar cancer is made by biopsy of the suspicious lesion, which is most commonly found on the labia majora.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 284

15. When describing the various types of reproductive tract cancers to a local women's group, the nurse would identify which cancer as the least common type?

- A. vulvar
- B. vaginal
- C. endometrial
- D. ovarian

Answer: B

Rationale: Of the cancers listed, vaginal cancer is the rarest. Only about one of every 1,100 women will develop vaginal cancer in her lifetime. Vulvar cancer represents approximately 4% of female genital cancers. Endometrial cancer is the fourth most common gynecologic malignancy in the United States and sixth most common cancer globally. It accounts for 7% of all cancers in women in the United States (one in 40 women). Ovarian cancer is the fifth most common cancer among women and the most common cause of cancer deaths for women in the United States.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 282

16. Vulvar cancer is suspected in a client. When reviewing the client's history which report would the nurse **most** likely find? Select all that apply.

- A. dyspareunia
- B. persistent vulvar itching
- C. history of herpes simplex
- D. lesion on the cervix
- E. abnormal Papanicolaou test result

Answer: A, B, C

Rationale: Leading presenting reports of women with vulvar cancer include dyspareunia, long history of pruritis, ulcers on the "outside" genitalia, vulvar swelling, vulvar bleeding, and urinary problems. In most cases, the woman with vulvar cancer reports persistent vulvar itching, burning, and edema that does not improve with the use of creams or ointments. A history of condyloma, gonorrhea, and herpes simplex are some of the factors for greater risk for vulvar intraepithelial neoplasia. Abnormal vaginal bleeding, lesion on the cervix, or abnormal Papanicolaou test result are not associated with vulvar cancer.

Question format: Multiple Select

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 284

17. A nurse is reviewing the medical record of a woman diagnosed with vulvar cancer. Which information would the nurse identify as a risk factor for this cancer? Select all that apply.

- A. 55 years of age
- B. history of breast cancer
- C. monogamous sexual partner
- D. HSV-type 2 exposure
- E. obesity

Answer: A, B, D, E

Rationale: Risk factors associated with vulvar cancer include age over 50 years, history of exposure to HSV type 2, history of breast cancer, multiple sex partners, obesity, hypertension, and diabetes.

Question format: Multiple Select

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 284

18. A nurse is assisting with the collection of a Papanicolaou test. When collecting the specimen, which action is done **first**?

- A. insertion of the speculum
- B. swabbing of the endocervix
- C. spreading of the labia
- D. insertion of the cytobrush

Answer: C

Rationale: For a Papanicolaou test, the practitioner obtains a sample by spreading the labia; inserting the speculum; inserting the cytobrush and swabbing the endocervix; and inserting the plastic spatula and swabbing the cervix.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 279

19. The plan of care for a woman diagnosed with a suspected reproductive cancer includes a nursing diagnosis of disturbed body image related to suspected reproductive tract cancer and impact on sexuality as evidenced by the client's statement that she is worried that she will not be the same. Which outcome would be appropriate for this client?

- A. Client will verbalize positive statements about self and sexuality.
- B. Client will demonstrate understanding of the condition and associated treatment.
- C. Client will exhibit positive coping strategies related to diagnosis.
- D. Client will identify misconceptions related to her diagnosis.

Answer: A

Rationale: An appropriate outcome for disturbed body image would be that the client verbalizes positive statements about herself and her sexuality. Demonstrating understanding of the condition and treatment and identifying misconceptions would be appropriate for a nursing diagnosis of deficient knowledge. Exhibiting positive coping strategies would be appropriate for a nursing diagnosis of anxiety.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Reference: p. 265

20. During a routine health check-up, a young adult woman asks the nurse about ways to prevent endometrial cancer. Which actions would the nurse **most** likely include? Select all that apply.

- A. eating a high-fat diet
- B. having regular pelvic exams
- C. engaging in daily exercise
- D. becoming pregnant
- E. using estrogen contraceptives

Answer: B, C, D

Rationale: Measures to prevent endometrial cancer include eating a low-fat diet, having regular pelvic exams after the age of 21, engaging in daily exercise, becoming pregnant (pregnancy serves as a protective factor), and asking the practitioner about the use of combination estrogen and progestin pills.

Question format: Multiple Select

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 274

21. A woman is scheduled for diagnostic testing to evaluate for endometrial cancer. The nurse would expect to prepare the woman for which procedure?

- A. CA-125 testing
- B. transvaginal ultrasound
- C. Papanicolaou test
- D. mammography

Answer: B

Rationale: A transvaginal ultrasound would be used to evaluate endometrial thickness to determine if an endometrial biopsy is needed. CA-124 testing is a nonspecific blood test used as

a tumor marker. A Papanicolaou test is used to screen for cervical cancer. A mammography is used to screen for breast cancer.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 272

22. A nurse is conducting a class for a local woman's group about recommendations for a Papanicolaou test. One of the participants asks, "At what age should a woman have her first test?" The nurse responds by stating that a woman should have her first Papanicolaou test at which age?

- A. 18
- B. 21
- C. 25
- D. 28

Answer: B

Rationale: Although professional medical organizations disagree as to the recommended frequency of screening for cervical cancer, ACOG (2018b) recommends that cervical cancer screening should begin at age 21 years (regardless of sexual history), since women younger than age 21 are at very low risk of cancer.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 275

23. A client has an abnormal Papanicolaou test result that is classified as ASC-US. Based on the nurse's understanding of this classification, the nurse would expect which procedure?

- A. immediate colposcopy
- B. testing for human papillomavirus (HPV)
- C. repeat Papanicolaou test in 4 to 6 months
- D. cone biopsy

Answer: C

Rationale: For the classification of ASC-US, the client would have a repeat Papanicolaou test in 4 to 6 months or be referred for a colposcopy. A referral for colposcopy with HPV testing is indicated if the results indicated ASC-H classification. An immediate colposcopy would be indicated for atypical glandular cells and adenocarcinoma in situ. A cone biopsy would be used to evaluate the lesion and may be used as treatment to remove any precancers and very early cancers.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 277

24. The nurse is preparing a presentation for a local women's group about ways to reduce the risk of reproductive tract cancers. Which practice would the nurse include?
- A. blood pressure evaluation every 6 months
 - B. yearly Papanicolaou test starting at age 40
 - C. yearly cholesterol screening starting at age 45
 - D. consumption of two to three glasses of red wine per day

Answer: C

Rationale: Staying healthy is a major way to reduce one's risk for cancer. Cholesterol should be checked annually starting at age 45. Blood pressure should be evaluated at least every 2 years. A Papanicolaou test is recommended every 1 to 3 years for sexually active women, starting at age 21. Alcohol should be consumed in moderation (not more than one drink per day), if at all.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 264

25. When assessing a female client for the possibility of vulvar cancer, the nurse would **most** likely expect the client to report which symptoms? Select all that apply.
- A. abnormal vaginal bleeding
 - B. persistent vulvar itching
 - C. history of herpes simplex
 - D. lesion on the cervix
 - E. abnormal Papanicolaou test result

Answer: B, C

Rationale: In most cases, the woman with vulvar cancer reports persistent vulvar itching, burning, and edema that does not improve with the use of creams or ointments. A history of condyloma, gonorrhea, and herpes simplex are some of the factors for greater risk for vulvar intraepithelial neoplasia. Abnormal vaginal bleeding, lesion on the cervix, or abnormal Papanicolaou test result are not associated with vulvar cancer.

Question format: Multiple Select

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 284

26. A nurse is reviewing the medical record of a woman diagnosed with vulvar cancer. Which information would the nurse identify as risk factors for this cancer? Select all that apply.

- A. age under 40 years
- B. HPV 16 exposure
- C. monogamous sexual partner
- D. hypertension
- E. diabetes

Answer: B, D, E

Rationale: Risk factors associated with vulvar cancer include age over 50 years, history of exposure to HPV 16, multiple sex partners, hypertension, and diabetes.

Question format: Multiple Select

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 284

27. A nurse is conducting an in-service program for a group of nurses about cervical cancer. The nurse determines that the teaching was successful when the group identifies which area as **most** commonly involved?

- A. internal cervical os
- B. junction of the cervix and fundus
- C. squamous-columnar junction
- D. external cervical os

Answer: C

Rationale: Cervical cancer starts with abnormal changes in the cellular lining or surface of the cervix. Typically these changes occur in the squamous–columnar junction of the cervix. Here, cylindrical secretory epithelial cells (columnar) meet the protective flat epithelial cells (squamous) from the outer cervix and vagina in what is termed the transformation zone.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 276

28. A client is scheduled to undergo a cone biopsy. When explaining this procedure to the client, the nurse understands that the specimen will be obtained from which area?

- A. clitoris
- B. uterine fundus
- C. transformation zone
- D. ovarian follicle

Answer: C

Rationale: When a cone biopsy is performed, a cone-shaped section of the cervix is removed. The base of the cone is formed by the ectocervix (outer part of the cervix) and the point or apex of the cone is from the endocervical canal. The transformation zone is contained within the cone sample. A cone biopsy is not obtained from the clitoris, uterine fundus, or ovarian follicle.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 278

29. A nurse is conducting a class for a group of young adult women at a local women's health clinic. The nurse is describing ovarian cancer and ways to reduce the risk. The nurse determines that the teaching was successful based on which statement(s) from the group? Select all that apply.

- A. "We should avoid using any kind of talc near our genitals."
- B. "Breastfeeding is better than bottle feeding to lower our risk."
- C. "We should eat foods that have a higher fat content."
- D. "Keeping our weight fairly even and at a healthy level is important."
- E. "Birth control with diaphragms is better than using birth control pills."

Answer: A, B, D

Rationale: Ways to reduce the risk of ovarian cancer include getting pregnant, using oral contraceptives (for 3 years or longer), breastfeeding (before the age of 30), and avoiding the use of talc and hygiene sprays on the genitals. It is also important to maintain healthy lifestyles, including maintaining a healthy weight and eating a low-fat diet.

Question format: Multiple Select

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 270

30. A client is scheduled for a loop electrosurgical excision procedure (LEEP) to evaluate an abnormal Papanicolaou (Pap) test. After teaching the client about this procedure, the nurse determines that the teaching was successful based on which client statement?

- A. "I will have this procedure done in the outpatient surgery department."
- B. "I will need to get general anesthesia for this procedure."
- C. "I should expect the procedure to take about 1 to 2 hours."
- D. "I might have some mild cramping and bleeding for a few weeks."

Answer: D

Rationale: With LEEP or LLETZ (large loop excision of the transformation zone), the abnormal cervical tissue is removed with a wire that is heated by an electrical current. For this procedure, a

local anesthetic is used. It is performed in the health care provider's office in approximately 10 minutes. Mild cramping and bleeding may persist for several weeks after the procedure.

Question format: Multiple Choice

Chapter 8: Cancers of the Female Reproductive Tract

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Teaching/Learning

Reference: p. 278

Chapter 9

1. The nurse is presenting a class at a local community health center on violence during pregnancy. Which possible complication would the nurse include?
- A. gestational hypertension
 - B. chorioamnionitis
 - C. placenta previa
 - D. postterm labor

Answer: B

Rationale: Women assaulted during pregnancy are at risk for chorioamnionitis, placental abruption, preterm labor, stillbirth, miscarriage, uterine rupture, and injuries to the mother and fetus. Gestational hypertension is not associated with violence during pregnancy.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 298

2. Which approach would be most appropriate when counseling a client who is a suspected victim of intimate partner violence?
- A. Offer the client a pamphlet about the local shelter for victims of intimate partner violence.
 - B. Call the client at home to ask some questions about the marriage.
 - C. Wait until the client comes in a few more times to make a better assessment.
 - D. Ask, "Have you ever been physically hurt by your partner?"

Answer: D

Rationale: If intimate partner violence is suspected, the nurse must use direct or indirect questions to screen for abuse. Asking the client if he or she has ever been physically hurt by the partner is most appropriate. Offering the client a pamphlet, calling the client at home, or waiting until the client returns are inappropriate and do not validate the suspicion.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 301

3. When describing an episode of intimate partner violence, the victim reports attempting to calm the partner down to keep things from escalating. The nurse interprets this behavior as reflecting which phase of the cycle of violence?

- A. battering
- B. honeymoon

- C. tension-building
- D. reconciliation

Answer: C

Rationale: During the first phase of intimate partner violence, tension-building, the victim attempts to keep the situation from exploding based on the belief that the partner's anger is legitimately directed at him or her. The battering phase involves the explosion of violence. The honeymoon or reconciliation phase is manifested by a period of calm, loving, contrite behavior on the part of the batterer. The batterer may be genuinely sorry for the pain caused.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Reference: p. 295

4. A physically abused pregnant woman reports to the nurse that her spouse has stopped hitting her and promises never to hurt her again. Which response by the nurse would be **most** appropriate?

- A. "That's great. I wish you both the best."
- B. "Remember, the cycle of violence often repeats itself."
- C. "He probably didn't mean to hurt you."
- D. "You need to consider leaving him."

Answer: B

Rationale: The cycle of violence typically increases in frequency and severity as it is repeated over and over again. The woman needs to understand this.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 295

5. A nurse is developing a plan of care for a victim of intimate partner violence. Which intervention would be **least** appropriate for the nurse to include?

- A. assisting the client to project anger
- B. providing information about a safe home and crisis line
- C. teaching the client about the cycle of violence
- D. discussing the client's legal and personal rights

Answer: A

Rationale: The goal of intervention is to enable the victim to gain control by providing sensitive, predictable care in an accepting setting. Assisting the client to project anger would not be helpful when the client needs support and education.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 300

6. A nurse is describing the cycle of violence to a community group. When explaining the first phase, the nurse would include which description?

- A. somehow triggered by the victim's behavior
- B. characterized by tension-building and minor battery
- C. associated with loss of physical and emotional control
- D. like a honeymoon that lulls the victim

Answer: B

Rationale: The cyclic behavior begins with a time of tension-building arguments, progresses to violence, and settles into a making-up or calm period.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 295

7. A nurse is working with a victim of violence. Which statement would be **most** appropriate to empower the victim to take action?

- A. "Give your partner more time to come around."
- B. "Remember—children do best in two-parent families."
- C. "Change your behavior so as not to trigger the violence."
- D. "You are a good person, and you deserve better than this."

Answer: D

Rationale: To help the victim gain control over his or her life, the nurse should emphasize that violence is never okay and that the victim did not deserve the violent attack or ask for it. Telling the victim to give the partner more time, saying that children need two parents, and suggesting that the client change his or her behavior do not promote control, rather they attempt to excuse the partner's behavior.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 300

8. When a nurse suspects that a client may be a victim of intimate partner violence, the **first** action should be to:

- A. ask the client about the injuries and if they are related to intimate partner violence.

- B. encourage the client to leave the abuser immediately.
- C. set up an appointment with an intimate partner violence counselor.
- D. ask the suspected abuser about the victim's injuries.

Answer: A

Rationale: The first step is to screen for intimate partner violence and identify the connection between the client's injuries and that abuse. Once intimate partner violence is detected, the nurse should immediately isolate the client to provide privacy and prevent retaliation by the abuser. Encouraging the client to leave the abuser immediately is not realistic. Setting up an appointment with a counselor would be appropriate once intimate partner violence is detected and the client is safe. Questioning the suspected abuser might worsen the situation.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 300

9. A nurse is listening to a client who is a victim of intimate partner violence. The client is describing how events would unfold with the partner. The nurse interprets the client's statements and identifies which action as characteristic of the second phase of the cycle of violence?
- A. The batterer is contrite and attempts to apologize for the behavior.
 - B. The physical battery is abrupt and unpredictable.
 - C. Verbal assaults begin to escalate toward the victim.
 - D. The victim accepts the anger as legitimately directed at him or her.

Answer: B

Rationale: During the second phase of the cycle of violence, the violence explodes and the batterer loses control physically and emotionally. During the honeymoon or third phase, the batterer is contrite and attempts to apologize for the behavior. During the first phase or tension-building phase, verbal or minor battery occurs and the victim often accepts the partner's building anger as legitimately directed toward him or her.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 296

10. In addition to providing privacy, which action would be most appropriate **initially** in situations involving suspected intimate partner violence?
- A. Allow the client to have a good cry over the situation.
 - B. Tell the client, "Injuries like these don't usually happen by accident."
 - C. Call the police immediately so they can question the victim.
 - D. Ask the abuser to describe his side of the story first.

Answer: B

Rationale: Communicating support through a nonjudgmental attitude and telling the victim that no one deserves to be abused are the first steps in establishing trust and rapport. Allowing the client to cry is appropriate after the client is safe, the client's privacy is protected, and the nurse has emphasized that there is a problem. Notifying the police is done once the assessment reveals suspicion or actual indications of intimate partner violence. Asking the abuser to describe the story is inappropriate because asking the abuser about the situation may trigger an abusive episode.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 300

11. When the nurse is alone with a client, the client says, "It was all my fault. The house was so messy when my partner got home, and I know my partner hates that." Which response would be **most** appropriate?

- A. "It is not your fault. No one deserves to be hurt."
- B. "What else did you do to make your partner so angry with you?"
- C. "You need to start to clean the house early in the day."
- D. "Remember, your partner works hard and you need to meet your partner's needs."

Answer: A

Rationale: The nurse needs to communicate nonjudgmental support and explain that no one deserves to be abused. Doing so helps to establish trust and rapport. Asking the victim what he or she did to make the partner so angry, telling the victim to clean the house earlier in the day, and telling the victim to meet the partner's needs all shift the blame to the victim and are thus inappropriate.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 304

12. When developing a presentation for a local community organization on violence, the nurse is planning to include statistics on intimate partner violence and its effects on children. When addressing these statistics, what is the rate of the cases involving a parent and the children being abused?

- A. 1 in 8
- B. 1 in 3
- C. 1 in 5
- D. 1 in 10

Answer: A

Rationale: In many cases when a parent is abused, the children are abused as well. Approximately 1 in 8 children are abused annually in the United States.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Reference: p. 295

13. A nurse is working with a group of clients who are victims of intimate partner violence. The nurse focuses interventions on which area as the **primary** goal?

- A. convincing them to leave the abuser soon
- B. helping them cope with their life as it is
- C. empowering them to regain control of their life
- D. arresting the abuser so he or she cannot abuse again

Answer: C

Rationale: The goal of interventions is to enable the victim to gain control over life. Although the nurse can encourage a victim to leave an abuser, the choice to leave must be made by the victim. The nurse can provide support and assistance with coping, but the ultimate goal is for the victim to become empowered. Arresting the abuser does not necessarily stop the abuse.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 304

14. A nurse is preparing a teaching plan for victims who are recovering from intimate partner violence. The nurse would focus the teaching on ways to:

- A. enhance their personal appearance and hairstyle.
- B. develop their creativity and work ethic.
- C. improve their communication skills and assertiveness.
- D. plan more nutritious meals to improve their own health.

Answer: C

Rationale: Providing reassurance and support to victims of intimate partner violence is key if the violence is to end. Appropriate actions can help victims express their thoughts and feelings in constructive ways and strengthen their control over their lives. Although interventions related to personal appearance and creativity can enhance the victim's self-esteem, they are not helpful in dealing with intimate partner violence. Planning nutritious meals helps to promote a healthy lifestyle but is ineffective in dealing with intimate partner violence.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 305

15. During a follow-up visit to the clinic, a victim of sexual assault reports changing jobs and moving to another town. The client tells the nurse, "I pretty much stay to myself at work and at home." The nurse interprets these findings to indicate that the client is in which phase of rape recovery?

- A. disorganization
- B. denial
- C. reorganization
- D. integration

Answer: C

Rationale: During the reorganization phase, the survivor attempts to make life adjustments by moving or changing jobs and uses emotional distancing to cope. The disorganization phase is characterized by shock, fear, disbelief, anger, shame, guilt, and feelings of uncleanliness. During the denial or outward adjustment phase, the survivor appears outwardly composed and returns to work or school and refuses to discuss the assault and denies the need for counseling. During the integration and recovery phase, the survivor begins to feel safe and starts to trust others.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Integrated Process: Culture and Spirituality

Reference: p. 309

16. A nurse is assessing a rape survivor for posttraumatic stress disorder. The nurse asks the survivor, "Do you feel as though you are reliving the trauma?" The nurse is assessing for which effect of the trauma?

- A. physical symptoms
- B. intrusive thoughts
- C. avoidance
- D. hyperarousal

Answer: B

Rationale: The question is used to assess the survivor for intrusive thoughts that reflect the client reexperiencing the trauma. Physical symptoms would be assessed with questions about sleeping, eating, palpitations and other problems. Avoidance would be reflected in questions involving withdrawal socially, avoiding situations that remind the survivor of the rape. Hyperarousal would be noted by irritability and an exaggerated startle response.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Reference: p. 311

17. A group of nurses are preparing a program about rape and sexual assault for a community health center. Which information would the nurses include as being **most** accurate? Select all that apply.

- A. Most victims of rape tell someone about it.
- B. Few people falsely cry "rape."
- C. Women have rape fantasies desiring to be raped.
- D. A rape victim feels vulnerable and betrayed afterwards.
- E. Medication and counseling can help a rape victim cope.

Answer: B, D, E

Rationale: The majority of victims never tell anyone about a rape. Almost two-thirds of victims never report it to the police. The victim feels vulnerable, betrayed, and insecure after a rape. Few women falsely cry "rape." Reality and fantasy are different, and dreams have nothing to do with the brutal violation of rape. Medication can help initially, but counseling is usually needed.

Question format: Multiple Select

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 308

18. After teaching a class at a local college campus on date rape, the nurse determines that the teaching was successful when the class identifies which substance as the **most** common date rape drug?

- A. gamma hydroxybutyrate
- B. liquid ecstasy
- C. ketamine
- D. rohypnol

Answer: D

Rationale: Rohypnol is the most common date rape drug. Others include gamma hydroxybutyrate (or liquid ecstasy) and ketamine.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 309

19. A nurse is caring for a recent rape victim. The nurse would expect this client to experience which phase **first**?

- A. denial
- B. disorganization
- C. reorganization

D. integration

Answer: B

Rationale: The acute phase of rape recovery is disorganization characterized by shock, fear, disbelief, anger, shame, guilt and feelings of uncleanness. This is followed by denial (outward adjustment), reorganization, and finally integration and recovery.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 309

20. A group of nurses is preparing a violence prevention program. The group is researching information about risk factors for intimate partner violence related to the individual. Based on their research, which risk factors would the nurses expect to address? Select all that apply.

- A. dysfunctional family system
- B. low academic achievement
- C. victim of childhood violence
- D. heavy alcohol consumption
- E. economic stress

Answer: B, C, D

Rationale: Individual risk factors associated with intimate partner violence include young age, heavy drinking, low academic achievement, and experience of or witnessing of violence as a child. Dysfunctional family system and economic stress are risk factors associated with the relationship.

Question format: Multiple Select

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 294

21. A nurse is working with a victim of intimate partner violence, helping the client develop a safety plan. Which items would the nurse suggest that the client take when leaving? Select all that apply.

- A. driver's license
- B. Social Security number
- C. cash
- D. phone cards
- E. health insurance cards

Answer: A, B, C, E

Rationale: When leaving an abusive relationship, the victim should take a driver's license or photo ID, Social Security number or green card/work permit, birth certificates, any court papers or orders, credit cards, cash, and health insurance cards. The victim should avoid phone cards because they leave a trail to follow.

Question format: Multiple Select

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 305

22. A nurse is presenting a discussion on sexual violence at a local community college. When describing the incidence of sexual violence, the nurse would identify that a woman has which chance of experiencing a sexual assault in her lifetime?

- A. 1 in 3
- B. 1 in 5
- C. 2 in 15
- D. 3 in 20

Answer: B

Rationale: According to the National Sexual Violence Resource Center (NSVRC), nearly one in five women and one in 9 men in the United States have experienced rape, physical violence, and/or stalking by a partner with IPV-related impact in their lifetimes.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 292

23. A nurse is reading a journal article about sexual abuse. Which age range would the nurse expect to find as the peak age for such abuse?

- A. 7 to 10 years
- B. 8 to 12 years
- C. 14 to 18 years
- D. 18 to 22 years

Answer: B

Rationale: Current estimates indicate that 1 of 5 girls is sexually assaulted, and the peak ages of such abuse are from 8 to 12 years of age. At every age in the life span, females are more likely to be victims of sexual violence by father, brother, family member, neighbor, boyfriend, husband, partner or ex-partner than by a stranger or anonymous assailant.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 306

24. A nurse is conducting an in-service program on sexual abuse and violence for a group of nurses working at the community clinic. After teaching the group, the nurse determines that the teaching was successful when the group describes incest as involving which action?
- A. sexual exploitation by blood or surrogate relatives
 - B. sexual abuse of individuals over age 18
 - C. violent aggressive assault on a person
 - D. consent between perpetrator and victim.

Answer: A

Rationale: Incest is any type of sexual exploitation between blood relatives or surrogate relatives before the victim reaches 18 years of age. Rape is a violent, aggressive assault on the victim's body and integrity. Rape is a legal rather than a medical term. It denotes penile penetration of the vagina, mouth, or rectum of the female or male without consent. It may or may not include the use of a weapon.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Reference: p. 306-307

25. A nurse is teaching a group of college students about rape and sexual assault. The nurse determines that additional teaching is necessary based on which statements by the group? Select all that apply.

- A. Most victims of rape tell someone about it.
- B. Few individuals falsely cry "rape."
- C. Women have rape fantasies desiring to be raped.
- D. A rape victim feels vulnerable and betrayed afterwards.
- E. Medication and counseling can help a rape victim cope.

Answer: A, C

Rationale: The majority of victims never tell anyone about a rape. Almost two-thirds of victims never report it to the police. The victim feels vulnerable, betrayed, and insecure after a rape. Few individuals falsely cry "rape." Reality and fantasy are different, and dreams have nothing to do with the brutal violation of rape. Medication can help initially, but counseling is usually needed.

Question format: Multiple Select

Chapter 9: Violence and Abuse

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 308

26. While obtaining a history from a woman at a regularly scheduled physical, the nurse notices various bruises on the client's upper extremity. The client dismisses the bruising and changes the

subject. Which additional information about the woman as a victim would the nurse discuss with the healthcare provider when relaying the physical assessment data? Select all that apply.

- A. A dysfunctional family system
- B. A low academic achievement
- C. A victim of childhood violence
- D. Limited alcohol consumption
- E. Economic stress

Answer: A, B, C, E

Rationale: Victims often will not describe themselves as abused. In **battered woman syndrome**, the woman has experienced deliberate and repeated physical or sexual assault by an intimate partner over an extended period of time. She is terrified and feels trapped, helpless, and alone. She reacts to any expression of anger or threat by avoidance and withdrawal behavior. Some women believe that the abuse is caused by a personality flaw or inadequacy in themselves (e.g., inability to keep the partner happy). These feelings of failure are reinforced and exploited by their partners. After being told repeatedly that they are "bad," some women begin to believe it. Many victims were abused as children and may have poor self-esteem, poor health, post-traumatic stress disorder (PTSD), depression, insomnia, low education achievement, or a history of suicide attempts, injury, or drug and alcohol abuse.

Question format: Multiple Select

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 297

27. A nurse is working with a victim of violence to develop a safety plan. The nurse teaches the client about the necessary items to take when leaving. The nurse determines that additional teaching is needed when the client identifies which items? Select all that apply.

- A. photo ID
- B. phone cards
- C. most of her clothing
- D. cash
- E. health insurance cards

Answer: B, C

Rationale: When leaving an abusive relationship, the victim should take the following items: driver's license or photo ID; Social Security number or green card/work permit; birth certificates for oneself and one's children; phone numbers for social services or shelter; deed or lease to the home or apartment; any court papers or orders; a change of clothing for oneself and one's children; pay stubs, checkbook, credit cards, and cash; and health insurance cards. Phone cards should not be used because they leave a trail to follow.

Question format: Multiple Select

Chapter 9: Violence and Abuse

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Reference: p. 305

28. A nurse suspects that a client is experiencing intimate partner violence and uses a screening protocol to gather additional information from the client. When asking the client direct questions, which behavior by the nurse would be appropriate to elicit accurate information? Select all that apply.

- A. Look away from the client when asking any questions.
- B. Avoid the use of technical language.
- C. Minimize what the client says.
- D. Use leading questions.
- E. Wait patiently for the client to answer.

Answer: B, E

Rationale: When asking the client direct questions using the SAVE model, the nurse should maintain continuous eye contact with the client, avoid the use of technical or medical language, not dismiss or minimize what the client says, even if the client does so, use direct, to the point questions, not leading questions, and wait for each answer patiently.

Question format: Multiple Select

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 301

29. A nurse is working with a victim of intimate partner violence. Which intervention would be most important for this client?

- A. providing for the client's safety
- B. reassuring the client he or she is not alone
- C. documenting the violence
- D. educating about the cycle of violence

Answer: A

Rationale: Although reassurance, documentation, and education are important for the client experiencing intimate partner violence, ensuring safety is the most important.

Question format: Multiple Choice

Chapter 9: Violence and Abuse

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Reference: p. 301

30. After teaching a group of young adults about sexual violence, the nurse determines that the teaching was successful when the group identifies which acts as a type of sexual violence? Select all that apply.

- A. female genital mutilation

- B. bondage
- C. infanticide
- D. human trafficking
- E. prostitution

Answer: A, B, C, D

Rationale: Sexual violence includes IPV, human trafficking, incest, female genital cutting, forced prostitution, bondage, exploitation, neglect, infanticide, and sexual assault.

Question format: Multiple Select

Chapter 9: Violence and Abuse

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Reference: p. 305

Chapter 10

1. The nurse is teaching a couple about the pros and cons of genetic testing. Which statement by the nurse **best** describes the limits of genetic testing?
- A. "Various genetic tests help the primary care provider choose appropriate treatments."
 - B. "Genetic testing helps couples avoid having children with fatal diseases."
 - C. "Genetic tests identify people at high risk for preventable conditions."
 - D. "Some genetic tests can give a probability for developing a disorder."

Answer: D

Rationale: The fact that some tests only provide a probability for developing a disorder raises a problem. A serious limitation of these susceptibility tests is that some people who carry a disease-associated mutation never develop the disease. Choosing appropriate treatments, avoiding having children with fatal diseases, and identifying those at high risk affirm the value of genetic tests.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 342

2. The nurse is counseling a couple who suspect that they could bear a child with a genetic abnormality. What would be **most** important for the nurse to do when working with this family?
- A. Gather information for three generations.
 - B. Inform the family of the need for information.
 - C. Maintain the confidentiality of the information.
 - D. Present the information in a factual, nondirective manner.

Answer: D

Rationale: It is essential to respect client autonomy and present information in a factual, nondirective manner. In these situations, the nurse needs to understand that the choice is the couple's to make. Gathering information for three generations obtains a broad overview of what has been seen in both sides of the family. Maintaining confidentiality of the information is as important as with any other client information gathered. Informing the family of the need for information is necessary because of its personal nature.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Integrated Process: Teaching/Learning

Reference: p. 343-344

3. The nurse is teaching a couple about X-linked disorders because they are concerned that they might pass on hemophilia to their children. Which response indicates the need for further teaching?

- A. "The father can't be a carrier if he doesn't have hemophilia."
- B. "If the father doesn't have it, then his kids won't either."
- C. "If the mother is a carrier, her daughter could be one too."
- D. "If the mother is a carrier, her sons will have hemophilia."

Answer: B

Rationale: Males are more affected than females. A male has only one X chromosome, and all the genes on his X chromosome will be expressed whereas a female will usually need both X chromosomes to carry the disease. There is no male-to-male transmission (since no X chromosome from the male is transmitted to male offspring), but any man who is affected will have carrier daughters. If a woman is a carrier, there is a 50% chance that her sons will be affected and a 50% chance that her daughters will be carriers.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 339

4. A pregnant woman undergoes a triple screen at 16 to 18 weeks' gestation. What would the nurse suspect if the woman's estriol and alpha-fetoprotein levels are decreased with high hCG levels?

- A. Down syndrome
- B. sickle-cell anemia
- C. cardiac defects
- D. respiratory disorders

Answer: A

Rationale: Decreased levels might indicate Down syndrome or trisomy 18. Sickle cell anemia may be identified by chorionic villus sampling. Levels would be increased with cardiac defects, such as tetralogy of Fallot. It does not detect respiratory disorders.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 345

5. The nurse is conducting a presentation for a young adult community group about fetal development and pregnancy. The nurse determines that the teaching was successful when the group identifies that the sex of offspring is determined at which time?

- A. during meiosis cell division

- B. at fertilization
- C. when the morula forms
- D. during oogenesis

Answer: B

Rationale: Sex determination occurs at the time of fertilization. Meiosis refers to cell division resulting in the formation of an ovum or sperm with half the number of chromosomes. The morula develops after a series of four cleavages following the formation of the zygote. Oogenesis refers to the development of a mature ovum, which has half the number of chromosomes.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 324

6. During a prenatal visit, a pregnant woman says, "I know the amniotic fluid is important, but can you tell me more about it?" When describing amniotic fluid to a pregnant woman, which description would the nurse **most** likely include?

- A. "This fluid acts as transport mechanism for oxygen and nutrients."
- B. "The fluid is mostly protein to provide nourishment to your baby."
- C. "This fluid acts as a cushion to help to protect your baby from injury."
- D. "The amount of fluid remains fairly constant throughout the pregnancy."

Answer: C

Rationale: Amniotic fluid protects the floating embryo and cushions the fetus from trauma. The placenta acts as a transport mechanism for oxygen and nutrients. Amniotic fluid is primarily water with some organic matter. Throughout pregnancy, amniotic fluid volume fluctuates.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 329

7. Assessment of a pregnant woman reveals oligohydramnios. The nurse would be alert for the development of which condition?

- A. maternal diabetes
- B. placental insufficiency
- C. neural tube defects
- D. fetal gastrointestinal malformations

Answer: B

Rationale: A deficiency of amniotic fluid, oligohydramnios, is associated with uteroplacental insufficiency and fetal renal abnormalities. Excess amniotic fluid is associated with maternal diabetes, neural tube defects, and malformations of the gastrointestinal tract and central nervous system.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 329

8. A couple comes to the clinic for preconception counseling and care. As part of the visit, the nurse teaches the couple about fertilization and initial development, stating that the zygote formed by the union of the ovum and sperm consists of how many chromosomes?

- A. 22
- B. 23
- C. 44
- D. 46

Answer: D

Rationale: With fertilization, the ovum, containing 23 chromosomes, and the sperm, containing 23 chromosomes, join, forming a zygote with a diploid number or 46 chromosomes.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 324

9. After teaching a pregnant woman about the hormones produced by the placenta, the nurse determines that the teaching was successful when the woman identifies which hormone produced as being the basis for pregnancy tests?

- A. human placental lactogen (hPL)
- B. estrogen (estriol)
- C. progesterone (progesterin)
- D. human chorionic gonadotropin (hCG)

Answer: D

Rationale: The placenta produces hCG, which is the basis for pregnancy tests. This hormone preserves the corpus luteum and its progesterone production so that the endometrial lining is maintained. Human placental lactogen modulates fetal and maternal metabolism and participates in the development of the breasts for lactation. Estrogen causes enlargement of the woman's breasts, uterus, and external genitalia and stimulates myometrial contractility. Progesterone maintains the endometrium.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 330

10. When describing genetic disorders to a group of couples planning to have children, the nurse would identify which as an example of an autosomal dominant inheritance disorder?

A. Huntington disease

B. sickle cell disease

C. phenylketonuria

D. cystic fibrosis

Answer: A

Rationale: Huntington disease is an example of an autosomal dominant inheritance disorder.

Sickle cell disease, phenylketonuria, and cystic fibrosis are examples of autosomal recessive inheritance disorders.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 338

11. Which mother is in the fetal stage of development?

A. a pregnant mother who is one week pregnant

B. a pregnant mother who is five weeks' pregnant

C. a pregnant mother who is seven weeks' pregnant

D. a pregnant mother who is thirty weeks' pregnant

Answer: D

Rationale: The fetal stage of development during pregnancy occurs at the end of the eighth week and continues through to birth. The mother at one week gestation is in the preembryonic stage.

The mothers at five weeks and seven weeks are in the embryonic stage.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 331

12. Which event will result in zygote formation?

A. The nucleus of the ovum and sperm make contact and combine chromosomes.

B. The nucleus of the ovum carries forth the genetic information at implantation.

C. The nucleus of the sperm and the fallopian tube make contact and combines chromosomes.

D. The nucleus of the sperm carries forth the genetic information at implantation.

Answer: A

Rationale: When the nucleus from the ovum and the nucleus of the sperm make contact, they lose their respective nuclear membranes and combine their maternal and paternal chromosomes. Because each nucleus contains a haploid number of chromosomes (23), this union restores the diploid number (46). The resulting zygote begins the process of a new life.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 324

13. When describing gender determination at a prenatal class, the nurse would include which statement?

- A. "Gender is determined when the primary oocyte completes its first mitotic division."
- B. "Gender is determined when the sperm and the oocyte undergo the process of mitosis."
- C. "Gender is determined when the ovum and the spermatozoon undergo the process of meiosis."
- D. "Gender is determined at fertilization when the ovum is fertilized."

Answer: D

Rationale: Gender is determined at fertilization and depends on whether the ovum is fertilized by a Y-bearing sperm or an X-bearing sperm. Approximately half of sperm carry the XX chromosome, and the other half carries XY. An XX zygote will become a female, and an XY zygote will become a male. X- and Y-bearing sperm determine the gender.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 324

14. During a prenatal class, the nurse is describing what happens when the ovum is fertilized by the sperm. Which statement would the nurse **most** likely include?

- A. The zygote is transported into the uterine cavity.
- B. The embryo is transported into the uterine cavity.
- C. Genetic material is shared with the embryo upon implantation.
- D. The placenta begins to form in the fallopian tube.

Answer: A

Rationale: When the ovum is fertilized by the sperm (now called a zygote), the zygote is transported into the uterine cavity. The resulting zygote is not yet an embryo to be transported, nor is genetic material shared with an embryo. The placenta does not form in the fallopian tube.

Question format: Multiple Select

Chapter 10: Fetal Development and Genetics

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 324

15. Which processes that occur after fertilization would lead to a normal pregnancy? Select all that apply.

- A. The morula divides into specialized cells that will form fetal structures.
- B. Within the morula is a blastocyst that will form the embryo.
- C. The morula develops into the embryonic membranes, the chorion, and placenta.
- D. The morula enters the uterine cavity about 72 hours after fertilization.
- E. The blastocyst reaches the uterine cavity immediately after fertilization.

Answer: A, B, D

Rationale: With additional cell division, the morula divides into specialized cells that will later form fetal structures. Within the morula, an off-center, fluid-filled space appears, transforming it into a hollow ball of cells called a blastocyst. The outer layer of cells surrounding the blastocyst cavity is called a trophoblast, which develops into one of the embryonic membranes, the chorion, and helps to form the placenta. The morula reaches the uterine cavity about 72 hours after fertilization.

Question format: Multiple Select

Chapter 10: Fetal Development and Genetics

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Reference: p. 324

16. Which processes, if they occur during the formation of the placenta, would lead to a successful pregnancy? Select all that apply.

- A. Implantation of the trophoblast occurs in the upper uterus.
- B. Three days after conception, the trophoblast makes human chorionic gonadotropin (hCG).
- C. The trophoblast attaches to the fallopian tube for nourishment.
- D. The placenta is fully developed by the end of fourth week.
- E. The trophoblast develops into the placenta.

Answer: A, B, E

Rationale: Implantation occurs in the upper uterus (fundus), where a rich blood supply is available. As early as 3 days after conception, the trophoblasts make human chorionic gonadotropin (hCG). By the end of the second week, the placenta is developing. The precursor cells of the placenta, the trophoblasts, first appear 4 days after fertilization. The trophoblast attaches to the wall of the uterus, not the fallopian tube.

Question format: Multiple Select

Chapter 10: Fetal Development and Genetics

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Reference: p. 326

17. Which characteristics about amniotic fluid would alert the prenatal nurse to further investigate? Select all that apply.

- A. Oligohydramnios is noted on assessment.
- B. The amount of amniotic fluid fluctuates at each checkup.
- C. Polyhydramnios is noted on assessment.
- D. The client has approximately 2 L of amniotic fluid at term.
- E. The client has approximately 1 L of amniotic fluid at term.

Answer: A, C, D

Rationale: Amniotic fluid surrounds the embryo and increases in volume as the pregnancy progresses, reaching approximately 1 L at term. Its volume changes constantly as the fetus swallows and voids. Oligohydramnios is too little amniotic fluid (500 mL at term) and is associated with uteroplacental insufficiency, fetal renal abnormalities, and a higher risk of surgical births and low birth weight infants. Too much amniotic fluid (2,000 mL at term), termed polyhydramnios, is associated with maternal diabetes, neural tube defects, chromosomal deviations, and malformations of the central nervous system and/or gastrointestinal tract that prevent normal swallowing of amniotic fluid by the fetus.

Question format: Multiple Select

Chapter 10: Fetal Development and Genetics

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 329

18. A client's recent prenatal ultrasound assessment reveals a normal placenta. Which outcomes would the nurse expect? Select all that apply.

- A. The placenta will filter out toxins that the mother ingests.
- B. The hormones made by the placenta support fetal growth.
- C. The placenta removes the fetal waste products such as stool.
- D. The placenta protects the fetus from an immune attack created by the mother.
- E. The placenta produces hormones that ready the fetus for extrauterine life.

Answer: B, D, E

Rationale: The placenta will not filter out all toxins. The placenta begins to make hormones that control the basic physiology of the mother so the fetus is supplied with the nutrients and oxygen needed for growth. The placenta also protects the fetus from immune attack by the mother and removes waste products from the fetus. The placenta produces hormones that ready fetal organs for life outside the uterus.

Question format: Multiple Select

Chapter 10: Fetal Development and Genetics

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 331

19. A prenatal nurse is conducting a class on healthy pregnancy and explains the role of placental hormones. Which statements would the nurse make? Select all that apply.

- A. Human chorionic gonadotropin is the basis for pregnancy tests.
- B. Human placental lactogen participates in the development of maternal breasts for lactation.
- C. Thyroxin modulates fetal and maternal metabolism.
- D. Progesterone stimulates maternal metabolism and breast development.
- E. Relaxin causes enlargement of a woman's breasts, uterus, and external genitalia.
- F. Estrogen causes enlargement of a woman's breasts.

Answer: A, B, D, F

Rationale: Human chorionic gonadotropin is the basis for pregnancy tests. Human placental lactogen modulates fetal and maternal metabolism and participates in the development of maternal breasts for lactation. Estrogen (estriol) causes enlargement of a woman's breasts, uterus, and external genitalia and stimulates myometrial contractility. Progesterone (progesterin) maintains the endometrium, decreases the contractility of the uterus, and stimulates maternal metabolism and breast development. Relaxin acts with progesterone to maintain pregnancy and causes relaxation of the pelvic ligaments. Progesterone maintains the endometrium, decreases the contractility of the uterus, and stimulates maternal metabolism and breast development. Thyroxin is not a placental hormone.

Question format: Multiple Select

Chapter 10: Fetal Development and Genetics

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 331

20. A client at a prenatal class requests information on how the gender of a baby is determined.

Which statement made by the nurse would be **most** accurate?

- A. "Gender is determined by week 20 of gestation and depends on whether the ovum is fertilized by a Y-bearing or an X-bearing sperm."
- B. "Gender is determined as the embryo is fertilized by a Y-bearing or an X-bearing sperm."
- C. "Gender is determined at conception and depends on whether the ovum is fertilized by a Y-bearing or an X-bearing sperm."
- D. "Gender is determined at conception and depends on whether the sperm is fertilized by a Y-bearing or X-bearing ovum."

Answer: C

Rationale: Sex determination is also determined at fertilization and depends on whether the ovum is fertilized by a Y-bearing sperm or an X-bearing sperm. Approximately half of sperm carry the XX chromosome and the other half carries XY. An XX zygote will become a female, and an XY zygote will become a male. That is why it is scientifically correct to say that the sex of the infant is determined by the father and not by the mother. Gender is determined before the embryo stage and at conception by sperm carrying Y- or X-bearing chromosomes.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 324

21. A client who is six weeks' pregnant asks the prenatal nurse, "What development has taken place with my baby by now?" Which information should the nurse include in the response?

Select all that apply.

- A. "By week 3 there would be the beginning development of the brain, spinal cord, and heart."
- B. "By week 4 the arms and legs begin to grow and develop."
- C. "By week 5 the heart now beats and the eyes and ears can be seen."
- D. "By week 6 the lungs begin forming and the baby circulation is established."
- E. "By week 6 the baby makes active movements with sucking motions made with the mouth."

Answer: A, B, C, D

Rationale: By week 3 there is the beginning development of brain and spinal cord, and the heart becomes more developed. Limb buds grow and develop at week 4. By week 5 the heart now beats at a regular rhythm. Beginning structures of eyes and ears are seen. Week 6 shows the lungs beginning to form and fetal circulation is established. At weeks 13 to 16 the fetus will make active movement, not at week 6. Sucking motions are made with the mouth in week 12, not in week 6.

Question format: Multiple Select

Chapter 10: Fetal Development and Genetics

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 328

22. At a prenatal class, the participants ask the nurse who would benefit from genetic counseling. Which responses by the nurse are correct? Select all that apply.

- A. "A woman who is a grand multigravida."
- B. "A woman whose husband is age 50 years or older."
- C. "A woman who has been exposed to teratogens."
- D. "A young teenager experiencing her first pregnancy."
- E. "A woman who receives an abnormal alpha-fetoprotein result."

Answer: B, C, E

Rationale: Those shown to benefit from genetic counseling are women over the maternal age 35 years or older when the baby is born; couples where the paternal age is 50 years or older; when a pregnancy screening abnormality is noted, including the alpha-fetoprotein. Genetic screening is encouraged where there has been teratogen exposure or risk. Teenage pregnancies or having multiple pregnancies do not qualify for genetic counselling unless the above risks have been identified.

Question format: Multiple Select

Chapter 10: Fetal Development and Genetics

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 342

23. In order for conception to take place, it is **most** common for a woman to get pregnant:

- A. two weeks after her normal menstrual period.
- B. two weeks before her normal menstrual period.
- C. immediately after a normal menstrual period.
- D. during her menstrual period.

Answer: A

Rationale: Fertilization is the union of ovum and sperm, which is the starting point of pregnancy. Fertilization typically happens around 2 weeks after the last normal menstrual period in a 28-day cycle.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 324

24. A couple asks the nurse at a preconception class for information on becoming pregnant.

Which response made by the nurse is correct?

- A. "The 200 million sperm in ejaculated semen are necessary for conception to take place."
- B. "The 1 million sperm in ejaculated semen are necessary for conception to take."
- C. "Fertilization will typically occur 2 weeks before your last normal menstrual period."
- D. "Fertilization will typically occur 1 week after the last normal menstrual period."

Answer: A

Rationale: Although more than 200 million sperm/mL are contained in the ejaculated semen, only one is able to enter the ovum to fertilize it. Fertilization would occur around 2 weeks after the last normal menstrual period.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 324

25. A couple attends genetic counseling. What are the chances that the couple will have a child with Down syndrome?

- A. Chromosomal abnormalities occur in about 1 in 150 live-born infants.

- B. Chromosomal abnormalities cannot be inherited and occur at random.
- C. If a woman is a carrier, there is a 25% chance that her daughter will be affected.
- D. If a man is a carrier, there is a 25% chance that he will have an unaffected son.

Answer: A

Rationale: Chromosomal abnormalities occur in about 1 in 150 live-born infants according to the March of Dimes. It is among the most common trisomies of chromosomes. Although some chromosomal disorders can be inherited, most occur due to random events during early fetal development.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 341

26. The nurse is assessing a 12-hour-old newborn and hears a heart murmur. What **initial** action should the nurse take?

- A. Document the finding as normal for age
- B. Report the finding to the health care provider
- C. Assess the infant every 2 hours for worsening symptoms
- D. Allow the infant to room in with the parents if temperature is stable

Answer: A

Rationale: The ductus arteriosus is a fetal shunt allowing blood to bypass the lungs. It closes functionally within 72 hours of life and permanently by 3 to 4 weeks of life. On assessment a murmur can be heard with delayed closure, but this murmur is not related to a cardiac issue. The nurse should initially document the finding as normal for age. The information can be relayed to the health care provider. The nurse should continue to assess the newborn during the hospital stay and note any changes to the murmur. If the infant is stable, the infant should be allowed to remain with the parents.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 331

27. A client asks about a child inheriting an autosomal recessive disorder. What must occur for an offspring to demonstrate signs and symptoms of the disorder with this type of inheritance?

- A. Both parents must be carriers.
- B. One parent must have the disease.
- C. One parent, usually the mother, must be a carrier.
- D. One parent, usually the father, must not be a carrier or have the disease.

Answer: A

Rationale: Autosomal recessive inheritance occurs when two copies of the mutant or abnormal gene in the homozygous state are necessary to produce the phenotype. In other words, two abnormal genes are needed for the individual to demonstrate signs and symptoms of the disorder. Both parents of the affected person must be carriers of the gene, either clinically normal or expresses the disorder.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 338

28. At prenatal classes a client asks the nurse how long it takes to actually become pregnant after having sexual intercourse. What is the nurse's **best** response?

- A. "Conception happens immediately after fertilization of the ovum."
- B. "Conception happens about 12 hours after fertilization of the ovum."
- C. "Conception happens about 24 hours after fertilization of the ovum."
- D. "Conception happens about 72 hours after fertilization of the ovum."

Answer: A

Rationale: For conception to occur, a healthy ovum from the woman is released from the ovary, passes into an open fallopian tube, and starts its journey downward. Sperm from the male is deposited into the vagina and swims approximately 7 inches to meet the ovum at the outermost portion of the fallopian tube, the area where fertilization takes place. This process occurs in about an hour. When one spermatozoon penetrates the ovum's thick outer membrane, pregnancy begins. All this activity takes place within a 5-hour time span.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 324

29. A nurse teaching a couple says that when X-linked recessive inheritance is present in a family, the genogram will reveal that:

- A. mostly males in the family have the disorder.
- B. the parents of the affected man have the disorder.
- C. sons of an affected man are also affected.
- D. all daughters and no sons will inherit the condition.

Answer: A

Rationale: In X-linked recessive pattern of inheritance, a genogram will reveal there are more affected males than females because all the genes on a man's X chromosome will be expressed

since a male has only one X chromosome. There is no male-to-male transmission (since no X chromosome from the male is transmitted to male offspring), but any man who is affected with an X-linked recessive disorder will have carrier daughters. If a woman is a carrier, there is a 25% chance she will have an affected son, a 25% chance that her daughter will be a carrier, a 25% chance that she will have an unaffected son, and a 25% chance her daughter will be a noncarrier. With X-linked dominant inheritance, all of the daughters and none of the sons of an affected male will inherit the condition, while both male and female offspring of an affected woman have a 50% chance of inheriting the condition.

Question format: Multiple Choice

Chapter 10: Fetal Development and Genetics

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 338

30. A woman visits the prenatal clinic and is noted to have oligohydramnios. The client asks, "Why is this fluid important anyway?" Which statements would be included in the nurse's response? Select all that apply.

- A. "Amniotic fluid helps maintain your baby's body temperature."
- B. "The fetus ingests amniotic fluid for its nourishment."
- C. "Too little amniotic fluid is linked with placental problems."
- D. "Amniotic fluid keeps your baby free from any teratogens."
- E. "It acts like a cushion protecting your baby from trauma that may occur."

Answer: A, C, E

Rationale: Sufficient amounts of amniotic fluid help maintain a constant body temperature for the fetus and cushion the fetus from trauma. Oligohydramnios is associated with placental problems. The fetus does ingest amniotic fluid but not for nourishment. Amniotic fluid does not protect the fetus from teratogens.

Question format: Multiple Select

Chapter 10: Fetal Development and Genetics

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 326

Chapter 11

1. During a vaginal exam, the nurse notes that the lower uterine segment is softened. The nurse documents this finding as:
- A. Hegar sign.
 - B. Goodell sign.
 - C. Chadwick sign.
 - D. Ortolani sign.

Answer: A

Rationale: Hegar sign refers to the softening of the lower uterine segment or isthmus. Bluish coloration of the cervix is termed Chadwick sign. Goodell sign refers to the softening of the cervix. Ortolani sign is a maneuver done to identify developmental dysplasia of the hip in infants.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 354

2. The nurse teaches a primigravida client that lightening occurs about 2 weeks before the onset of labor. What will the mother likely experience at that time?

- A. dysuria
- B. dyspnea
- C. constipation
- D. urinary frequency

Answer: D

Rationale: Lightening refers to the descent of the fetal head into the pelvis and engagement. With this descent, pressure on the diaphragm decreases, easing breathing, but pressure on the bladder increases, leading to urinary frequency. Dysuria might indicate a urinary tract infection.

Constipation may occur throughout pregnancy due to decreased peristalsis, but it is unrelated to lightening.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 354

3. A gravida 2 para 1 client in the 10th week of her pregnancy says to the nurse, "I've never urinated as often as I have for the past three weeks." Which response would be **most** appropriate for the nurse to make?

- A. "Having to urinate so often is annoying. I suggest that you watch how much fluid you are drinking and limit it."
- B. "You shouldn't be urinating this frequently now; it usually stops by the time you're eight weeks pregnant. Is there anything else bothering you?"
- C. "By the time you are 12 weeks pregnant, this frequent urination should really decrease, but it is likely to return toward the end of your pregnancy."
- D. "Women having their second child generally don't have frequent urination. Are you experiencing any burning sensations?"

Answer: C

Rationale: As the uterus grows, it presses on the urinary bladder, causing the increased frequency of urination during the first trimester. This complaint lessens during the second trimester only to reappear in the third trimester as the fetus begins to descend into the pelvis, causing pressure on the bladder.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 354

4. In a client's seventh month of pregnancy, she reports feeling "dizzy, like I'm going to pass out, when I lie down flat on my back." The nurse explains that this is due to:

- A. pressure of the gravid uterus on the vena cava.
- B. a 50% increase in blood volume.
- C. physiologic anemia due to hemoglobin decrease.
- D. pressure of the presenting fetal part on the diaphragm.

Answer: A

Rationale: The client is describing symptoms of supine hypotension syndrome, which occurs when the heavy gravid uterus falls back against the superior vena cava in the supine position. The vena cava is compressed, reducing venous return, cardiac output, and blood pressure, with increased orthostasis. The increased blood volume and physiologic anemia are unrelated to the client's symptoms. Pressure on the diaphragm would lead to dyspnea.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 354

5. A primiparous client is being seen in the clinic for her first prenatal visit. It is determined that she is 11 weeks pregnant. The nurse develops a teaching plan to educate the client about what she will most likely experience during this period. Which possible effect would the nurse include?

- A. ankle edema

- B. urinary frequency
- C. backache
- D. hemorrhoids

Answer: B

Rationale: The client is in her first trimester and would most likely experience urinary frequency as the growing uterus presses on the bladder. Ankle edema, backache, and hemorrhoids would be more common during the later stages of pregnancy.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 354

6. The nurse is discussing the insulin needs of a primiparous client with diabetes who has been using insulin for the past few years. The nurse informs the client that her insulin needs will increase during pregnancy based on the nurse's understanding that the placenta produces:
- A. hCG, which increases maternal glucose levels.
 - B. hPL, which deceases the effectiveness of insulin.
 - C. estriol, which interferes with insulin crossing the placenta.
 - D. relaxin, which decreases the amount of insulin produced.

Answer: B

Rationale: Human placental lactogen (hPL) acts as an antagonist to insulin, so the mother must produce more insulin to overcome this resistance. If the mother has diabetes, then her insulin need would most likely increase to meet this demand. Human chorionic gonadotropin (hCG) does not affect insulin and glucose level. Estrogen, not estriol, is believed to oppose insulin. In addition, insulin does not cross the placenta. Relaxin is not associated with insulin resistance.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 362

7. When teaching a pregnant client about the physiologic changes of pregnancy, the nurse reviews the effect of pregnancy on glucose metabolism. Which underlying reason for the effect would the nurse include?
- A. Pancreatic function is affected by pregnancy.
 - B. Glucose is utilized more rapidly during a pregnancy.
 - C. The pregnant woman increases her dietary intake.
 - D. Glucose moves through the placenta to assist the fetus.

Answer: D

Rationale: The growing fetus has large needs for glucose, amino acids, and lipids, placing demands on maternal glucose stores. During the first half of pregnancy, much of the maternal glucose is diverted to the growing fetus. The pancreas continues to function during pregnancy. However, the placental hormones can affect maternal insulin levels. The demand for glucose by the fetus during pregnancy is high, but it is not necessarily used more rapidly. Placental hormones, not the woman's dietary intake, play a major role in glucose metabolism during pregnancy.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 362

8. A nurse strongly encourages a pregnant client to avoid eating swordfish and tilefish because these fish contain which component?

- A. excess folic acid, which could increase the risk for neural tube defects
- B. mercury, which could harm the developing fetus if eaten in large amounts
- C. lactose, which leads to abdominal discomfort, gas, and diarrhea
- D. low-quality protein that does not meet the woman's requirements

Answer: B

Rationale: Nearly all fish and shellfish contain traces of mercury, and some contain higher levels of mercury that may harm the developing fetus if ingested by pregnant women in large amounts. Among these fish are shark, swordfish, king mackerel, and tilefish. Folic acid is found in dark green vegetables, baked beans, black-eyed peas, citrus fruits, peanuts, and liver. Folic acid supplements are needed to prevent neural tube defects. Women who are lactose-intolerant experience abdominal discomfort, gas, and diarrhea if they ingest foods containing lactose. Fish and shellfish are an important part of a healthy diet because they contain high-quality proteins, are low in saturated fat, and contain omega-3 fatty acids.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 368

9. Which change in the musculoskeletal system would the nurse mention when teaching a group of pregnant women about the physiologic changes of pregnancy?

- A. ligament tightening
- B. decreased swayback
- C. increased lordosis
- D. joint contraction

Answer: C

Rationale: With pregnancy, the woman's center of gravity shifts forward, requiring a realignment of the spinal curvatures. There is an increase in the normal lumbosacral curve (lordosis).

Ligaments of the sacroiliac joints and pubis symphysis soften and stretch. Increased swayback and an upper spine extension to compensate for the enlarging abdomen occur. Joint relaxation and increased mobility occur due to the influence of the hormones relaxin and progesterone.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 365

10. Assessment of a pregnant woman reveals a pigmented line down the middle of her abdomen. The nurse documents this as which finding?

- A. linea nigra
- B. striae gravidarum (stretch marks)
- C. melasma (chloasma)
- D. vascular spiders

Answer: A

Rationale: Linea nigra refers to the darkened line of pigmentation down the middle of the abdomen in pregnant women. Striae gravidarum refers to stretch marks, irregular reddish streaks on the abdomen, breasts, and buttocks. Melasma (chloasma) refers to the increased pigmentation on the face, also known as the "mask of pregnancy." Vascular spiders are small, spiderlike blood vessels that appear usually above the waist and on the neck, thorax, face, and arms.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 360

11. A nurse is assessing a pregnant woman on a routine checkup. When assessing the woman's gastrointestinal tract, what would the nurse expect to find? Select all that apply.

- A. hyperemic gums
- B. increased peristalsis
- C. reports of bloating
- D. heartburn
- E. nausea

Answer: A, C, D, E

Rationale: Gastrointestinal system changes include hyperemic gums due to estrogen and increased proliferation of blood vessels and circulation to the mouth; slowed peristalsis; acid indigestion and heartburn; bloating and nausea and vomiting.

Question format: Multiple Select

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 365

12. A woman suspecting she is pregnant asks the nurse about which signs would confirm her pregnancy. The nurse would explain that which sign would confirm the pregnancy?

- A. absence of menstrual period
- B. abdominal enlargement
- C. palpable fetal movement
- D. morning sickness

Answer: C

Rationale: Only positive signs of pregnancy would confirm a pregnancy. The positive signs of pregnancy confirm that a fetus is growing in the uterus. Visualizing the fetus by ultrasound, palpating for fetal movements, and hearing a fetal heartbeat are all signs that make the pregnancy a certainty. Absence of menstrual period and morning sickness are presumptive signs, which can be due to conditions other than pregnancy. Abdominal enlargement is a probable sign.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 353

13. A nurse is developing a teaching plan about nutrition for a group of pregnant women. Which recommendations would the nurse include in the discussion? Select all that apply.

- A. Keep weight gain to 15 lb (6.8 kg).
- B. Eat three meals with snacking.
- C. Limit the use of salt in cooking.
- D. Avoid using diuretics.
- E. Participate in physical activity.

Answer: B, D, E

Rationale: To promote optimal nutrition, the nurse would recommend gradual and steady weight gain based on the client's prepregnant weight, eating three meals with one or two snacks daily, not restricting the use of salt unless instructed to do so by the health care provider, avoiding the use of diuretics, and participating in reasonable physical activity daily.

Question format: Multiple Select

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 371

14. Assessment of a pregnant woman reveals that she compulsively craves ice. The nurse documents this finding as:

- A. quickening.
- B. pica.
- C. ballottement.
- D. linea nigra.

Answer: B

Rationale: Pica refers to the compulsive ingestion of nonfood substances such as ice. Quickening refers to the mother's sensation of fetal movement. Ballottement refers to the feeling of rebound from a floating fetus when an examiner pushes against the woman's cervix during a pelvic examination. Linea nigra refers to the pigmented line that develops in the middle of the woman's abdomen.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 372

15. A woman in her second trimester comes for a follow-up visit and says to the nurse, "I feel like I'm on an emotional roller-coaster." Which response by the nurse would be **most** appropriate?

- A. "How often has this been happening to you?"
- B. "Maybe you need some medication to level things out."
- C. "Mood swings are completely normal during pregnancy."
- D. "Have you been experiencing any thoughts of harming yourself?"

Answer: C

Rationale: Emotional lability is characteristic throughout most pregnancies. One moment a woman can feel great joy, and within a short time she can feel shock and disbelief. Frequently, pregnant women will start to cry without any apparent cause. Some women feel as though they are riding an "emotional roller-coaster." These extremes in emotion can make it difficult for partners and family members to communicate with the pregnant woman without placing blame on themselves for their mood changes. Clear explanations about how common mood swings are during pregnancy are essential.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 373

16. While talking with a woman in her third trimester, the nurse understands that which behavior indicates that the woman is learning to give of oneself?

- A. showing concern for self and fetus as a unit
- B. unconditionally accepting the pregnancy without rejection
- C. longing to hold infant

D. questioning ability to become a good mother

Answer: D

Rationale: Learning to give of oneself would be demonstrated when the woman questions her ability to become a good mother to the infant. Showing concern for herself and fetus as a unit reflects the task of ensuring safe passage throughout pregnancy and birth. Unconditionally accepting the pregnancy reflects the task of seeking acceptance of the infant by others. Longing to hold the infant reflects the task of seeking acceptance of self in the maternal role to the infant.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Reference: p. 374

17. A nurse is assessing a client who may be pregnant. The nurse reviews the client's history for presumptive signs. Which signs would the nurse **most** likely note? Select all that apply.

- A. amenorrhea
- B. nausea
- C. abdominal enlargement
- D. Braxton-Hicks contractions
- E. fetal heart sounds

Answer: A, B

Rationale: Presumptive signs include amenorrhea, nausea, breast tenderness, urinary frequency and fatigue. Abdominal enlargement and Braxton-Hicks contractions are probable signs of pregnancy. Fetal heart sounds are a positive sign of pregnancy.

Question format: Multiple Select

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 351

18. After teaching a refresher class to a group of prenatal clinic nurses about pregnancy, insulin, and glucose, the nurse determines that additional teaching is needed when the group identifies which hormone as being involved with opposing insulin?

- A. prolactin
- B. estrogen
- C. progesterone
- D. aldosterone

Answer: D

Rationale: Prolactin, estrogen, and progesterone are all thought to oppose insulin. As a result, glucose is less likely to enter the mother's cells and is more likely to cross over the placenta to the fetus. Aldosterone does not oppose insulin.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 362

19. A pregnant woman comes to the clinic and tells the nurse that she has been having a whitish vaginal discharge. The nurse suspects vulvovaginal candidiasis based on which assessment finding?

- A. fever
- B. vaginal itching
- C. urinary frequency
- D. incontinence

Answer: B

Rationale: Vaginal secretions become more acidic, white, and thick during pregnancy. Most women experience an increase in a whitish vaginal discharge, called leukorrhea. This is normal except when it is accompanied by itching and irritation, possibly suggesting *Candida albicans*, a monilial vaginitis, which is a very common occurrence in this glycogen-rich environment. Fever would suggest a more serious infection. Urinary frequency occurs commonly in the first trimester, disappears during the second trimester, and reappears during the third trimester. Incontinence would not be associated with a vulvovaginal candidiasis. Incontinence would require additional evaluation.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 355

20. A woman is at 20 weeks' gestation. The nurse would expect to find the fundus at which area?

- A. just above the symphysis pubis
- B. midway between the pubis and umbilicus
- C. at the level of the umbilicus
- D. midway between the umbilicus and xiphoid process

Answer: C

Rationale: The uterus, which starts as a pear-shaped organ, becomes ovoid as length increases over width. By 20 weeks' gestation, the fundus, or top of the uterus, is at the level of the umbilicus and measures 20 cm. A monthly measurement of the height of the top of the uterus in centimeters, which corresponds to the number of gestational weeks, is commonly used to date the pregnancy.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 354

21. A woman comes to the prenatal clinic for an evaluation because she thinks that she may be pregnant. The nurse is assisting the health care provider with the vaginal examination. The exam reveals a vaginal mucosa and cervix that are bluish-purple in color. Based on this information, the nurse suspects that the client is **most** likely how many weeks pregnant?

- A. 5 weeks
- B. 6 weeks
- C. 14 weeks
- D. 16 weeks

Answer: B

Rationale: The finding indicates Chadwick's sign, a bluish-purple discoloration of the vaginal mucosa and cervix. This typically occurs between 6 to 8 weeks. Goodell's sign (softening of the cervix) occurs at about 5 weeks. Abdominal enlargement typically begins at about 14 weeks and ballottement (when the examiner pushes against the woman's cervix during a pelvic examination and feels a rebound from the floating fetus) usually occurs at about 16 weeks.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 355

22. A nurse is monitoring a client's hCG levels because she has had a previous ectopic pregnancy and one spontaneous abortion. Which finding would the nurse interpret as indicating that the pregnancy is progressing appropriately?

- A. doubling of the level every 2 to 3 days
- B. plateauing of the level at 7 days
- C. gradually increasing levels every month
- D. abruptly declining levels after 60 days

Answer: A

Rationale: Human chorionic gonadotropin (hCG) is a glycoprotein and the earliest biochemical marker for pregnancy. Many pregnancy tests are based on the recognition of hCG or a beta subunit of hCG. hCG levels in normal pregnancy usually double every 48 to 72 hours until they peak approximately 60 to 70 days after fertilization. At this point, they decrease to a plateau at 100 to 130 days of pregnancy.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential
Reference: p. 352

23. A nurse is providing nutritional counseling to a pregnant woman and gives her suggestions about consuming foods that are high in folic acid. As part of the plan of care, the client is to keep a food diary that the client and nurse will review at the next visit. When reviewing the client's diary, which meals would indicate to the nurse that the client is increasing her intake of folic acid? Select all that apply.

- A. chicken breast with baked potato and broccoli
- B. cheeseburger with spinach and baked beans
- C. pork chop with mashed potatoes and green beans
- D. strawberry walnut salad with romaine lettuce
- E. fried chicken sandwich with mayonnaise and avocado

Answer: A, B, D

Rationale: Good food sources of folic acid include dark green vegetables, such as broccoli, romaine lettuce, and spinach; baked beans; black-eyed peas; citrus fruits; peanuts; and liver. So the meals containing chicken breast with baked potato and broccoli, cheeseburger with spinach and baked beans, and the strawberry walnut salad with romaine lettuce demonstrate an intake of foods high in folic acid.

Question format: Multiple Select

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 367

24. A pregnant woman asks the nurse, "I've heard that I should avoid eating certain types of fish. So what fish can I eat?" Which type of fish would the nurse recommend? Select all that apply.

- A. shark
- B. tilefish
- C. shrimp
- D. salmon
- E. catfish

Answer: C, D, E

Rationale: The nurse should recommend eating up to 12 ounces (two average meals) weekly of low-mercury-level fish such as shrimp, canned light tuna, salmon, pollock, and catfish and avoid eating shark, swordfish, king mackerel, orange roughy, ahi tuna, and tilefish because they are high in mercury levels.

Question format: Multiple Select

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 368

25. A woman in her second trimester comes to the clinic for a routine follow-up visit. The woman's prepregnancy blood pressure was 112/70 mm Hg. On this visit, the woman's blood pressure is 104/64 mm Hg. The nurse would interpret this finding as suggestive of which event?
- A. A normal pregnancy finding secondary to progesterone effects
 - B. Indication that the woman is experiencing orthostatic hypotension
 - C. Signal that the woman is developing gestational hypertension
 - D. Sign that the woman is anemic

Answer: A

Rationale: Blood pressure, especially the diastolic pressure, declines slightly during pregnancy as a result of peripheral vasodilation caused by progesterone. It usually reaches a low point mid-pregnancy and thereafter increases to prepregnancy levels until term. During the first trimester, blood pressure typically remains at the prepregnancy level. During the second trimester, the blood pressure decreases 5 to 10 mm Hg and thereafter returns to first-trimester levels. This decrease in blood pressure begins at about 7 weeks' gestation and persists until 32 weeks' gestation, when it begins to rise to prepregnancy levels. The client's blood pressure suggests a normal finding related to peripheral vasodilation from progesterone. Any significant rise in blood pressure during pregnancy should be investigated to rule out gestational hypertension.

Gestational hypertension is a clinical diagnosis defined by the new onset of hypertension (systolic of 140 mm Hg or higher and/or diastolic of 90 mm Hg or higher) after 20 weeks' gestation. A lower blood pressure does not suggest anemia. Orthostatic hypotension occurs when the blood pressure drops more than 20 mm Hg systolic or 10 mm Hg diastolic with a change in position, such as going from a lying to a standing position.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 357

26. At a routine visit, a pregnant woman nearing the end of her second trimester tells the nurse, "It is so strange. I lie down to go to sleep and then I have to get up to go to the bathroom. This always happens when I am trying to sleep." Which response by the nurse would be appropriate?
- A. "You might be developing a urinary tract infection. Let's get a urine sample."
 - B. "Your kidneys increase their activity when you lie down causing you to urinate."
 - C. "Lying on your side instead of lying on your back will help stop this problem."
 - D. "Maybe you are drinking too much fluid before you go to bed."

Answer: B

Rationale: The activity of the kidneys normally increases when a person lies down and decreases upon standing. This difference is amplified during pregnancy, which is one reason a pregnant woman feels the need to urinate frequently while trying to sleep. Late in the pregnancy (third trimester), the increase in kidney activity is even greater when the woman lies on her side rather

than her back. Lying on either side relieves the pressure that the enlarged uterus puts on the vena cava carrying blood from the legs. Subsequently, venous return to the heart increases, leading to increased cardiac output. Increased cardiac output results in increased renal perfusion and glomerular filtration. The woman has not voiced any reports suggesting a urinary tract infection. Fluid intake may be contributing to the woman's urination concern, but it is important for the woman to drink adequate amounts of fluid.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 358

27. A nurse is teaching a pregnant woman about ways to prevent the development of the food-borne illness listeriosis. The nurse determines that the teaching was successful when the woman identifies the need to avoid which food(s)? Select all that apply.

- A. Soft cheeses
- B. Refrigerated meat spreads
- C. Canned tuna fish
- D. Store-made chicken salad
- E. Pasteurized milk

Answer: A, B, D

Rationale: To prevent listeriosis, the woman should avoid soft cheeses such as feta, Brie, Camembert, and blue-veined cheeses, refrigerated pâté or meat spreads, refrigerated smoked seafood unless it is an ingredient in a cooked dish such as a casserole, salads made in the store such as ham salad, chicken salad, egg salad, tuna salad, or seafood salad, and unpasteurized milk. It is safe to eat canned or shelf-stable pâté and meat spreads and canned fish such as salmon and tuna or shelf-stable smoked seafood.

Question format: Multiple Select

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 369

28. The nurse is assessing a pregnant woman who is at 12 weeks' gestation. The woman's BMI was 18 prior to becoming pregnant. Her prepregnancy weight was 98 lb (44.5 kg). Which measurement would the nurse determine as appropriate weight gain for the woman during the first trimester?

- A. 99 lb (45 kg)
- B. 100 lb (45.5 kg)
- C. 102 lb (46 kg)
- D. 104 lb (47 kg)

Answer: D

Rationale: During the first trimester, for underweight women, weight gain should be at least 5 lb (2.25 kg). For this woman with a prepregnancy weight of 98 lb (44.5), a weight of 104 lb (47 kg) would meet this criteria.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 369

29. A nurse is conducting a class for a group of pregnant women in their first trimester about the emotional responses that occur during pregnancy. Which response would the nurse identify as being seen commonly during the second trimester?

- A. Introversion
- B. Ambivalence
- C. Acceptance
- D. Emotional balance

Answer: C

Rationale: During the second trimester, the physical changes of pregnancy, including an enlarging abdomen and fetal movement, bring a sense of reality and validity to the pregnancy leading to acceptance. Ambivalence, or having conflicting feelings at the same time, is a universal feeling and is considered normal when preparing for a lifestyle change and new role. Pregnant women commonly experience ambivalence during the first trimester. Usually ambivalence evolves into acceptance by the second trimester, when fetal movement is felt. Introversion seems to heighten during the first and third trimesters, when the woman's focus is on behaviors that will ensure a safe and healthy pregnancy outcome. Emotional lability, not emotional balance, is characteristic throughout most pregnancies. One moment a woman can feel great joy, and within a short time, she can feel shock and disbelief. It is not more common during one trimester or another.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 373

30. A nurse is assessing a pregnant woman and suspects that the woman may be experiencing pica. To help support this suspicion, the nurse evaluates the woman for signs and symptoms of which condition?

- A. Iron-deficiency anemia
- B. Urinary tract infection
- C. Diarrhea

D. Heartburn

Answer: A

Rationale: Three main substances consumed by women with pica are soil or clay (geophagia), ice (pagophagia), and laundry starch (amylophagia). Because each of these can lead to iron-deficiency anemia, the nurse should evaluate the client for the condition. Urinary tract infection, diarrhea, and heartburn are not associated with pica.

Question format: Multiple Choice

Chapter 11: Maternal Adaptation During Pregnancy

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 372

Chapter 12

1. A woman in the 34th week of pregnancy says to the nurse, "I still feel like having intercourse with my husband." The woman's pregnancy has been uneventful. The nurse responds based on the understanding that:

- A. it is safe to have intercourse at this time.
- B. intercourse at this time is likely to cause rupture of membranes.
- C. there are other ways that the couple can satisfy their needs.
- D. intercourse at this time is likely to result in premature labor.

Answer: A

Rationale: Sexual activity is permissible during pregnancy unless there is a history of vaginal bleeding, placenta previa, risk of preterm labor, multiple gestation, incompetent cervix, premature rupture of membranes, or presence of infection. Rupture of membranes or premature labor is unlikely since the woman's pregnancy has been uneventful so far. Alternative sexual positions may be necessary as the woman's abdomen increases in size.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 398

2. On the first prenatal visit, examination of the woman's internal genitalia reveals a bluish coloration of the cervix and vaginal mucosa. The nurse documents this finding as:

- A. Hagar sign.
- B. Goodall sign.
- C. Chadwick sign.
- D. Homans sign.

Answer: C

Rationale: Chadwick sign refers to the bluish coloration of the cervix and vaginal mucosa. Hegar sign refers to softening of the isthmus. Goodell sign refers to softening of the cervix. Homans sign indicates pain on dorsiflexion of the foot.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 375

3. A nurse is teaching a pregnant couple about birth education. The nurse determines that the teaching was successful when the couple makes which statement?

- A. "We'll have the knowledge to ensure a pain-free birth."

- B. "We'll know what to do to actively take part in our child's birth."
- C. "We won't be anxious, so the birth will be uncomplicated."
- D. "We will be in total control of the birth process."

Answer: B

Rationale: The primary focus of birth education is to provide information and support to clients and their families to foster a more active role in the upcoming birth. Some methods of birth education focus on pain-free childbirth. Information provided in birth education classes helps to minimize anxiety and provide the couple with control over the situation, but elimination of anxiety or total control is unrealistic.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 404

4. When assessing a woman at follow-up prenatal visits, the nurse would anticipate which procedure to be performed?

- A. hemoglobin and hematocrit
- B. urine for culture
- C. fetal ultrasound
- D. fundal height measurement

Answer: D

Rationale: On every follow-up visit, fundal height measurements are performed to evaluate fetal growth and gestation. Hemoglobin and hematocrit, as part of a complete blood count, would be done on the initial visit and then repeated if the woman's status indicates a need for doing so. Urine is checked for protein, glucose, ketones, and nitrates. A culture would be done if there are signs and symptoms of an infection. Fetal ultrasound can be done at any time during the prenatal period, but it is not done at every visit.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 377

5. During a routine prenatal visit, a client, 36 weeks pregnant, states she has difficulty breathing and feels like her pulse rate is really fast. The nurse finds her pulse to be 100 beats per minute (increased from baseline readings of 70 to 74 beats per minute) and irregular, with bilateral crackles in the lower lung bases. Which nursing diagnosis would be the priority for this client?

- A. Ineffective tissue perfusion related to supine hypotensive syndrome
- B. Impaired gas exchange related to pulmonary congestion
- C. Activity intolerance related to increased metabolic requirements
- D. Anxiety related to fear of pregnancy outcome

Answer: B

Rationale: Typically, heart rate increases by approximately 10 to 15 beats per minute during pregnancy and the lungs should be clear. Dyspnea may occur during the third trimester as the enlarging uterus presses on the diaphragm. However, the findings described indicate that the woman is experiencing impaired gas exchange. There is no evidence to support supine hypotensive syndrome, increased metabolism, or anxiety.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 393

6. When preparing a woman for an amniocentesis, the nurse would instruct her to perform which action?

- A. Shower with an antiseptic scrub.
- B. Swallow the preprocedure sedative.
- C. Empty the bladder.
- D. Lie on the left side.

Answer: C

Rationale: Before an amniocentesis, the woman should empty her bladder to reduce the risk of bladder puncture during the procedure. Showering with an antiseptic scrub and preprocedural sedation are not necessary. The woman usually is positioned in a way that provides an adequate pocket of amniotic fluid on ultrasound.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 383

7. A client who is 4 months pregnant is at the prenatal clinic for her initial visit. Her history reveals she has 7-year-old twins who were born at 34 weeks' gestation, a 2-year-old son born at 39 weeks' gestation, and a spontaneous abortion (miscarriage) 1 year ago at 6 weeks' gestation. Using the GTPAL method, the nurse would document her obstetric history as:

- A. 3 2 1 0 3.
- B. 3 1 2 2 3.
- C. 4 1 1 1 3.
- D. 4 2 1 3 1.

Answer: C

Rationale: Using the GTPAL method, the woman's history would be documented as 4 (her fourth pregnancy), 1 (number of term pregnancies), 1 (number of pregnancies ending in preterm birth),

1 (number of pregnancies ending before 20 weeks or viability), and 3 (number of living children).

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Reference: p. 374

8. A client's last menstrual period was April 11. Using the Naegele rule, her estimated date of delivery (EDD) would be:

- A. January 4.
- B. January 18.
- C. January 25.
- D. February 24.

Answer: B

Rationale: To use the Naegele rule, subtract 3 months and then add 7 days to the first day of the client's LMP (April 11): April minus 3 months is January, plus 7 days is 18. Thus, her EDB would be January 18 of the next year.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 372

9. During a nonstress test, when monitoring the fetal heart rate, the nurse notes that when the expectant mother reports fetal movement, the heart rate increases 15 beats or more above the baseline. This occurs about 4 or 5 times during the testing period. The nurse interprets this as:

- A. variable decelerations.
- B. fetal tachycardia.
- C. a nonreactive pattern.
- D. reactive pattern.

Answer: D

Rationale: A reactive NST includes at least two fetal heart rate accelerations from the baseline of at least 15 bpm for at least 15 seconds within the 20-minute recording period. If the test does not meet these criteria after 40 minutes, it is considered nonreactive. A nonreactive NST is characterized by the absence of two fetal heart rate accelerations using the 15-by-15 criterion in a 20-minute time frame. An increase in the fetal heart rate does not indicate variable decelerations. Fetal tachycardia would be noted as a heart rate greater than 160 bpm.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 385

10. A nurse is assessing a pregnant woman in her last trimester. Which question would be **most** appropriate to use to gather information about weight gain and fluid retention?

- A. "What's your usual dietary intake for a typical week?"
- B. "What size maternity clothes are you wearing now?"
- C. "How puffy does your face look by the end of a day?"
- D. "How swollen do your ankles appear before you go to bed?"

Answer: D

Rationale: Edema, especially in the dependent areas such as the legs and feet, occurs throughout the day due to gravity. It improves after a night's sleep. Therefore, questioning the client about ankle swelling would provide the most valuable information. Asking about her usual dietary intake would be valuable in assessing complaints of heartburn and indigestion. The size of maternity clothing may provide information about weight gain but would have little significance for fluid retention. Swelling in the face may suggest preeclampsia, especially if it is accompanied by dizziness, blurred vision, headaches, upper quadrant pain, or nausea.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 394

11. A pregnant woman in the 36th week of gestation reports that her feet are quite swollen at the end of the day. After careful assessment, the nurse determines that this is an expected finding at this stage of pregnancy. Which intervention is appropriate for the nurse to suggest?

- A. "Limit your intake of fluids."
- B. "Eliminate salt from your diet."
- C. "Try elevating your legs when you sit."
- D. "Wear spandex-type full-length pants."

Answer: C

Rationale: The client is experiencing dependent edema due to the effect of gravity and increased capillary permeability caused by elevated hormone levels and increased blood volume and accompanied by sodium and water retention. The best suggestion would be to encourage the woman to elevate her legs when sitting to promote venous return and minimize the effects of gravity. Neither fluids nor salt should be limited or eliminated. Six to eight glasses of water each day are necessary to replace fluids lost through perspiration. Foods high in sodium should be avoided. Spandex-type full-length pants would be constricting and interfere with venous return.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 394

12. A pregnant woman needs an update in her immunizations. Which vaccination would the nurse ensure that the woman receives?

- A. measles
- B. mumps
- C. rubella
- D. hepatitis B

Answer: D

Rationale: Hepatitis B vaccine should be considered during pregnancy. Immunizations for measles, mumps, and rubella are contraindicated during pregnancy.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 401

13. A pregnant woman is flying across the country to visit her family. After teaching the woman about traveling during pregnancy, which statement indicates that the teaching was successful?

- A. "I'll sit in a window seat so I can focus on the sky to help relax me."
- B. "I won't drink too much fluid so I don't have to urinate so often."
- C. "I'll get up and walk around the airplane about every 2 hours."
- D. "I'll do some upper arm stretches while sitting in my seat."

Answer: C

Rationale: When traveling by airplane, the woman should get up and walk about the plane every 2 hours to promote circulation. An aisle seat is recommended so that she can have easy access to the aisle. Drinking water throughout the flight is encouraged to maintain hydration. Calf-tensing exercises are important to improve circulation to the lower extremities.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 418

14. During a routine prenatal visit, a client, 36 weeks pregnant, states she has difficulty breathing and feels like her pulse rate is really fast. The nurse finds her pulse to be 100 beats per minute (increased from baseline readings of 70 to 74 beats per minute) and irregular, with bilateral crackles in the lower lung bases. Which nursing diagnosis would be the **priority** for this client?

- A. Ineffective tissue perfusion related to supine hypotensive syndrome
- B. Impaired gas exchange related to pulmonary congestion
- C. Activity intolerance related to increased metabolic requirements
- D. Anxiety related to fear of pregnancy outcome

Answer: B

Rationale: Typically, heart rate increases by approximately 10 to 15 beats per minute during pregnancy, and the lungs should be clear. Dyspnea may occur during the third trimester as the enlarging uterus presses on the diaphragm. However, the findings described indicate that the woman is experiencing impaired gas exchange. There is no evidence to support supine hypotensive syndrome, increased metabolism, or anxiety.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 411

15. A biophysical profile has been completed on a pregnant woman. The nurse interprets which score as normal?

- A. 9
- B. 7
- C. 5
- D. 3

Answer: A

Rationale: The biophysical profile is a scored test with five components, each worth 2 points if present. A total score of 10 is possible if the NST is used. Overall, a score of 8 to 10 is considered normal if the amniotic fluid volume is adequate. A score of 6 or below is suspicious, possibly indicating a compromised fetus; further investigation of fetal well-being is needed.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 404

16. A nurse is teaching a pregnant client in her first trimester about discomforts that she may experience. The nurse determines that the teaching was successful when the woman identifies which discomforts as common during the first trimester? Select all that apply.

- A. urinary frequency
- B. breast tenderness
- C. cravings
- D. backache
- E. leg cramps

Answer: A, B, C

Rationale: Discomforts common in the first trimester include urinary frequency, breast tenderness, and cravings. Backache and leg cramps are common during the second trimester. Legs cramps are also common during the third trimester.

Question format: Multiple Select

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 407

17. A nurse is reviewing the medical record of a pregnant woman and notes that she is gravida II. The nurse interprets this to indicate the number of:

- A. births.
- B. pregnancies.
- C. spontaneous abortions.
- D. preterm births.

Answer: B

Rationale: Gravida refers to a pregnant woman—gravida I (primigravida) during the first pregnancy, gravida II (secundigravida) during the second pregnancy, and so on. Para refers to the number of births at 20 weeks or greater that a woman has, regardless of whether the newborn is born alive or dead. "A" would be used to denote the number of abortions and "P" would be used to denote the number of preterm births when using the GTPAL system.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 390

18. A nurse measures a pregnant woman's fundal height and finds it to be 28 cm. The nurse interprets this to indicate that the client is at how many weeks' gestation?

- A. 14 weeks' gestation
- B. 20 weeks' gestation
- C. 28 weeks' gestation
- D. 36 weeks' gestation

Answer: C

Rationale: Typically, the height of the fundus is measured when the uterus arises out of the pelvis to evaluate fetal growth. At 12 weeks' gestation the fundus can be palpated at the symphysis pubis. At 16 weeks' gestation the fundus is midway between the symphysis and the umbilicus. At 20 weeks the fundus can be palpated at the umbilicus and measures approximately 20 cm from the symphysis pubis. By 36 weeks the fundus is just below the xiphoid process and measures approximately 36 cm.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 396

19. A pregnant woman has a rubella titer drawn on her first prenatal visit. The nurse explains that this test measures:

- A. platelet level.
- B. Rh status.
- C. immunity to German measles.
- D. red blood cell count.

Answer: C

Rationale: A rubella titer detects antibodies for the virus that causes German measles. If the titer is 1:8 or less, the woman is not immune and requires immunization after birth. Platelet level and red blood cell count would be determined by a complete blood count. Rh status would be determined by blood typing.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 394

20. A nurse is working with a pregnant client to schedule follow-up visits for the pregnancy. Which statement by the client indicates that she understands the scheduling?

- A. "I need to make visits every 2 months until I am 36 weeks' pregnant."
- B. "Once I get to 28 weeks' pregnant, I have to come twice a month."
- C. "From now until I am 28 weeks' pregnant, I will be coming once a month."
- D. "I will make sure to get a day off every 2 weeks to make my visits."

Answer: C

Rationale: Continuous prenatal care is important for a successful pregnancy outcome. The recommended follow-up visit schedule for a healthy pregnant woman is as follows: every 4 weeks up to 28 weeks' (7 months') gestation; every 2 weeks from 29 to 36 weeks' gestation; every week from 37 weeks' gestation to birth.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 395

21. A nurse is describing the various birth methods to pregnant couples. Which information would the nurse include as part of the Lamaze method?

- A. focus on the pleasurable sensations of birth
- B. concentration on sensations while turning on to own bodies
- C. interruption of the fear-tension-pain cycle
- D. use of specific breathing and relaxation techniques

Answer: D

Rationale: Lamaze is a psychoprophylactic ("mind prevention") method of preparing for labor and birth that promotes the use of specific breathing and relaxation techniques. The Bradley method emphasizes the pleasurable sensations of birth, teaching women to concentrate on these sensations while "turning on" to their own bodies. The Dick-Read method seeks to interrupt the circular pattern of fear, tension, and pain during the labor and birthing process.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 421

22. After teaching a group of prospective new parents about the different perinatal education methods, the nurse determines that the teaching was successful when the parents identify which method as the Bradley method?

- A. psychoprophylactic method
- B. partner-coached method
- C. natural birth method
- D. mind prevention method

Answer: B

Rationale: The Bradley method is also a partner-coached method that uses various exercises and slow, controlled abdominal breathing to accomplish relaxation and active participation of the partner as labor coach. The Lamaze method is a psychoprophylactic or mind prevention method. The Dick-Read method is referred to as natural birth. Dick-Read believed that prenatal instruction was essential for pain relief and that emotional factors during labor interfered with the normal labor progression. The woman achieves relaxation and reduces pain by arming herself with the knowledge of normal childbirth and using abdominal breathing during contractions.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 421

23. A pregnant woman in her second trimester tells the nurse, "I've been passing a lot of gas and feel bloated." Which suggestion would be helpful for the woman? Select all that apply.

- A. "Watch how much beans and onions you eat."
- B. "Limit the amount of fluid you drink with meals."
- C. "Try exercising a little more."
- D. "Some say that eating mints can help."
- E. "Cut down on your intake of cheeses."

Answer: A, C, D, E

Rationale: For gas and bloating, the nurse would instruct the woman to avoid gas-forming foods, such as beans, cabbage, and onions, as well as foods that have a high content of white sugar. Adding more fiber to the diet, increasing fluid intake, and increasing physical exercise are also helpful in reducing flatus. In addition, reducing the amount of swallowed air when chewing gum or smoking will reduce gas build-up. Reducing the intake of carbonated beverages and cheese and eating mints can also help reduce flatulence during pregnancy.

Question format: Multiple Select

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 411

24. When describing perinatal education to a pregnant woman and her partner, the nurse emphasizes which goal as the **primary** one?

- A. Equip a couple with the knowledge to experience a pain-free birth.
- B. Provide knowledge and skills to actively participate in birth and parenting.
- C. Eliminate anxiety so that they can have an uncomplicated birth.
- D. Empower the couple to totally control the birth process.

Answer: B

Rationale: The primary focus of perinatal education is to provide information and support to clients and their families to foster a more active role in the upcoming birth. It also includes preparation for breastfeeding, infant care, transition to new parenting roles, relationships skills, family health promotion, and sexuality. Some methods of birth education focus on pain-free birth. Information provided in birth education classes helps to minimize anxiety and provide the couple with control over the situation, but elimination of anxiety or total control is unrealistic.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 420

25. During a routine prenatal visit, a client at 36 weeks' gestation states she has difficulty breathing and feels like her pulse rate is really fast. The nurse finds her pulse to be 100 beats per minute (increased from baseline readings of 70 to 74 beats per minute) and irregular, with bilateral crackles in the lower lung bases. The nurse would develop a plan of care identifying interventions to promote which area as the **priority**?

- A. tissue perfusion
- B. gas exchange
- C. activity
- D. anxiety

Answer: B

Rationale: Typically, heart rate increases by approximately 10 to 15 beats per minute during pregnancy and the lungs should be clear. Dyspnea may occur during the third trimester as the enlarging uterus presses on the diaphragm. However, the findings described indicate that the woman is experiencing impaired gas exchange. There is no evidence to support problems with tissue perfusion, activity, or anxiety.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 411

26. A pregnant woman is scheduled to undergo an amniocentesis. When explaining this test to the client, the nurse would also include information about which test being done at the same time?

- A. ultrasound
- B. chorionic villus sampling
- C. biophysical profile
- D. Doppler flow study

Answer: A

Rationale: An ultrasound is used to confirm placental location during amniocentesis. Chorionic villus sample, biophysical profile, and Doppler flow study are not done at the same time as an amniocentesis.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 401

27. A nurse is auscultating the chest of a client at 16 weeks' gestation. The nurse immediately notifies the health care provider about which finding?

- A. heart rate 25 bpm above baseline
- B. soft systolic murmur
- C. clear breath sounds
- D. symmetrical chest movement.

Answer: A

Rationale: Heart rate typically increases by 10 to 15 bpm starting between 14 to 20 weeks of pregnancy. However, an increase of 25 bpm would be a cause for concern. A soft systolic murmur, clear breath sounds, and symmetrical chest movement are normal findings.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 392

28. A nurse is reviewing the results of four clients who have undergone amniocentesis. Which client would the nurse recommend that the health care provider see **first**?

- A. client at 16 weeks' gestation with placenta previa and high alpha-fetoprotein level
- B. client at 34 weeks' gestation with gestational diabetes and L/S ratio of 2:1
- C. client at 36 weeks' gestation with preeclampsia and amniotic fluid negative for bilirubin
- D. client at 38 weeks' gestation with fetal heart rate of 110 and green amniotic fluid sample

Answer: D

Rationale: The client at 38 weeks' gestation should be evaluated first because the green amniotic fluid suggests possible meconium staining and the fetal heart rate is bradycardic. Immediate evaluation and intervention would be essential. A high alpha fetoprotein level may suggest a neural tube defect or possible chromosomal abnormality. Although important to address, this client would not be the priority. The client at 34 weeks' with gestational diabetes and an L/S ratio of 2:1 indicates that the lung of the fetus are mature, should delivery be necessary. Amniotic fluid that is negative for bilirubin is a normal finding.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Analyze

Client Needs: Safe, Effective Care Environment: Management of Care

Reference: p. 402

29. A pregnant woman is scheduled for chorionic villus sampling. The nurse is describing the procedure and the potential for complications. When providing care to the client after the testing, the nurse would be alert for which complication as the **most** common? Select all that apply.

- A. vaginal bleeding
- B. cramping
- C. spontaneous abortion
- D. rupture of membranes
- E. hematoma

Answer: A, B

Rationale: Although spontaneous abortion, rupture of membranes, and hematoma can occur after chorionic villus sampling, vaginal bleeding and cramping are the most common.

Question format: Multiple Select

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 403

30. A 24-year-old client who is planning to become pregnant comes to the clinic for an evaluation. When assessing the client, which finding would alert the nurse to implement measures to reduce the client's risk for problems during pregnancy? Select all that apply.

- A. drinks wine 3 to 4 times/week
- B. quit smoking 4 years ago
- C. follows a vegetarian diet
- D. has a BMI of 22
- E. uses ibuprofen daily

Answer: A, E

Rationale: The use of alcohol and prescription and over-the-counter drugs can be harmful to a growing fetus. Thus the nurse would need to address these areas with the client. If the client was still smoking, then that too would need to be addressed. Healthy nutrition is important, but being a vegetarian does not necessarily indicate that the client is a nutritional risk. A BMI of 22 is considered normal and would not pose a problem.

Question format: Multiple Select

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 382

31. A client comes to the prenatal clinic for her first visit. When determining the client's estimated due date, the nurse understands what method is the **most** accurate?

- A. Nagele's rule
- B. gestational wheel
- C. birth calculator
- D. ultrasound

Answer: D

Rationale: Although there are several methods for determining the EDD, the ultrasound is considered the most accurate method for dating the pregnancy.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 390

32. The nurse is assessing the latest laboratory results of a pregnant client who is at 17 weeks gestation. The nurse should prepare to teach the client about which possible defects after noting the maternal serum alpha-fetoprotein level is elevated above normal?

- A. fetal hypoxia
- B. open spinal defects
- C. Down syndrome
- D. maternal hypertension

Answer: B

Rationale: Elevated MSAFP levels are associated with open neural tube defects, underestimation of gestational age, the presence of multiple fetuses, gastrointestinal defects, low birth weight, oligohydramnios, maternal age, diabetes, and decreased maternal weight. Lower-than-expected MSAFP levels are seen when fetal gestational age is overestimated or in cases of fetal death, hydatidiform mole, increased maternal weight, maternal type 1 diabetes, and fetal trisomy 21 (Down syndrome) or 18. Fetal hypoxia would be noted with fetal heart rate tracings and via nonstress and contraction stress testing. Maternal hypertension would be noted via serial blood pressure monitoring.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 399

33. The nurse is preparing a client for a chorionic villi sampling procedure. Which factor should the nurse point out in the teaching session to the client?

- A. "The results should be available in about 2 weeks."
- B. "You'll have an ultrasound first and then the test."
- C. "Afterward, you can resume your exercise program."
- D. "This test is very helpful for identifying spinal defects."

Answer: B

Rationale: With CVS, an ultrasound is done to confirm gestational age and viability. Then, under continuous ultrasound guidance, CVS is performed using either a transcervical or transabdominal approach. With the transcervical approach, the woman is placed in the lithotomy position and a sterile catheter is introduced through the cervix and inserted in the placenta, where a sample of chorionic villi is aspirated. This approach requires the client to have a full bladder to push the uterus and placenta into a position that is more accessible to the catheter. A full bladder also helps in better visualization of the structures. With the transabdominal approach, an 18-gauge spinal needle is inserted through the abdominal wall into the placental tissue and a sample of chorionic villi is aspirated. Regardless of the approach used, the sample is sent to the cytogenetics laboratory for analysis. The results are usually available in less than one week. After the procedure, the woman is assisted into a position of comfort and any excess lubricant or secretions are cleaned from the area. The woman is instructed about signs to watch for and report, such as fever, cramping, and vaginal bleeding. The woman is also urged not to engage in any strenuous activity for the next 48 hours. RhoGAM is given to an unsensitized Rh-negative woman after the procedure. CVS can be used to detect numerous genetic disorders but not neural tube defects as no amniotic fluid is collected with this procedure. The woman would need to have MSAFP levels drawn at 16 to 18 weeks' gestation to test for neural tube defects.

Question format: Multiple Choice

Chapter 12: Nursing Management During Pregnancy

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 403

Chapter 13

1. A woman in her 40th week of pregnancy calls the nurse at the clinic and says she is not sure whether she is in true or false labor. Which statement by the client would lead the nurse to suspect that the woman is experiencing false labor?

- A. "I'm feeling contractions mostly in my back."
- B. "My contractions are about 6 minutes apart and regular."
- C. "The contractions slow down when I walk around."
- D. "If I try to talk to my partner during a contraction, I can't."

Answer: C

Rationale: False labor is characterized by contractions that are irregular and weak, often slowing down with walking or a position change. True labor contractions begin in the back and radiate around toward the front of the abdomen. They are regular and become stronger over time; the woman may find it extremely difficult if not impossible to have a conversation during a contraction.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 440

2. A client is in the third stage of labor. Which finding would alert the nurse that the placenta is separating?

- A. uterus becomes globular
- B. fetal head at vaginal opening
- C. umbilical cord shortens
- D. mucous plug is expelled

Answer: A

Rationale: Placental separation is indicated by the uterus changing shape to globular and upward rising of the uterus. Additional signs include a sudden trickle of blood from the vaginal opening, and lengthening (not shortening) of the umbilical cord. The fetal head at the vaginal opening is termed crowning and occurs before birth of the head. Expulsion of the mucous plug is a premonitory sign of labor.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 460

3. When assessing cervical effacement of a client in labor, the nurse assesses which characteristic?

- A. extent of opening to its widest diameter
- B. degree of thinning
- C. passage of the mucous plug
- D. fetal presenting part

Answer: B

Rationale: Effacement refers to the degree of thinning of the cervix. Cervical dilation refers to the extent of opening at the widest diameter. Passage of the mucous plug occurs with bloody show as a premonitory sign of labor. The fetal presenting part is determined by vaginal examination and is commonly the head (cephalic), pelvis (breech), or shoulder.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Reference: p. 438

4. A woman calls the health care facility stating that she is in labor. The nurse would urge the client to come to the facility if the client reports which symptom?

- A. increased energy level with alternating strong and weak contractions
- B. moderately strong contractions every 4 minutes, lasting about 1 minute
- C. contractions noted in the front of abdomen that stop when she walks
- D. pink-tinged vaginal secretions and irregular contractions lasting about 30 seconds

Answer: B

Rationale: Moderately strong regular contractions 60 seconds in duration indicate that the client is probably in the active phase of the first stage of labor. Alternating strong and weak contractions, contractions in the front of the abdomen that change with activity, and pink-tinged secretions with irregular contractions suggest false labor.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 457

5. A woman is in the first stage of labor. The nurse would encourage her to assume which position to facilitate the progress of labor?

- A. supine
- B. lithotomy
- C. upright
- D. knee-chest

Answer: C

Rationale: The use of any upright position helps to reduce the length of labor. Research shows that women who assumed the upright position during the first stage of labor experienced significant improvement in the progress of labor, faster fetal head descent, significant reduction of pain, and a good Apgar score. Additionally, studies show that recumbent positions result in supine hypotension, diminishing uterine activity and reducing the dimensions of the pelvic outlet. The knee–chest position would assist in rotating the fetus in a posterior position.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 452

6. A client has not received any medication during her labor. She is having frequent contractions about every 1 to 2 minutes and has become irritable with her coach and no longer will allow the nurse to palpate her fundus during contractions. Her cervix is 8 cm dilated and 90% effaced. The nurse interprets these findings as indicating:

- A. latent phase of the first stage of labor.
- B. perineal phase of the first stage of labor.
- C. late active phase of the first stage of labor.
- D. early phase of the third stage of labor.

Answer: C

Rationale: Late in the active phase of labor, contractions become more frequent (every 2 to 5 minutes) and increase in duration (45 to 60 seconds). The woman's discomfort intensifies (moderate to strong by palpation). She becomes more intense and inwardly focused, absorbed in the serious work of her labor. She limits interactions with those in the room. The latent phase is characterized by mild contractions every 5 to 10 minutes, cervical dilation of 0 to 3 cm and effacement of 0% to 40%, and excitement and frequent talking by the mother. The pelvic phase of the second stage of labor is characterized by complete cervical dilation and effacement, with strong contractions every 2 to 3 minutes; the mother focuses on pushing. The perineal phase of the second stage is the period of active pushing. The third stage, placental expulsion, starts after the newborn is born and ends with the separation and birth of the placenta

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 456

7. The fetus of a nulliparous woman is in a shoulder presentation. The nurse would prepare the client for which type of birth?

- A. cesarean
- B. vaginal
- C. forceps-assisted
- D. vacuum extraction

Answer: A

Rationale: The fetus is in a transverse lie with the shoulder as the presenting part, necessitating a cesarean birth. Vaginal birth, forceps-assisted, and vacuum extraction births are not appropriate.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 446

8. Assessment of a woman in labor reveals cervical dilation of 3 cm, cervical effacement of 30%, and contractions occurring every 7 to 8 minutes, lasting about 40 seconds. The nurse determines that this client is in:

- A. latent phase of the first stage.
- B. active phase of the first stage.
- C. pelvic phase of the second stage.
- D. early phase of the third stage.

Answer: A

Rationale: The latent phase of the first stage of labor involves cervical dilation of 0 to 3 cm, cervical effacement of 0% to 40%, and contractions every 5 to 10 minutes lasting 30 to 45 seconds. The active phase is characterized by cervical dilation of 4 to 7 cm, effacement of 40% to 80%, and contractions occurring every 2 to 5 minutes lasting 45 to 60 seconds. The perineal phase of the second stage occurs with complete cervical dilation and effacement, contractions occurring every 2 to 3 minutes and lasting 60 to 90 seconds, and a tremendous urge to push by the mother. The third stage, placental expulsion, starts after the newborn is born and ends with the separation and birth of the placenta.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 457

9. A client is admitted to the labor and birthing suite in early labor. On review of her prenatal history, the nurse determines that the client's pelvic shape as identified in the antepartal progress notes is the most favorable one for a vaginal birth. Which pelvic shape would the nurse have noted?

- A. platypelloid
- B. gynecoid
- C. android
- D. anthropoid

Answer: B

Rationale: The most favorable pelvic shape for vaginal birth is the gynecoid shape. The anthropoid pelvis is favorable for vaginal birth, but it is not the most favorable shape. The android pelvis is not considered favorable for a vaginal birth because descent of the fetal head is slow and failure of the fetus to rotate is common. Women with a platypelloid pelvis usually require cesarean birth.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 441

10. A woman telephones the prenatal clinic and reports that her water just broke. Which suggestion by the nurse would be **most** appropriate?

- A. "Call us back when you start having contractions."
- B. "Come to the clinic or emergency department for an evaluation."
- C. "Drink 3 to 4 glasses of water and lie down."
- D. "Come in as soon as you feel the urge to push."

Answer: B

Rationale: When the amniotic sac ruptures, the barrier to infection is gone, and there is the danger of cord prolapse if engagement has not occurred. Therefore, the nurse should suggest that the woman come in for an evaluation. Calling back when contractions start, drinking water, and lying down are inappropriate because of the increased risk for infection and cord prolapse. Telling the client to wait until she feels the urge to push is inappropriate because this occurs during the second stage of labor.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 439

11. A nurse is conducting a continuing education program for a group of nurses working in the perinatal unit. After reviewing information about the maternal bony pelvis with the group, the nurse determines that the teaching was successful based on which statement by the group?

- A. The bony pelvis plays a lesser role during labor than soft tissue.
- B. The pelvic outlet is associated with the true pelvis.
- C. The false pelvis lies below the imaginary linea terminalis.
- D. The false pelvis is the passageway through which the fetus travels.

Answer: B

Rationale: The maternal bony pelvis consists of the true and false portions. The true pelvis is made up of three planes—the inlet, the mid pelvis, and the outlet. The bony pelvis is more important part of the passageway because it is relatively unyielding. The false pelvis lies above

the imaginary linea terminalis. The true pelvis is the bony passageway through which the fetus must travel.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 440

12. A nurse is providing care to a pregnant client in labor. Assessment of a fetus identifies the buttocks as the presenting part, with the legs extended upward. The nurse identifies this as which type of breech presentation?

- A. frank
- B. full
- C. complete
- D. footling

Answer: A

Rationale: In a frank breech, the buttocks present first, with both legs extended up toward the face. In a full or complete breech, the fetus sits cross-legged above the cervix. In a footling breech, one or both legs are presenting.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 445

13. A woman in her third trimester comes to the clinic for a prenatal visit. During assessment the woman reports that her breathing has become much easier in the last week but she has noticed increased pelvic pressure, cramping, and lower back pain. The nurse determines that which event has **most** likely occurred?

- A. cervical dilation
- B. lightening
- C. bloody show
- D. Braxton Hicks contractions

Answer: B

Rationale: Lightening occurs when the fetal presenting part begins to descend into the maternal pelvis. The uterus lowers and moves into the maternal pelvis. The shape of the abdomen changes as a result of the change in the uterus. The woman usually notes that her breathing is much easier. However, she may complain of increased pelvic pressure, cramping, and lower back pain. Although cervical dilation also may be occurring, it does not account for the woman's complaints. Bloody show refers to passage of the mucous plug that fills the cervical canal during pregnancy. It occurs with the onset of labor. Braxton Hicks contractions increase in strength and

frequency and aid in moving the cervix from a posterior position to an anterior position. They also help in ripening and softening the cervix.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 438

14. A nurse is conducting an in-service program for a group of nurses working in the labor and birth suite of the facility. After teaching the group about the factors affecting the labor process, the nurse determines that the teaching was successful when the group identifies which component as part of the true pelvis? Select all that apply.

- A. pelvic inlet
- B. cervix
- C. mid pelvis
- D. pelvic outlet
- E. vagina
- F. pelvic floor muscles

Answer: A, C, D

Rationale: The true pelvis is made up of three planes: the pelvic inlet, mid pelvis, and pelvic outlet. The cervix, vagina, and pelvic floor muscles are the soft tissues of the passageway.

Question format: Multiple Select

Chapter 13: Labor and Birth Process

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 440

15. A nurse is providing care to a woman in labor. After assessment of the fetus, the nurse documents the fetal lie. Which term would the nurse use?

- A. flexion
- B. extension
- C. longitudinal
- D. cephalic

Answer: C

Rationale: Fetal lie refers to the relationships of the long axis (spine) of the fetus to the long axis (spine) of the mother. There are three primary lies: longitudinal, oblique, and transverse. Flexion and extension are terms used to describe fetal attitude. Cephalic is a term used to describe fetal presentation.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 444

16. The nurse is reviewing the medical record of a woman in labor and notes that the fetal position is documented as LSA. The nurse interprets this information as indicating which part as the presenting part?

- A. occiput
- B. face
- C. buttocks
- D. shoulder

Answer: C

Rationale: The second letter denotes the presenting part which in this case is "S" or the sacrum or buttocks. The letter "O" would denote the occiput or vertex presentation. The letter "M" would denote the mentum (chin) or face presentation. The letter "A" would denote the acromion or shoulder presentation.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 446

17. A nurse is preparing a class for pregnant women about labor and birth. When describing the typical movements that the fetus goes through as it travels through the passageway, which movements would the nurse include? Select all that apply.

- A. internal rotation
- B. abduction
- C. descent
- D. pronation
- E. flexion

Answer: A, C, E

Rationale: The positional changes that occur as the fetus moves through the passageway are called the cardinal movements of labor and include engagement, descent, flexion, internal rotation, extension, external rotation, and expulsion. The fetus does not undergo abduction or pronation.

Question format: Multiple Select

Chapter 13: Labor and Birth Process

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 448

18. The nurse is reviewing the monitoring strip of a woman in labor who is experiencing a contraction. The nurse notes the time the contraction takes from its onset to reach its highest intensity. The nurse interprets this time as which phase?

- A. increment
- B. acme
- C. peak
- D. decrement

Answer: A

Rationale: Each contraction has three phases: increment or the buildup of the contraction; acme or the peak or highest intensity; and the decrement or relaxation of the uterine muscle fibers. The time from the onset to the highest intensity corresponds to the increment.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 450, Uterine Contractions, Figure 13-13

19. A nurse is assessing a woman in labor. Which finding would the nurse identify as a cause for concern during a contraction?

- A. heart rate increase from 76 bpm to 90 bpm
- B. blood pressure rise from 110/60 mm Hg to 120/74
- C. white blood cell count of 12,000 cells/mm³
- D. respiratory rate of 10 breaths/minute

Answer: D

Rationale: During labor, the mother experiences various physiologic responses including an increase in heart rate by 10 to 20 bpm, a rise in blood pressure by up to 35 mm Hg during a contraction, an increase in white blood cell count to 25,000 to 30,000 cells/mm³, perhaps as a result of tissue trauma, and an increase in respiratory rate with greater oxygen consumption due to the increase in metabolism. A drop in respiratory rate would be a cause for concern.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 455

20. A nurse is caring for several women in labor. The nurse determines that which woman is in the latent phase of labor?

- A. contractions every 5 minutes, cervical dilation 3 cm
- B. contractions every 3 minutes, cervical dilation 6 cm
- C. contractions every 2 1/2 minutes, cervical dilation 8 cm
- D. contractions every 1 minute, cervical dilation 9 cm

Answer: A

Rationale: Contractions every 5 minutes with cervical dilation of 3 cm is typical of the latent phase. Contractions every 3 minutes with cervical dilation of 6 cm, contractions every 2½ minutes with cervical dilation of 8 cm, and contractions every 1 minute with cervical dilation of 9 cm suggest the active phase of labor.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 456

21. A nurse is preparing a presentation for a group of pregnant women about the labor experience. Which factors would the nurse include when discussing measures to promote coping for a positive labor experience? Select all that apply.

- A. presence of a support partner
- B. view of birth as a stressor
- C. low anxiety level
- D. fear of loss of control
- E. participation in a pregnancy exercise program

Answer: A, C, E

Rationale: Numerous factors can affect a woman's coping ability during labor and birth. Having the presence and support of a valued partner during labor, engaging in exercise during pregnancy, viewing the birthing experience as a meaningful rather than stressful event, and a low anxiety level can promote a woman's ability to cope. Excessive anxiety may interfere with the labor progress, and fear of labor and loss of control may enhance pain perception, increasing the fear.

Question format: Multiple Select

Chapter 13: Labor and Birth Process

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 455

22. During a follow-up prenatal visit, a pregnant woman asks the nurse, "How long do you think I will be in labor?" Which response by the nurse would be **most** appropriate?

- A. "It's difficult to predict how your labor will progress, but we'll be there for you the entire time."
- B. "Since this is your first pregnancy, you can estimate it will be about 10 hours."
- C. "It will depend on how big the baby is when you go into labor."
- D. "Time isn't important; your health and the baby's health are key."

Answer: A

Rationale: It is difficult to predict how a labor will progress and therefore equally difficult to determine how long a woman's labor will last. There is no way to estimate the likely strength and frequency of uterine contractions, the extent to which the cervix will soften and dilate, and how

much the fetal head will mold to fit the birth canal. We cannot know beforehand whether the complex fetal rotations needed for an efficient labor will take place properly. All of these factors are unknowns when a woman starts labor. Telling the woman an approximate time would be inappropriate because there is no way to determine the length of labor. It is highly individualized. Although fetal size and maternal and fetal health are important considerations, these responses do not address the woman's concern.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 453

23. A nurse is describing how the fetus moves through the birth canal. Which component would the nurse identify as being **most** important in allowing the fetal head to move through the pelvis?

- A. sutures
- B. fontanelles
- C. frontal bones
- D. biparietal diameter

Answer: A

Rationale: Sutures are important because they allow the cranial bones to overlap in order for the head to adjust in shape (elongate) when pressure is exerted on it by uterine contractions or the maternal bony pelvis. Fontanelles are the intersections formed by the sutures. The frontal bones, along with the parietal and occipital bones are bones of the cranium that are soft and pliable. The biparietal diameter is an important diameter that can affect the birth process.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 443

24. Assessment of a pregnant woman reveals that the presenting part of the fetus is at the level of the maternal ischial spines. The nurse documents this as which station?

- A. -2
- B. -1
- C. 0
- D. +1

Answer: C

Rationale: Station refers to the relationship of the presenting part to the level of the maternal pelvic ischial spines. Fetal station is measured in centimeters and is referred to as a minus or plus, depending on its location above or below the ischial spines. Zero (0) station is designated when the presenting part is at the level of the maternal ischial spines. When the presenting part is

above the ischial spines, the distance is recorded as minus stations. When the presenting part is below the ischial spines, the distance is recorded as plus stations.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Reference: p. 447

25. A nurse is providing care to a pregnant woman in labor. The woman is in the first stage of labor. When describing this stage to the client, which event would the nurse identify as the major change occurring during this stage?

- A. regular contractions
- B. cervical dilation (dilatation)
- C. fetal movement through the birth canal
- D. placental separation

Answer: B

Rationale: The primary change occurring during the first stage of labor is progressive cervical dilation (dilatation). Contractions occur during the first and second stages of labor. Fetal movement through the birth canal is the major change during the second stage of labor. Placental separation occurs during the third stage of labor.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 457

26. A nurse is providing care to a woman in labor. The nurse determines that the client is in the active phase based on which assessment findings? Select all that apply.

- A. cervical dilation of 6 cm
- B. contractions every 2 to 3 minutes
- C. cervical effacement of 30%
- D. contractions every 90 seconds
- E. strong desire to push

Answer: A, B

Rationale: During the active phase, the cervix usually dilates from 6 to 10 cm, with 40% to 100% effacement taking place. Contractions become more frequent, occurring every 2–5 min and increase in duration (45 to 60 seconds). Effacement of 30% reflects the latent phase.

Contractions occurring every 90 seconds suggest the second stage of labor. A strong urge to push reflects the later perineal phase of the second stage of labor.

Question format: Multiple Select

Chapter 13: Labor and Birth Process

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 456

27. A pregnant woman comes to the labor and birth unit in labor. The woman tells the nurse, "Yesterday, I had this burst of energy and cleaned everything in sight, but I don't know why." Which response by the nurse would be **most** appropriate?

- A. "You had a burst of epinephrine, which is common before labor."
- B. "You were trying to get everything ready for your baby."
- C. "You felt your mind telling you that you were about to go into labor."
- D. "You were looking forward to the birth of your baby."

Answer: A

Rationale: Some women report a sudden increase in energy before labor. This is sometimes referred to as nesting because many women will focus this energy toward childbirth preparation by cleaning, cooking, preparing the nursery, and spending extra time with other children in the household. The increased energy level usually occurs 24 to 48 hours before the onset of labor. It is thought to be the result of an increase in epinephrine (adrenaline) release caused by a decrease in progesterone. The burst of energy is unrelated to getting everything ready, the mind telling the woman that she will be going into labor, or looking forward to the birth.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 438

28. A nurse is conducting a class for a group of nurses new to the labor and birth unit about labor and the passage of the fetus through the birth canal. As part of the class, the nurse explains that specific diameters of the fetal skull can affect the birth process. Which diameter would the nurse identify as being most important in affecting the birth process? Select all that apply.

- A. Occipitofrontal
- B. Occipitomental
- C. Suboccipitobregmatic
- D. Biparietal
- E. Diagonal conjugate

Answer: C, D

Rationale: The diameter of the fetal skull is an important consideration during the labor and birth process. Fetal skull diameters are measured between the various landmarks of the skull.

Diameters include occipitofrontal, occipitomental, suboccipitobregmatic, and biparietal. The two most important diameters that can affect the birth process are the suboccipitobregmatic (approximately 9.5 cm at term) and the biparietal (approximately 9.25 cm at term) diameters. Diagonal conjugate is a measure of the pelvic inlet of the mother.

Question format: Multiple Select

Chapter 13: Labor and Birth Process

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 443

29. Assessment of a woman in labor reveals that the fetus is in a cephalic presentation and engagement has occurred. The nurse interprets this finding to indicate that the presenting part is at which station?

- A. -2
- B. -1
- C. 0
- D. +1

Answer: C

Rationale: Fetal engagement signifies the entrance of the largest diameter of the fetal presenting part (usually the fetal head) into the smallest diameter of the maternal pelvis. The fetus is said to be engaged in the pelvis when the presenting part reaches 0 station.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 447

30. A nurse is providing care to a client in labor. A pelvic exam reveals a vertex presentation with the presenting part tilted toward the left side of the mother's pelvis and directed toward the anterior portion of the pelvis. When developing this client's plan of care, which intervention would the nurse include?

- A. implementing measures for a vaginal birth
- B. preparing the client for a cesarean birth
- C. assisting with artificial rupture of the membranes
- D. instituting continuous internal fetal monitoring

Answer: A

Rationale: The fetal presentation and position is left occiput anterior position or LOA, which is the most common and most favorable fetal position for birth. LOA along with right occiput anterior position are optimal positions for vaginal birth. Therefore the nurse should implement measures for a vaginal birth. This fetal presentation is not an indication for cesarean birth. Nor is there need for artificially rupturing the membranes. Continuous internal fetal monitoring would be warranted if the woman or fetus was considered to be high risk.

Question format: Multiple Choice

Chapter 13: Labor and Birth Process

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 446

Chapter 14

1. A woman in labor who received an opioid for pain relief develops respiratory depression. The nurse would expect which agent to be administered?
- A. butorphanol
 - B. fentanyl
 - C. naloxone
 - D. promethazine

Answer: C

Rationale: Naloxone is an opioid antagonist used to reverse the effects of opioids such as respiratory depression. Butorphanol and fentanyl are opioids and would cause further respiratory depression. Promethazine is an ataractic used as an adjunct to potentiate the effectiveness of the opioid.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 489

2. A client's membranes spontaneously ruptured, as evidenced by a gush of clear fluid with a contraction. What would the nurse do **next**?
- A. Check the fetal heart rate.
 - B. Perform a vaginal exam.
 - C. Notify the primary care provider immediately.
 - D. Change the linen saver pad.

Answer: A

Rationale: When membranes rupture, the priority focus is on assessing fetal heart rate first to identify a deceleration, which might indicate cord compression secondary to cord prolapse. A vaginal exam may be done later to evaluate for continued progression of labor. The primary care provider should be notified, but this is not a priority at this time. Changing the linen saver pad would be appropriate once the fetal status is determined and the primary care provider has been notified.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 497

3. A woman is admitted to the labor and birthing suite. Vaginal examination reveals that the presenting part is approximately 2 cm above the ischial spines. The nurse documents this finding as:

- A. +2 station.
- B. 0 station.
- C. -2 station.
- D. crowning.

Answer: C

Rationale: The ischial spines serve as landmarks and are designated as zero status. If the presenting part is palpated higher than the maternal ischial spines, a negative number is assigned. Therefore, the nurse would document the finding as -2 station. If the presenting part is below the ischial spines, then the station would be +2. Crowning refers to the appearance of the fetal head at the vaginal opening.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Reference: p. 468

4. A client states, "I think my water broke! I felt this gush of fluid between my legs." The nurse tests the fluid with nitrazine paper and confirms membrane rupture if the swab turns:

- A. yellow.
- B. olive green.
- C. pink.
- D. blue.

Answer: D

Rationale: Amniotic fluid is alkaline and turns Nitrazine paper blue. Nitrazine swabs that remain yellow to olive green suggests that the membranes are most likely intact.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 469

5. A woman in labor is to receive continuous internal electronic fetal monitoring. The nurse prepares the client for this monitoring based on the understanding that which criterion must be present?

- A. intact membranes
- B. cervical dilation of 2 cm or more
- C. floating presenting fetal part
- D. a neonatologist to insert the electrode

Answer: B

Rationale: For continuous internal electronic fetal monitoring, four criteria must be met: ruptured membranes, cervical dilation of at least 2 cm, fetal presenting part low enough to allow placement of the electrode, and a skilled practitioner available to insert the electrode.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 476

6. A woman in labor has chosen to use hydrotherapy as a method of pain relief. Which statement by the woman would lead the nurse to suspect that the woman needs additional teaching?

- A. "The warmth and buoyancy of the water has a nice relaxing effect."
- B. "I can stay in the bath for as long as I feel comfortable."
- C. "My cervix should be dilated more than 5 cm before I try using this method."
- D. "The temperature of the water should be at least 105? (40.5?)."

Answer: D

Rationale: Hydrotherapy is an effective pain relief method. The water temperature should not exceed body temperature. Therefore, a temperature of 105? (40.5?) would be too warm. The warmth and buoyancy have a relaxing effect, and women are encouraged to stay in the bath as long as they feel comfortable. The woman should be in active labor with cervical dilation greater than 5 cm.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Basic Care and Comfort

Reference: p. 482

7. A woman in labor received an opioid close to the time of birth. The nurse would assess the newborn for which effect?

- A. respiratory depression
- B. urinary retention
- C. abdominal distention
- D. hyperreflexia

Answer: A

Rationale: Opioids given close to the time of birth can cause central nervous system depression, including respiratory depression, in the newborn, necessitating the administration of naloxone. Urinary retention may occur in the woman who received neuraxial opioids. Abdominal distention is not associated with opioid administration. Hyporeflexia would be more commonly associated with central nervous system depression due to opioids.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 488

8. When applying the ultrasound transducer for continuous external electronic fetal monitoring, the nurse would place the transducer at which location on the client's body to record the FHR?
- A. over the uterine fundus where contractions are most intense
 - B. above the umbilicus toward the right side of the diaphragm
 - C. between the umbilicus and the symphysis pubis
 - D. between the xiphoid process and umbilicus

Answer: C

Rationale: The ultrasound transducer is positioned on the maternal abdomen in the midline between the umbilicus and the symphysis pubis. The tocotransducer is placed over the uterine fundus in the area of greatest contractility.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 475

9. After describing continuous internal electronic fetal monitoring to a laboring woman and her partner, which statement by the woman would indicate the need for additional teaching?
- A. "This type of monitoring is the most accurate method for our baby."
 - B. "Unfortunately, I'm going to have to stay quite still in bed while it is in place."
 - C. "This type of monitoring can only be used after my membranes rupture."
 - D. "You'll be inserting a special electrode into my baby's scalp."

Answer: B

Rationale: With continuous internal electronic monitoring, maternal position changes and movement do not interfere with the quality of the tracing. Continuous internal monitoring is considered the most accurate method, but it can be used only if certain criteria are met, such as rupture of membranes. A spiral electrode is inserted into the fetal presenting part, usually the head.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 476

10. Which action is a **priority** when caring for a woman during the fourth stage of labor?
- A. assessing the uterine fundus
 - B. offering fluids as indicated

- C. encouraging the woman to void
- D. assisting with perineal care

Answer: A

Rationale: During the fourth stage of labor, a priority is to assess the woman's fundus to prevent postpartum hemorrhage. Offering fluids, encouraging voiding, and assisting with perineal care are important but not an immediate priority.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 506

11. When palpating the fundus during a contraction, the nurse notes that it feels like a chin. The nurse interprets this finding as indicating which type of contraction?

- A. intense
- B. strong
- C. moderate
- D. mild

Answer: C

Rationale: A contraction that feels like the chin typically represents a moderate contraction. A contraction described as feeling like the tip of the nose indicates a mild contraction. A strong or intense contraction feels like the forehead.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 469

12. When planning the care of a woman in the latent phase of labor, the nurse would anticipate assessing the fetal heart rate at which interval?

- A. every 30 to 60 minutes
- B. every 60 to 90 minutes
- C. every 15 to 30 minutes
- D. every 10 to 15 minutes

Answer: A

Rationale: FHR is assessed every 30 to 60 minutes during the latent phase of labor and every 15 to 30 minutes during the active phase. The woman's temperature is typically assessed every 4 hours during the first stage of labor and every 2 hours after ruptured membranes. Blood pressure, pulse, and respirations are assessed every hour during the latent phase and every 30 minutes during the active and transition phases. Contractions are assessed every 30 to 60 minutes during

the latent phase and every 15 to 30 minutes during the active phase, and every 15 minutes during transition.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 497

13. A nurse palpates a woman's fundus to determine contraction intensity. What would be **most** appropriate for the nurse to use for palpation?

- A. finger pads
- B. palm of the hand
- C. finger tips
- D. back of the hand

Answer: A

Rationale: To palpate the fundus for contraction intensity, the nurse would place the pads of the fingers on the fundus and describe how it feels. Using the finger tips, palm, or back of the hand would be inappropriate.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 469

14. A woman's amniotic fluid is noted to be cloudy. The nurse interprets this finding as:

- A. normal.
- B. a possible infection.
- C. meconium passage.
- D. transient fetal hypoxia.

Answer: B

Rationale: Amniotic fluid should be clear when the membranes rupture, either spontaneously or artificially through an amniotomy (a disposable plastic hook [Amnihook] is used to perforate the amniotic sac). Cloudy or foul-smelling amniotic fluid indicates infection. Green fluid may indicate that the fetus has passed meconium secondary to transient hypoxia, prolonged pregnancy, cord compression, intrauterine growth restriction, maternal hypertension, diabetes, or chorioamnionitis; however, it is considered a normal occurrence if the fetus is in a breech presentation.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 471

15. A nurse is conducting a class for a group of nurses who are newly hired for the labor and birth unit. After teaching the group about fetal heart rate patterns, the nurse determines the need for additional teaching when the group identifies which finding as indicating normal fetal acid–base status? Select all that apply.

- A. sinusoidal pattern
- B. recurrent variable decelerations
- C. fetal bradycardia
- D. absence of late decelerations
- E. moderate baseline variability

Answer: A, B, C

Rationale: Predictors of normal fetal acid–base status include a baseline rate between 110 and 160 bpm, moderate baseline variability, and absences of later or variable decelerations.

Sinusoidal pattern, recurrent variable decelerations, and fetal bradycardia are predictive of abnormal fetal acid–base status.

Question format: Multiple Select

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 477

16. A nurse is reviewing the fetal heart rate pattern and observes abrupt decreases in FHR below the baseline, appearing as a U-shape. The nurse interprets these changes as reflecting which type of deceleration?

- A. early decelerations
- B. variable decelerations
- C. prolonged decelerations
- D. late decelerations

Answer: B

Rationale: Variable decelerations present as visually apparent abrupt decreases in FHR below baseline and have an unpredictable shape on the FHR baseline, possibly demonstrating no consistent relationship to uterine contractions. The shape of variable decelerations may be U, V, or W, or they may not resemble other patterns. Early decelerations are visually apparent, usually symmetrical and characterized by a gradual decrease in the FHR in which the nadir (lowest point) occurs at the peak of the contraction. They are thought to be a result of fetal head compression that results in a reflex vagal response with a resultant slowing of the FHR during uterine contractions. Late decelerations are visually apparent, usually symmetrical, transitory decreases in FHR that occur after the peak of the contraction. The FHR does not return to baseline levels until well after the contraction has ended. Delayed timing of the deceleration occurs, with the nadir of the uterine contraction. Late decelerations are associated with uteroplacental insufficiency. Prolonged decelerations are abrupt FHR declines of at least 15 bpm that last longer than 2 minutes but less than 10 minutes.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 478

17. A nurse is explaining the use of effleurage as a pain relief measure during labor. Which statement would the nurse **most** likely use when explaining this measure?

- A. "This technique focuses on manipulating body tissues."
- B. "The technique requires focusing on a specific stimulus."
- C. "This technique redirects energy fields that lead to pain."
- D. "The technique involves light stroking of the abdomen with breathing."

Answer: D

Rationale: Effleurage involves light stroking of the abdomen in rhythm with breathing.

Therapeutic touch is an energy therapy and is based on the premise that the body contains energy fields that lead to either good or ill health and that the hands can be used to redirect the energy fields that lead to pain. Attention focusing and imagery involve focusing on a specific stimulus. Massage focuses on manipulating body tissues.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Physiological Integrity: Basic Care and Comfort

Reference: p. 486

18. A nurse is reading a journal article about the various medications used for pain relief during labor. Which drug would the nurse note as producing amnesia but no analgesia?

- A. midazolam
- B. prochlorperazine
- C. fentanyl
- D. meperidine

Answer: A

Rationale: Midazolam is given intravenously and produces good amnesia but no analgesia. It is most commonly used as an adjunct for anesthesia. Prochlorperazine is typically given with an opioid such as morphine to counteract the nausea of the opioid. Fentanyl and meperidine are opioids that produce analgesia.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 489

19. A nurse is describing the different types of regional analgesia and anesthesia for labor to a group of pregnant women. Which statement by the group indicates that the teaching was successful?
- A. "We can get up and walk around after receiving combined spinal–epidural analgesia."
 - B. "Higher anesthetic doses are needed for patient-controlled epidural analgesia."
 - C. "A pudendal nerve block is highly effective for pain relief in the first stage of labor."
 - D. "Local infiltration using lidocaine is an appropriate method for controlling contraction pain."

Answer: A

Rationale: When compared with traditional epidural or spinal analgesia, which often keeps the woman lying in bed, combined spinal–epidural analgesia allows the woman to ambulate ("walking epidural"). Patient-controlled epidural analgesia provides equivalent analgesia with lower anesthetic use, lower rates of supplementation, and higher client satisfaction. Pudendal nerve blocks are used for the second stage of labor, an episiotomy, or an operative vaginal birth with outlet forceps or vacuum extractor. Local infiltration using lidocaine does not alter the pain of uterine contractions, but it does numb the immediate area of the episiotomy or laceration.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 491

20. A nurse is completing the assessment of a woman admitted to the labor and birth suite. Which information would the nurse expect to include as part of the physical assessment? Select all that apply.

- A. current pregnancy history
- B. fundal height measurement
- C. support system
- D. estimated date of birth
- E. membrane status
- F. contraction pattern

Answer: B, E, F

Rationale: As part of the admission physical assessment, the nurse would assess fundal height, membrane status, and contractions. Current pregnancy history, support systems, and estimated date of birth would be obtained when collecting the maternal health history.

Question format: Multiple Select

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 494

21. A pregnant woman admitted to the labor and birth suite undergoes rapid HIV testing and is found to be HIV-positive. Which action would the nurse expect to include when developing a plan of care for this woman? Select all that apply.

- A. administrating of penicillin G at the onset of labor
- B. avoiding scalp electrodes for fetal monitoring
- C. refraining from obtaining fetal scalp blood for pH testing
- D. administering antiretroviral therapy at the onset of labor
- E. electing for the use of forceps-assisted birth

Answer: B, C, D

Rationale: To reduce perinatal transmission, HIV-positive women are given a combination of antiretroviral drugs. To further reduce the risk of perinatal transmission, ACOG and the U.S. Public Health Service recommend that HIV-infected women with plasma viral loads of more than 1,000 copies per milliliter be counseled regarding the benefits of elective cesarean birth. Additional interventions to reduce the transmission risk would include avoiding use of scalp electrode for fetal monitoring or doing a scalp blood sampling for fetal pH, delaying amniotomy, encouraging formula feeding after birth, and avoiding invasive procedures such as forceps or vacuum-assisted devices.

Question format: Multiple Select

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Reference: p. 497

22. Which positions would be **most** appropriate for the nurse to suggest as a comfort measure to a woman who is in the first stage of labor? Select all that apply.

- A. walking with partner support
- B. straddling with forward leaning over a chair
- C. closed knee-chest position
- D. rocking back and forth with foot on chair
- E. supine with legs raised at a 90-degree angle

Answer: A, B, D

Rationale: Positioning during the first stage of labor includes walking with support from the partner, side-lying with pillows between the knees, leaning forward by straddling a chair, table, or bed or kneeling over a birthing ball, lunging by rocking weight back and forth with a foot up on a chair or birthing ball, or an open knee-chest position.

Question format: Multiple Select

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Physiological Integrity: Basic Care and Comfort

Reference: p. 499

23. Which suggestion by the nurse about pushing would be **most** appropriate to a woman in the second stage of labor?

- A. "Lying flat with your head elevated on two pillows makes pushing easier."
- B. "Choose whatever method you feel most comfortable with for pushing."
- C. "Let me help you decide when it is time to start pushing."
- D. "Bear down like you're having a bowel movement with every contraction."

Answer: B

Rationale: The role of the nurse should be to support the woman in her choice of pushing method and to encourage confidence in her maternal instinct of when and how to push. In the absence of any complications, nurses should not be controlling this stage of labor, but empowering women to achieve a satisfying experience. Common practice in many labor units is still to coach women to use closed glottis pushing with every contraction, starting at 10 cm of dilation, a practice that is not supported by research. Research suggests that directed pushing during the second stage may be accompanied by a significant decline in fetal pH and may cause maternal muscle and nerve damage if done too early. Effective pushing can be achieved by assisting the woman to assume a more upright or squatting position. Supporting spontaneous pushing and encouraging women to choose their own method of pushing should be accepted as best clinical practice.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 499

24. A nurse is assessing a woman after birth and notes a second-degree laceration. The nurse interprets this as indicating that the tear extends through which area?

- A. skin
- B. muscles of perineal body
- C. anal sphincter
- D. anterior rectal wall

Answer: B

Rationale: The extent of the laceration is defined by depth: a first-degree laceration extends through the skin; a second-degree laceration extends through the muscles of the perineal body; a third-degree laceration continues through the anal sphincter muscle; and a fourth-degree laceration also involves the anterior rectal wall.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 499

25. A nurse is assisting with the birth of a newborn. The fetal head has just emerged. Which action would be performed **next**?

- A. suctioning of the mouth and nose
- B. clamping of the umbilical cord
- C. checking for the cord around the neck
- D. drying of the newborn

Answer: C

Rationale: Once the fetal head has emerged, the primary care provider explores the fetal neck to see if the umbilical cord is wrapped around it. If it is, the cord is slipped over the head to facilitate delivery. Then the health care provider suctions the newborn's mouth first (because the newborn is an obligate nose breather) and then the nares with a bulb syringe to prevent aspiration of mucus, amniotic fluid, or meconium. Finally the umbilical cord is double-clamped and cut between the clamps. The newborn is placed under the radiant warmer, dried, assessed, wrapped in warm blankets, and placed on the woman's abdomen for warmth and closeness.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 503

26. A nurse is providing care to a woman during the third stage of labor. Which finding would alert the nurse that the placenta is separating?

- A. boggy, soft uterus
- B. uterus becoming discoid shaped
- C. sudden gush of dark blood from the vagina
- D. shortening of the umbilical cord

Answer: C

Rationale: Signs that the placenta is separating include a firmly contracting uterus; a change in uterine shape from discoid to globular ovoid; a sudden gush of dark blood from the vaginal opening; and lengthening of the umbilical cord protruding from the vagina.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 505

27. A nurse is preparing to auscultate the fetal heart rate of a pregnant woman at term admitted to the labor and birth suite. Assessment reveals that the fetus is in a cephalic presentation. At which area on the woman's body would the nurse best hear the sounds?

- A. At the level of the woman's umbilicus
- B. In the area above the woman's umbilicus
- C. In the woman's lower abdominal quadrant
- D. At the upper outer quadrant of the woman's abdomen

Answer: C

Rationale: The fetal heart rate is heard most clearly at the fetal back. In a cephalic presentation, the fetal heart rate is best heard in the lower quadrant of the maternal abdomen. In a breech presentation, it is heard at or above the level of the maternal umbilicus.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 47

28. A pregnant woman is discussing nonpharmacologic pain control measures with the nurse in anticipation of labor. After discussing the various breathing patterns that can be used, the woman decides to use slow-paced breathing. Which instruction would the nurse provide to the woman about this technique?

- A. "Inhale through your nose and exhale through pursed lips."
- B. "Inhale and exhale through your mouth about 4 times in 5 seconds."
- C. "Forcefully exhale every so often after inhaling and exhaling through your mouth."
- D. "Take a cleansing breath before but not after each contraction."

Answer: A

Rationale: Many couples learn patterned-paced breathing during their childbirth education classes. Three levels may be taught, each beginning and ending with a cleansing breath or sigh after each contraction. In the first pattern, also known as slow-paced breathing, the woman inhales slowly through her nose and exhales through pursed lips. The breathing rate is typically 6 to 9 breaths/min. In the second pattern, the woman inhales and exhales through her mouth at a rate of 4 breaths every 5 seconds. The rate can be accelerated to 2 breaths/sec to assist her to relax. The third pattern is similar to the second pattern except that the breathing is punctuated every few breaths by a forceful exhalation through pursed lips. All breaths are kept equal and rhythmic and can increase as contractions increase in intensity.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Physiological Integrity: Basic Care and Comfort

Integrated Process: Teaching/Learning

Reference: p. 487

29. A nurse is performing Leopold maneuvers on a pregnant woman. The nurse determines which information with the first maneuver?

- A. Fetal presentation
- B. Fetal position
- C. Fetal attitude
- D. Fetal flexion

Answer: A

Rationale: Leopold maneuvers are a method for determining the presentation, position, and lie of the fetus through the use of four specific steps. The first maneuver determines presentation; the second maneuver determines position; the third maneuver confirms presentation by feeling for the presenting part; the fourth maneuver determines attitude based on whether the fetal head is flexed and engaged in the pelvis.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 470

30. A pregnant woman with a fetus in the cephalic presentation is in the latent phase of the first stage of labor. Her membranes rupture spontaneously. The fluid is green in color. Which action by the nurse would be appropriate?

- A. Check the pH to ensure the fluid is amniotic fluid.
- B. Prepare to administer an antibiotic.
- C. Notify the health care provider about possible meconium.
- D. Check the maternal heart rate.

Answer: C

Rationale: Amniotic fluid should be clear when the membranes rupture. Green fluid may indicate that the fetus has passed meconium secondary to transient hypoxia, prolonged pregnancy, cord compression, intrauterine growth restriction, maternal hypertension, diabetes, or chorioamnionitis. Therefore, the nurse would notify the health care provider. Antibiotic therapy would be indicated if the fluid was cloudy or foul-smelling, suggesting an infection. Color of the fluid has nothing to do with the pH of the fluid. Spontaneous rupture of membranes can lead to cord compression, so checking fetal heart rate, not maternal heart rate, would be appropriate.

Question format: Multiple Choice

Chapter 14: Nursing Management During Labor and Birth

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 471

Chapter 15

1. A primipara client gave birth vaginally to a healthy newborn girl 12 hours ago. The nurse palpates the client's fundus. Which finding would the nurse identify as expected?
- A. two fingerbreadths above the umbilicus
 - B. at the level of the umbilicus
 - C. two fingerbreadths below the umbilicus
 - D. four fingerbreadths below the umbilicus

Answer: B

Rationale: During the first 12 hours postpartum, the fundus of the uterus is located at the level of the umbilicus. Over the first few days after birth, the uterus typically descends from the level of the umbilicus at a rate of 1 cm (one fingerbreadth) per day. By 3 days, the fundus lies two to three fingerbreadths below the umbilicus (or slightly higher in multiparous women). By the end of 10 days, the fundus usually cannot be palpated because it has descended into the true pelvis.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 516

2. When caring for a mother who has had a cesarean birth, the nurse would expect the client's lochia to be:
- A. greater than after a vaginal birth.
 - B. about the same as after a vaginal birth.
 - C. less than after a vaginal birth.
 - D. saturated with clots and mucus.

Answer: C

Rationale: Women who have had cesarean births tend to have less flow because the uterine debris is removed manually along with delivery of the placenta.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 517

3. The nurse is developing a teaching plan for a client who has decided to bottle-feed her newborn. Which information would the nurse include in the teaching plan to facilitate suppression of lactation?
- A. encouraging the woman to manually express milk
 - B. suggesting that she take frequent warm showers to soothe her breasts

- C. telling her to limit the amount of fluids that she drinks
- D. instructing her to apply ice packs to both breasts every other hour

Answer: D

Rationale: If the woman is not breastfeeding, relief measures for engorgement include wearing a tight supportive bra 24 hours daily, applying ice to her breasts for approximately 15 to 20 minutes every other hour, and not stimulating her breasts by squeezing or manually expressing milk. Warm showers enhance the let-down reflex and would be appropriate if the woman was breastfeeding. Limiting fluid intake is inappropriate. Fluid intake is important for all postpartum women, regardless of the feeding method chosen.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 526

4. The nurse is making a follow-up home visit to a woman who is 12 days postpartum. Which finding would the nurse expect when assessing the client's fundus?

- A. cannot be palpated
- B. 2 cm below the umbilicus
- C. 6 cm below the umbilicus
- D. 10 cm below the umbilicus

Answer: A

Rationale: By the end of 10 days, the fundus usually cannot be palpated because it has descended into the true pelvis.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 517

5. A client who is breastfeeding her newborn tells the nurse, "I notice that when I feed him, I feel fairly strong contraction-like pain. Labor is over. Why am I having contractions now?" Which response by the nurse would be **most** appropriate?

- A. "Your uterus is still shrinking in size; that's why you're feeling this pain."
- B. "Let me check your vaginal discharge just to make sure everything is fine."
- C. "Your body is responding to the events of labor, just like after a tough workout."
- D. "The baby's sucking releases a hormone that causes the uterus to contract."

Answer: D

Rationale: The woman is describing afterpains, which are usually stronger during breastfeeding because oxytocin released by the sucking reflex strengthens uterine contractions. Afterpains are

associated with uterine involution, but the woman's description strongly correlates with the hormonal events of breastfeeding. All women experience afterpains, but they are more acute in multiparous women secondary to repeated stretching of the uterine muscles.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 517

6. When the nurse is assessing a postpartum client approximately 6 hours after birth, which finding would warrant further investigation?

- A. deep red, fleshy-smelling lochia
- B. voiding of 350 cc
- C. blood pressure 90/50 mm Hg
- D. profuse sweating

Answer: C

Rationale: In most instances of postpartum hemorrhage, blood pressure and cardiac output remain increased because of the compensatory increase in heart rate. Thus, a decrease in blood pressure and cardiac output are not expected changes during the postpartum period. Early identification is essential to ensure prompt intervention. Deep red, fleshy-smelling lochia is a normal finding 6 hours postpartum. Voiding in small amounts such as less than 150 cc would indicate a problem, but 350 cc would be appropriate. Profuse sweating also is normal during the postpartum period.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 519

7. A postpartum client who is bottle feeding her newborn asks, "When should my period return?" Which response by the nurse would be **most** appropriate?

- A. "It's difficult to say, but it will probably return in about 2 to 3 weeks."
- B. "It varies, but you can estimate it returning in about 7 to 9 weeks."
- C. "You won't have to worry about it returning for at least 3 months."
- D. "You don't have to worry about that now. It'll be quite a while."

Answer: B

Rationale: For the nonlactating woman, menstruation resumes 7 to 9 weeks after giving birth, with the first cycle being anovulatory. For the lactating woman, menses can return anytime from 2 to 18 months after birth.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance
Integrated Process: Teaching/Learning
Reference: p. 519

8. A nurse is providing care to a postpartum woman. The nurse determines that the client is in the taking-in phase based on which finding?
- A. The client states, "He has my eyes and nose."
 - B. The client shows interest in caring for the newborn.
 - C. The client performs self-care independently.
 - D. The client confidently cares for the newborn.

Answer: A

Rationale: During the taking-in phase, new mothers when interacting with their newborns spend time claiming the newborn and touching him or her, commonly identifying specific features in the newborn such as "he has my nose" or "his fingers are long like his father's." Independence in self-care and interest in caring for the newborn are typical of the taking-hold phase. Confidence in caring for the newborn is demonstrated during the letting-go phase.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 529

9. A nurse is observing the interaction between a new father and his newborn. The nurse determines that engrossment has yet to occur based on which behavior?
- A. demonstrates pleasure when touching or holding the newborn
 - B. identifies imperfections in the newborn's appearance
 - C. is able to distinguish his newborn from others in the nursery
 - D. shows feelings of pride with the birth of the newborn

Answer: B

Rationale: Identifying imperfections would not be associated with engrossment. Engrossment is characterized by seven behaviors: visual awareness of the newborn, tactile awareness of the newborn, perception of the newborn as perfect, strong attraction to the newborn, awareness of distinct features of the newborn, extreme elation, and increased sense of self-esteem.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 531

10. A postpartum client comes to the clinic for her 6-week postpartum checkup. When assessing the client's cervix, the nurse would expect the external cervical os to appear:
- A. shapeless.

- B. circular.
- C. triangular.
- D. slit-like.

Answer: D

Rationale: After birth, the external cervical os is no longer shaped like a circle but instead appears as a jagged slit-like opening, often described as a "fish mouth."

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 518

11. A nurse is teaching a postpartum client how to do muscle-clenching exercises for the perineum. The client asks the nurse, "Why do I need to do these exercises?" Which reason would the nurse **most** likely incorporate into the response?

- A. reduces lochia
- B. promotes uterine involution
- C. improves pelvic floor tone
- D. alleviates perineal pain

Answer: C

Rationale: Muscle clenching perineal exercises help to improve pelvic floor tone, strengthen perineal muscles, and promote healing, ultimately helping to prevent urinary incontinence later in life. Kegel exercises have no effect on lochia, involution, or pain.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 518

12. A father of a newborn tells the nurse, "I may not know everything about being a dad, but I'm going to do the best I can for my son." The nurse interprets this as indicating the father is in which stage of adaptation?

- A. expectations
- B. transition to mastery
- C. reality
- D. taking-in

Answer: B

Rationale: The father's statement reflects transition to mastery because he is making a conscious decision to take control and be at the center of the newborn's life regardless of his preparedness.

The expectations stage involves preconceptions about how life will be with a newborn. Reality occurs when fathers realize their expectations are not realistic. Taking-in is a phase of maternal adaptation.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Reference: p. 531

13. A postpartum client is experiencing subinvolution. When reviewing the woman's labor and birth history, which factor would the nurse identify as being a significant contributor to this condition?

- A. early ambulation
- B. short duration of labor
- C. breastfeeding
- D. use of anesthetics

Answer: D

Rationale: Factors that inhibit involution include prolonged labor and difficult birth, incomplete expulsion of amniotic membranes and placenta, uterine infection, overdistention of uterine muscles (such as by multiple gestation, hydramnios, or large singleton fetus), full bladder (which displaces the uterus and interferes with contractions), anesthesia (which relaxes uterine muscles), and close childbirth spacing. Factors that facilitate uterine involution include complete expulsion of amniotic membranes and placenta at birth, complication-free labor and birth process, breastfeeding, and early ambulation.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 516

14. A woman who gave birth 24 hours ago tells the nurse, "I've been urinating so much over the past several hours." Which response by the nurse would be **most** appropriate?

- A. "You must have an infection, so let me get a urine specimen."
- B. "Your body is undergoing many changes that cause your bladder to fill quickly."
- C. "Your uterus is not contracting as quickly as it should."
- D. "The anesthesia that you received is wearing off and your bladder is working again."

Answer: B

Rationale: Postpartum diuresis occurs as a result of several mechanisms: the large amounts of IV fluids given during labor, a decreasing antidiuretic effect of oxytocin as its level declines, the buildup and retention of extra fluids during pregnancy, and a decreasing production of aldosterone—the hormone that decreases sodium retention and increases urine production. All

these factors contribute to rapid filling of the bladder within 12 hours of birth. Diuresis begins within 12 hours after childbirth and continues throughout the first week postpartum.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 520

15. The nurse develops a teaching plan for a postpartum client and includes teaching about how to perform pelvic floor muscle training or Kegel exercises. The nurse includes this information for which reason?

- A. reduce lochia
- B. promote uterine involution
- C. improve pelvic floor tone
- D. alleviate perineal pain

Answer: C

Rationale: Pelvic floor muscle training or Kegel exercises help to improve pelvic floor tone, strengthen perineal muscles, and promote healing, ultimately helping to prevent urinary incontinence later in life. Kegel exercises have no effect on lochia, involution, or pain.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 518

16. When assessing a postpartum woman, the nurse suspects the woman is experiencing a problem based on which finding?

- A. elevated white blood cell count
- B. acute decrease in hematocrit
- C. increased levels of clotting factors
- D. pulse rate of 60 beats/minute

Answer: B

Rationale: Despite a decrease in blood volume after birth, hematocrit levels remain relatively stable and may even increase. An acute decrease is not an expected finding. Red blood cell production ceases early in the puerperium, causing mean hemoglobin and hematocrit levels to decrease slightly in the first 24 hours. During the next 2 weeks, both levels rise slowly. The white blood count, which increases in labor, remains elevated for first 4 to 6 days after birth but then falls to 6,000 to 10,000/mm³. The WBC count remains elevated for the first 4 to 6 days and clotting factors remain elevated for 2 to 3 weeks. Bradycardia (50 to 70 beats per minute) for the first two weeks reflects the decrease in cardiac output. The increase in cardiac output and stroke volume during pregnancy begins to diminish after birth once the placenta has been delivered.

This decrease in cardiac output is reflected in bradycardia (40 to 60 bpm) for up to the first 2 weeks postpartum.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 519

17. A nurse is teaching a new mother about breastfeeding. The nurse determines that the teaching was successful when the woman identifies which hormone as responsible for milk let-down?

- A. prolactin
- B. estrogen
- C. progesterone
- D. oxytocin

Answer: D

Rationale: Oxytocin is released from the posterior pituitary to promote milk let-down. Prolactin levels increase at term with a decrease in estrogen and progesterone; estrogen and progesterone levels decrease after the placenta is delivered. Prolactin is released from the anterior pituitary gland and initiates milk production.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 523

18. A nurse is making a home visit to a postpartum woman who gave birth to a healthy newborn 4 days ago. The woman's breasts are swollen, hard, and tender to the touch. The nurse documents this finding as:

- A. involution.
- B. engorgement.
- C. mastitis.
- D. engrossment.

Answer: B

Rationale: Engorgement is the process of swelling of the breast tissue as a result of an increase in blood and lymph supply as a precursor to lactation (Figure 15.4). Breast engorgement usually peaks in 3 to 5 days postpartum and usually subsides within the next 24 to 36 hours (Chapman, 2011). Engorgement can occur from infrequent feeding or ineffective emptying of the breasts and typically lasts about 24 hours. Breasts increase in vascularity and swell in response to prolactin 2 to 4 days after birth. If engorged, the breasts will be hard and tender to touch. Involution refers to the process of the uterus returning to its prepregnant state. Mastitis refers to an infection of the breasts. Engrossment refers to the bond that develops between the father and the newborn.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 524

19. A nurse is assessing a postpartum woman's adjustment to her maternal role. Which event would the nurse expect to occur **first**?

- A. reestablishing relationships with others
- B. demonstrating increasing confidence in care of the newborn
- C. assuming a passive role in meeting her own needs
- D. becoming preoccupied with the present

Answer: C

Rationale: The first task of adjusting to the maternal role is the taking-in phase in which the mother demonstrates dependent behaviors and assumes a passive role in meeting own basic needs. During the taking-hold phase, the mother becomes preoccupied with the present. During the letting-go phase, the mother reestablishes relationships with others and demonstrates increased responsibility and confidence in caring for the newborn.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 528

20. The partner of a woman who has given birth to a healthy newborn says to the nurse, "I want to be involved, but I'm not sure that I'm able to care for such a little baby." The nurse interprets this as indicating which stage?

- A. expectations
- B. reality
- C. transition to mastery
- D. taking-hold

Answer: B

Rationale: The partner's statement reflects stage 2 (reality), which occurs when fathers or partners realize that their expectations in stage 1 are not realistic. Their feelings change from elation to sadness, ambivalence, jealousy, and frustration. Many wish to be more involved in the newborn's care and yet do not feel prepared to do so. New fathers or partners pass through stage 1 (expectations) with preconceptions about what home life will be like with a newborn. Many men may be unaware of the dramatic changes that can occur when this newborn comes home to live with them. In stage 3 (transition to mastery), the father or partner makes a conscious decision to take control and be at the center of his newborn's life regardless of his preparedness. Taking-hold is a stage of maternal adaptation.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations
Cognitive Level: Analyze
Client Needs: Psychosocial Integrity
Reference: p. 531

21. A nurse is reviewing information about maternal and paternal adaptations to the birth of a newborn. The nurse observes the parents interacting with their newborn physically and emotionally. The nurse documents this as:

- A. puerperium.
- B. lactation.
- C. attachment.
- D. engrossment.

Answer: C

Rationale: Attachment is a formation of a relationship between a parent and her/his newborn through a process of physical and emotional interactions. Puerperium refers to the postpartum period. Lactation refers to the process of milk secretion by the breasts. Engrossment refers to the bond that develops between the father and the newborn.

Question format: Multiple Choice
Chapter 15: Postpartum Adaptations
Cognitive Level: Apply
Client Needs: Psychosocial Integrity
Reference: p. 527

22. The nurse is providing an in-service education program to a group of home health care nurses who provide care to postpartum women. After teaching the group about the process of involution, the nurse determines that additional teaching is needed when the group identifies which process as being involved?

- A. catabolism
- B. muscle fiber contraction
- C. epithelial regeneration
- D. vasodilation

Answer: D

Rationale: Involution involves three retrogressive processes: contraction of muscle fibers to reduce those previously stretched during pregnancy; catabolism, which reduces enlarged myometrial cells; and regeneration of uterine epithelium from the lower layer of the decidua after the upper layers have been sloughed off and shed during lochial discharge. Vasodilation is not involved.

Question format: Multiple Choice
Chapter 15: Postpartum Adaptations
Cognitive Level: Analyze
Client Needs: Health Promotion and Maintenance
Reference: p. 517

23. A nurse is visiting a postpartum woman who gave birth to a healthy newborn 5 days ago. Which finding would the nurse expect?

- A. bright red discharge
- B. pinkish brown discharge
- C. deep red mucus-like discharge
- D. creamy white discharge

Answer: B

Rationale: Lochia serosa is pinkish brown and is expelled 3 to 10 days postpartum. Lochia rubra is a deep-red mixture of mucus, tissue debris, and blood that occurs for the first 3 to 4 days after birth. Lochia alba is creamy white or light brown and consists of leukocytes, decidual tissue, and reduced fluid content and occurs from days 10 to 14 but can last 3 to 6 weeks postpartum.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 517

24. A nurse teaches a postpartum woman about her risk for thromboembolism. The nurse determines that additional teaching is required when the woman identifies which as a factor that increases her risk?

- A. increase in clotting factors
- B. vessel damage
- C. immobility
- D. increase in red blood cell production

Answer: D

Rationale: Clotting factors that increased during pregnancy tend to remain elevated during the early postpartum period. Giving birth stimulates this hypercoagulability state further. As a result, these coagulation factors remain elevated for 2 to 3 weeks postpartum (Silver & Major, 2010). This hypercoagulable state, combined with vessel damage during birth and immobility, places the woman at risk for thromboembolism (blood clots) in the lower extremities and the lungs. Red blood cell production ceases early in the puerperium, which leads to mean hemoglobin and hematocrit levels to decrease slightly in the first 24 hours and then rise slowly over the next 2 weeks.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 520

25. A nurse is preparing a presentation about changes in the various body systems during the postpartum period and their effects for a group of new mothers. The nurse explains which event as influencing a postpartum woman's ability to void? Select all that apply.

- A. use of an opioid anesthetic during labor
- B. generalized swelling of the perineum
- C. decreased bladder tone from regional anesthesia
- D. use of oxytocin to augment labor
- E. need for an episiotomy

Answer: B, C, D

Rationale: Many women have difficulty feeling the sensation to void after giving birth if they received an anesthetic block during labor (which inhibits neural functioning of the bladder) or if they received oxytocin to induce or augment their labor (antidiuretic effect). These women will be at risk for incomplete emptying, bladder distention, difficulty voiding, and urinary retention. In addition, urination may be impeded by perineal lacerations; generalized swelling and bruising of the perineum and tissues surrounding the urinary meatus; hematomas; decreased bladder tone as a result of regional anesthesia; and diminished sensation of bladder pressure as a result of swelling, poor bladder tone, and numbing effects of regional anesthesia used during labor.

Question format: Multiple Select

Chapter 15: Postpartum Adaptations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 520

26. A postpartum woman who has experienced diastasis recti asks the nurse about what to expect related to this condition. Which response by the nurse would be **most** appropriate?

- A. "You'll notice that this will fade to silvery lines."
- B. "Exercise will help to improve the muscles."
- C. "Expect the color to lighten somewhat."
- D. "You'll notice that your shoe size will increase."

Answer: B

Rationale: Separation of the rectus abdominis muscles, called diastasis recti, is more common in women who have poor abdominal muscle tone before pregnancy. After birth, muscle tone is diminished and the abdominal muscles are soft and flabby. Specific exercises are necessary to help the woman regain muscle tone. Fortunately, diastasis responds well to exercise, and abdominal muscle tone can be improved. Stretch marks (striae gravidarum) fade to silvery lines. The darkened pigmentation of the abdomen (linea nigra), face (melasma), and nipples gradually fades. Parous women will note a permanent increase in shoe size.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 521

27. As part of an education program for a group of pregnant women, the nurse teaches them about the changes that occur in the respiratory system during the postpartum period. The women demonstrate understanding of the information when they identify which occurrence as a postpartum adaptation?

- A. continued shortness of breath
- B. relief of rib aching
- C. diaphragmatic elevation
- D. decrease in respiratory rate

Answer: B

Rationale: Respirations usually remain within the normal adult range of 16 to 24 breaths per minute. As the abdominal organs resume their nonpregnant position, the diaphragm returns to its usual position. Anatomic changes in the thoracic cavity and rib cage caused by increasing uterine growth resolve quickly. As a result, discomforts such as shortness of breath and rib aches are relieved.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 522

28. A woman who gave birth to a healthy newborn several hours ago asks the nurse, "Why am I perspiring so much?" The nurse integrates knowledge that a decrease in which hormone plays a role in this occurrence?

- A. estrogen
- B. hCG
- C. hPL
- D. progesterone

Answer: A

Rationale: Although hCG, hPL, and progesterone decline rapidly after birth, decreased estrogen levels are associated with breast engorgement and with the diuresis of excess extracellular fluid accumulated during pregnancy.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 522

29. A primipara client gave birth vaginally to a healthy newborn girl 48 hours ago. The nurse palpates the client's fundus and documents which finding as normal?

- A. two fingerbreadths above the umbilicus
- B. at the level of the umbilicus

- C. two fingerbreadths below the umbilicus
- D. four fingerbreadths below the umbilicus

Answer: C

Rationale: During the first few days after birth, the uterus typically descends downward from the level of the umbilicus at a rate of 1 cm (1 fingerbreadth) per day so that by day 2, it is about 2 fingerbreadths below the umbilicus.

Question format: Multiple Choice

Chapter 15: Postpartum Adaptations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 517

30. A nurse is providing care to a woman of Latin American culture who delivered a healthy neonate 6 hours ago. When developing a plan of care that is culturally congruent for this client, which information would be important for the nurse to obtain **initially?** Select all that apply.

- A. Meanings associated with touch and gestures
- B. Woman's beliefs about the postpartum period
- C. Plans for care of the newborn after discharge
- D. Amount of help the partner is expected to provide
- E. Preferences for measures to relieve discomforts

Answer: A, B, D, E

Rationale: Although childbirth and the postpartum period are unique experiences for each woman, how the woman perceives and makes meaning of them is culturally defined. Nurses caring for childbearing families should consider all aspects of culture, including health beliefs, communication, space, and family roles. To ensure culturally congruent care, the nurse needs to gather initial information about the woman's health beliefs about the postpartum period because different cultures view the postpartum period differently, such as the need to balance hot and cold substances. This belief can influence the woman's preferences for relieving discomforts. The meaning of touch and gestures is also important to determine. The concept of personal space and the dimensions of comfort zones differ from culture to culture. Nurses must be sensitive to how people respond when being touched and should refrain from touching if the client's response indicates it is unwelcome. In addition, cultural norms also have an impact on family roles, expectations, and behaviors associated with a member's position in the family. For example, culture may influence whether a male partner actively participates in the woman's pregnancy and childbirth. In the Western countries, partners are expected to be involved, but this role expectation may conflict with that of many of the diverse groups now living in the countries. Plans for care of the newborn can be addressed at a later time.

Question format: Multiple Select

Chapter 15: Postpartum Adaptations

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Integrated Process: Culture and Spirituality

Reference: p. 526

Chapter 16

1. A woman who is 12 hours postpartum had a pulse rate around 80 beats per minute during pregnancy. Now, the nurse finds a pulse of 66 beats per minute. Which of these actions should the nurse take?
- A. Document the finding, as it is a normal finding at this time.
 - B. Contact the primary care provider, as it indicates early DIC.
 - C. Contact the primary care provider, as it is a first sign of postpartum eclampsia.
 - D. Obtain a prescription for a CBC, as it suggests postpartum anemia.

Answer: A

Rationale: Pulse rates of 60 to 80 beats per minute at rest are normal during the first week after birth. This pulse rate is called puerperal bradycardia.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 539

2. A client who has just given birth to a healthy newborn required an episiotomy. Which action would the nurse implement immediately after birth to decrease the client's pain from the procedure?

- A. Offer warm blankets.
- B. Encourage the woman to void.
- C. Apply an ice pack to the site.
- D. Offer a warm sitz bath.

Answer: C

Rationale: An ice pack is the first measure used after a vaginal birth to provide perineal comfort from edema, an episiotomy, or lacerations. Warm blankets would be helpful for the chills that the woman may experience. Encouraging her to void promotes urinary elimination and uterine involution. A warm sitz bath is effective after the first 24 hours.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Apply

Client Needs: Physiological Integrity: Basic Care and Comfort

Reference: p. 549

3. A postpartum client has a fourth-degree perineal laceration. The nurse would expect which medication to be prescribed?

- A. ferrous sulfate
- B. methylergonovine

- C. docusate
- D. bromocriptine

Answer: C

Rationale: A stool softener such as docusate may promote bowel elimination in a woman with a fourth-degree laceration, who may fear that bowel movements will be painful. Ferrous sulfate would be used to treat anemia. However, it is associated with constipation and would increase the discomfort when the woman has a bowel movement. Methylergonovine would be used to prevent or treat postpartum hemorrhage. Bromocriptine is used to treat hyperprolactinemia.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 551

4. A nurse is observing a new mother interacting with her newborn. Which statement would alert the nurse to the potential for impaired bonding between mother and newborn?
- A. "You have your daddy's eyes."
 - B. "He looks like a frog to me."
 - C. "Where did you get all that hair?"
 - D. "He seems to sleep a lot."

Answer: B

Rationale: Negative comments may indicate impaired bonding. Pointing out commonalities such as "daddy's eyes" and expressing pride such as "all that hair" are positive attachment behaviors. The statement about sleeping a lot indicates that the mother is assigning meaning to the newborn's actions, another positive attachment behavior.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Reference: p. 547

5. After a normal labor and birth, a client is discharged from the hospital 12 hours later. When the community health nurse makes a home visit 2 days later, which finding would alert the nurse to the need for further intervention?
- A. presence of lochia serosa
 - B. frequent scant voidings
 - C. fundus firm, below umbilicus
 - D. milk filling in both breasts

Answer: B

Rationale: Infrequent or insufficient voiding may be a sign of infection and is not a normal finding on the second postpartum day. Lochia serosa, a firm fundus below the umbilicus, and milk filling the breasts are expected findings.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 551

6. A primipara client who is bottle feeding her baby begins to experience breast engorgement on her third postpartum day. Which instruction by the nurse would be **most** appropriate to aid in relieving her discomfort?

- A. "Express some milk from your breasts every so often to relieve the distention."
- B. "Remove your bra to relieve the pressure on your sensitive nipples and breasts."
- C. "Apply ice packs to your breasts to reduce the amount of milk being produced."
- D. "Take several warm showers daily to stimulate the milk let-down reflex."

Answer: C

Rationale: For the woman with breast engorgement who is bottle feeding her newborn, encourage the use of ice packs to decrease pain and swelling. Expressing milk from the breasts and taking warm showers would be appropriate for the woman who was breastfeeding. Wearing a supportive bra 24 hours a day also is helpful for the woman with engorgement who is bottle feeding.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 561

7. The nurse administers Rho(D) immune globulin to an Rh-negative client after birth of an Rh-positive newborn based on the understanding that this drug will prevent her from:

- A. becoming Rh positive.
- B. developing Rh sensitivity.
- C. developing AB antigens in her blood.
- D. becoming pregnant with an Rh-positive fetus.

Answer: B

Rationale: The woman who is Rh-negative and whose infant is Rh-positive should be given Rho(D) immune globulin within 72 hours after birth to prevent sensitization.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 565

8. Which factor in a client's history would alert the nurse to an increased risk for postpartum hemorrhage?

- A. multiparity, age of mother, operative birth
- B. size of placenta, small baby, operative birth
- C. uterine atony, placenta previa, operative procedures
- D. prematurity, infection, length of labor

Answer: C

Rationale: Risk factors for postpartum hemorrhage include a precipitous labor less than three hours, uterine atony, placenta previa or abruption, labor induction or augmentation, operative procedures such as vacuum extraction, forceps, or cesarean birth, retained placental fragments, prolonged third stage of labor greater than 30 minutes, multiparity, and uterine overdistention such as from a large infant, twins, or hydramnios.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 538

9. When teaching parents about their newborn, the nurse describes the development of a close emotional attraction to a newborn by the parents during the first 30 to 60 minutes after birth. The nurse refers to this process by which term?

- A. reciprocity
- B. engrossment
- C. bonding
- D. attachment

Answer: C

Rationale: The development of a close emotional attraction to the newborn by parents during the first 30 to 60 minutes after birth describes bonding. Reciprocity is the process by which the infant's capabilities and behavioral characteristics elicit a parental response. Engrossment refers to the intense interest during early contact with a newborn. Attachment refers to the process of developing strong ties of affection between an infant and significant other.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 545

10. A nurse is reviewing the policies of a facility related to bonding and attachment with newborns. Which practice would the nurse identify as needing to be changed?

- A. allowing unlimited visiting hours on maternity units
- B. offering round-the-clock nursery care for all infants

- C. promoting rooming-in
- D. encouraging infant contact immediately after birth

Answer: B

Rationale: Factors that can affect attachment include separation of the infant and parents for long times during the day, such as if the infant was being cared for in the nursery throughout the day. Unlimited visiting hours, rooming-in, and infant contact immediately after birth promote bonding and attachment.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Reference: p. 545

11. A nurse is preparing a couple and their newborn for discharge. Which instructions would be **most** appropriate for the nurse to include in discharge teaching?
- A. introducing solid foods immediately to increase sleep cycle
 - B. demonstrating comfort measures to quiet a crying infant
 - C. encouraging daily outings to the shopping mall with the newborn
 - D. allowing the infant to cry for at least an hour before picking him or her up

Answer: B

Rationale: Discharge teaching typically would focus on several techniques to comfort a crying newborn. The nurse needs to emphasize the importance of responding to the newborn's cues, not allowing the infant to cry for an hour before being comforted. Information about solid foods is inappropriate for a newborn because solid foods are not introduced at this time. The mother and newborn need rest periods. Therefore, daily outings to a shopping mall would be inappropriate. Information about newborn sleep-wake cycles and measures for sensory enrichment and stimulation would be more appropriate.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 562

12. When developing the plan of care for the parents of a newborn, the nurse identifies interventions to promote bonding and attachment based on the rationale that bonding and attachment are **most** supported by which measure?
- A. early parent-infant contact following birth
 - B. expert medical care for the labor and birth
 - C. good nutrition and prenatal care during pregnancy
 - D. grandparent involvement in infant care after birth

Answer: A

Rationale: Optimal bonding requires a period of close contact between the parents and newborn within the first few minutes to a few hours after birth. Expert medical care, nutrition and prenatal care, and grandparent involvement are not associated with the promotion of bonding.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 545

13. Which method would be **most** effective in evaluating the parents' understanding about their newborn's care?

- A. Demonstrate all infant care procedures.
- B. Allow the parents to state the steps of the care.
- C. Observe the parents performing the procedures.
- D. Routinely assess the newborn for cleanliness.

Answer: C

Rationale: The most effective means to evaluate the parents' learning is to observe them performing the procedures. Parental roles develop and grow through interaction with their newborn. The nurse would involve both parents in the newborn's care and praise them for their efforts. Demonstrating the procedures to the parents and having the parents state the steps are helpful but do not guarantee that the parents understand them. Assessing the newborn for cleanliness would provide little information about parental learning.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 562

14. A postpartum woman is having difficulty voiding for the first time after giving birth. Which action would be **least** effective in helping to stimulate voiding?

- A. pouring warm water over her perineal area
- B. having her hear the sound of water running nearby
- C. placing her hand in a basin of cool water
- D. standing her in the shower with the warm water on

Answer: C

Rationale: Helpful measures to stimulate voiding include placing her hand in a basin of warm water, pouring warm water over her perineal area, hearing the sound of running water nearby, blowing bubbles through a straw, standing in the shower with the warm water turned on, and drinking fluids.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Apply

Client Needs: Physiological Integrity: Basic Care and Comfort

Reference: p. 551

15. The nurse is assisting a postpartum woman out of bed to the bathroom for a sitz bath. Which action would be a **priority**?

- A. placing the call light within her reach
- B. teaching her how the sitz bath works
- C. telling her to use the sitz bath for 30 minutes
- D. cleaning the perineum with the peri-bottle

Answer: A

Rationale: Tremendous hemodynamic changes are taking place within the woman, and safety must be a priority. Therefore, the nurse makes sure that the emergency call light is within her reach should she become dizzy or lightheaded. Teaching her how to use the sitz bath, including using it for 15 to 20 minutes, is appropriate but can be done once the woman's safety is ensured. The woman should clean her perineum with a peri-bottle before using the sitz bath, but this can be done once the woman's safety needs are met.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Reference: p. 550

16. A nurse is reviewing the medical record of a postpartum client. The nurse identifies that the woman is at risk for a postpartum infection based on which information? Select all that apply.

- A. history of diabetes
- B. labor of 12 hours
- C. rupture of membranes for 16 hours
- D. hemoglobin level 10 mg/dL
- E. placenta requiring manual extraction

Answer: A, D, E

Rationale: Risk factors for postpartum infection include history of diabetes, labor over 24 hours, hemoglobin less than 10.5 mg/dL, prolonged rupture of membranes (more than 24 hours), and manual extraction of the placenta.

Question format: Multiple Select

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 538

17. A nurse is completing a postpartum assessment. Which finding would alert the nurse to a potential problem?

- A. lochia rubra with a fleshy odor
- B. respiratory rate of 16 breaths per minute
- C. temperature of 101° F (38.3° C)
- D. pain rating of 2 on a scale from 0 to 10

Answer: C

Rationale: Typically, the new mother's temperature during the first 24 hours postpartum is within the normal range. Some women experience a slight fever, up to 100.4° F (38° C), during the first 24 hours. A temperature above 100.4° F (38° C) at any time or an abnormal temperature after the first 24 hours may indicate infection and must be reported. Foul-smelling lochia or lochia with an unexpected change in color or amount, shortness of breath, or respiratory rate below 16 or above 20 breaths per minute would also be a cause for concern. The goal of pain management is to have the woman's pain scale rating maintained between 0 to 2 points at all times, especially after breast-feeding.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 539

18. The nurse is assessing a postpartum client's lochia and finds that there is about a 4-inch stain on the perineal pad. The nurse interprets this finding as indicating which amount of blood loss?
- A. 10 mL
 - B. 10 to 25 mL
 - C. 25 to 50 mL
 - D. over 50 mL

Answer: B

Rationale: The amount of lochia is described as light or small for an approximately 4-inch stain and indicates a blood loss of 10 to 25 mL. Scant refers to a 1- to 2-inch stain of lochia and approximately 10 mL of blood loss; moderate refers to a 4- to 6-inch stain, suggesting a 25 to 50 mL blood loss; and large or heavy refers to a pad that is saturated within 1 hour after changing, indicating over 50 mL blood loss.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 542

19. The nurse is assessing a postpartum client's lochia and finds that there is about a 4-inch stain on the perineal pad. The nurse documents this finding as which description?
- A. scant
 - B. light
 - C. moderate

D. large

Answer: B

Rationale: The amount of lochia is described as light or small for an approximately 4-inch stain. Scant refers to a 1- to 2-inch stain of lochia; moderate refers to a 4- to 6-inch stain; and large or heavy refers to a pad that is saturated within 1 hour after changing.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 542

20. When reviewing the medical record of a postpartum client, the nurse notes that the client has experienced a third-degree laceration. The nurse understands that the laceration extends to which area?

- A. superficial structures above the muscle
- B. through the perineal muscles
- C. through the anal sphincter muscle
- D. through the anterior rectal wall

Answer: C

Rationale: A third-degree laceration extends through the anal sphincter muscle. A first-degree laceration involves only the skin and superficial structures above the muscle. A second-degree laceration extends through the perineal muscles. A fourth-degree laceration continues through the anterior rectal wall.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 543

21. A nurse is observing a postpartum client interacting with her newborn and notes that the mother is engaging with the newborn in the en face position. Which behavior would the nurse be observing?

- A. mother placing the newborn next to bare breast
- B. mother making eye-to-eye contact with the newborn
- C. mother gently stroking the newborn's face
- D. mother holding the newborn upright at the shoulder

Answer: B

Rationale: The en face position is characterized by the mother interacting with the newborn through eye-to-eye contact while holding the newborn. Bonding is a vital component of the attachment process and is necessary in establishing parent–infant attachment and a healthy,

loving relationship. During this early period of acquaintance, mothers touch their infants in a characteristic manner. Mothers visually and physically "explore" their infants, initially using their fingertips on the infant's face and extremities and progressing to massaging and stroking the infant with their fingers. This is followed by palm contact on the trunk. Eventually, mothers draw their infant toward them and hold the infant. Kangaroo care refers to skin-to-skin contact between the mother and newborn.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 545

22. After teaching a group of nurses during an in-service program about risk factors associated with postpartum hemorrhage, the nurse determines that the teaching was successful when the group identifies which risk factors? Select all that apply.

- A. prolonged labor
- B. placenta previa
- C. null parity
- D. hydramnios
- E. labor augmentation

Answer: B, D, E

Rationale: Risk factors for postpartum hemorrhage include precipitous labor less than 3 hours, placenta previa or abruption, multiparity, uterine overdistention such as with a large infant, twins, or hydramnios, and labor induction or augmentation. Prolonged labor over 24 hours is a risk factor for postpartum infection.

Question format: Multiple Select

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 538

23. A postpartum woman who is breastfeeding tells the nurse that she is experiencing nipple pain. After teaching the woman about possible suggestions, the nurse determines that more teaching is needed when the woman makes which statement?

- A. "I use a mild analgesic about 1 hour before breastfeeding."
- B. "I apply expressed breast milk to my nipples."
- C. "I apply glycerin-based gel to my nipples."
- D. "My baby latches on."

Answer: C

Rationale: Nipple pain is difficult to treat, although a wide variety of topical creams, ointments, and gels are available to do so. This group includes beeswax, glycerin-based products, petrolatum, lanolin, and hydrogel products. Many women find these products comforting.

Beeswax, glycerin-based products, and petrolatum all need to be removed before breastfeeding. These products should be avoided in order to limit infant exposure because the process of removal may increase nipple irritation. Mild analgesics such as acetaminophen or ibuprofen are considered relatively safe for breastfeeding mothers. Applying expressed breast milk to nipples and allowing it to dry has been suggested to reduce nipple pain. Usually the pain is due to incorrect latch-on and/or removal of the nursing infant from the breast. Early assistance with breastfeeding to ensure correct positioning can help prevent nipple trauma. In addition, applying expressed milk to nipples and allowing it to dry has been suggested to result in less nipple pain for many women.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 551

24. A nurse is developing a teaching plan about sexuality and contraception for a postpartum woman who is breastfeeding. Which information would the nurse **most** likely include? Select all that apply.

- A. resumption of sexual intercourse about two weeks after birth
- B. possible experience of fluctuations in sexual interest
- C. use of a water-based lubricant to ease vaginal discomfort
- D. use of combined hormonal contraceptives for the first three weeks
- E. possibility of increased breast sensitivity during sexual activity

Answer: B, C, E

Rationale: Typically, sexual intercourse can be resumed once bright-red bleeding has stopped and the perineum is healed from an episiotomy or lacerations. This is usually by the third to the sixth week postpartum. Fluctuations in sexual interest are normal. In addition, breastfeeding women may notice a let-down reflex during orgasm and find that breasts are very sensitive when touched by the partner. Precoital vaginal lubrication may be impaired during the postpartum period, especially in women who are breastfeeding. Use of water-based gel lubricants can help. The Centers for Disease Control and Prevention recommend that postpartum women not use combined hormonal contraceptives during the first 21 days after birth because of the high risk for venous thromboembolism (VTE) during this period.

Question format: Multiple Select

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 555

25. After teaching a postpartum woman about breastfeeding, the nurse determines that the teaching was successful when the woman makes which statement?

- A. "I should notice a decrease in abdominal cramping during breast-feeding."
- B. "I should wash my hands before starting to breastfeed."
- C. "The baby can be awake or sleepy when I start to feed him."

D. "The baby's mouth will open up once I put him to my breast."

Answer: B

Rationale: To promote successful breastfeeding, the mother should wash her hands before breast feeding and make sure that the baby is awake and alert and showing hunger signs. In addition, the mother should lightly tickle the infant's upper lip with her nipple to stimulate the infant to open the mouth wide and then bring the infant rapidly to the breast with a wide-open mouth. The mother also needs to know that her afterpains will increase during breastfeeding.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 559

26. A postpartum woman who is bottle-feeding her newborn asks the nurse, "About how much should my newborn drink at each feeding?" The nurse responds by saying that to feel satisfied, the newborn needs which amount at each feeding?

- A. 1 to 2 ounces
- B. 2 to 4 ounces
- C. 4 to 6 ounces
- D. 6 to 8 ounces

Answer: B

Rationale: Newborns need about 108 cal/kg or approximately 650 cal/day (Dudek, 2010).

Therefore, a newborn will need to 2 to 4 ounces to feel satisfied at each feeding.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 560

27. A nurse is observing a postpartum woman and her partner interact with their newborn. The nurse determines that the parents are developing parental attachment with their newborn when they demonstrate which behavior? Select all that apply.

- A. frequently ask for the newborn to be taken from the room
- B. identify common features between themselves and the newborn
- C. refer to the newborn as having a monkey-face
- D. make direct eye contact with the newborn
- E. refrain from checking out the newborn's features

Answer: B, D

Rationale: Positive behaviors that indicate attachment include identifying common features and making direct eye contact with the newborn. Asking for the newborn to be taken out of the room,

referring to the newborn as having a monkey-face, and refraining from checking out the newborn's features are negative attachment behaviors.

Question format: Multiple Select

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 547

28. A nurse is conducting a class for pregnant women who are in their third trimester. The nurse is reviewing information about the emotional changes that occur in the postpartum period, including postpartum blues and postpartum depression. After reviewing information about postpartum blues, the group demonstrates understanding when they make which statement about this condition?

- A. "Postpartum blues is a long-term emotional disturbance."
- B. "Getting some outside help for housework can lessen feelings of being overwhelmed."
- C. "The mother loses contact with reality."
- D. "Extended psychotherapy is needed for treatment."

Answer: B

Rationale: Postpartum blues require no formal treatment other than support and reassurance because they do not usually interfere with the woman's ability to function and care for her infant. Nurses can ease a mother's distress by encouraging her to vent her feelings and by demonstrating patience and understanding with her and her family. Suggest that getting outside help with housework and infant care might help her to feel less overwhelmed until the blues ease. Provide telephone numbers she can call when she feels down during the day. Making women aware of this disorder while they are pregnant will increase their knowledge about this mood disturbance, which may lessen their embarrassment and increase their willingness to ask for and accept help if it does occur.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Reference: p. 565

29. After teaching parents about their newborn, the nurse determines that the teaching was successful when they identify which concept as reflecting the enduring nature of their relationship, one that involves placing the infant at the center of their lives and finding their own way to assume the parental identity?

- A. reciprocity
- B. commitment
- C. bonding
- D. attachment

Answer: B

Rationale: Commitment refers to the enduring nature of the relationship. The components of this are twofold: centrality and parent role exploration. In centrality, parents place the infant at the center of their lives. They acknowledge and accept their responsibility to promote the infant's safety, growth, and development. Parent role exploration is the parents' ability to find their own way and integrate the parental identity into themselves. The development of a close emotional attraction to the newborn by parents during the first 30 to 60 minutes after birth describes bonding. Reciprocity is the process by which the infant's capabilities and behavioral characteristics elicit a parental response. Engrossment refers to the intense interest during early contact with a newborn. Attachment refers to the process of developing strong ties of affection between an infant and significant other.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 546

30. A woman gave birth to a healthy term neonate today at 1330. It is now 1430 and the nurse has completed the client's assessment. At which time would the nurse next assess the client?

- A. 1445
- B. 1500
- C. 1530
- D. 1830

Answer: B

Rationale: The woman is in her second hour postpartum. Typically, the nurse would assess the woman every 30 minutes. In this case, this would be 1500. During the first hour, assessments are usually completed every 15 minutes. After the second hour, assessments would be made every 4 hours for the first 24 hours and then every 8 hours.

Question format: Multiple Choice

Chapter 16: Nursing Management During the Postpartum Period

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 538

Chapter 17

1. A nurse is explaining to a group of new parents about the changes that occur in the neonate to sustain extrauterine life, describing the cardiac and respiratory systems as undergoing the most changes. Which information would the nurse integrate into the explanation to support this description?

- A. The cardiac murmur heard at birth disappears by 48 hours of age.
- B. Pulmonary vascular resistance (PVR) is decreased as lungs begin to function.
- C. Heart rate remains elevated after the first few moments of birth.
- D. Breath sounds will have rhonchi for at least the first day of life as fluid is absorbed.

Answer: B

Rationale: Although all the body systems of the newborn undergo changes, respiratory gas exchange along with circulatory modifications must occur immediately to sustain extrauterine life. With the first breath, PVR decreases, and the heart rate initially increases but then decreases to 120 to 130 bpm after a few minutes. The ductal murmur will go away in 80+% of infants by 48 hours. Rhonchi caused by retained amniotic fluid is an abnormal finding and would not be expected.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 579

2. A new mother reports that her newborn often spits up after feeding. Assessment reveals regurgitation. Which factor would the nurse integrate into the response?

- A. newborn being placed prone after feeding
- B. limited ability of digestive enzymes
- C. underdeveloped pyloric sphincter
- D. relaxed cardiac sphincter

Answer: D

Rationale: The cardiac sphincter and nervous control of the stomach is immature, which may lead to uncoordinated peristaltic activity and frequent regurgitation. Placement of the newborn is unrelated to regurgitation. Most digestive enzymes are available at birth, but they are limited in their ability to digest complex carbohydrates and fats; this results in fatty stools, not regurgitation. Immaturity of the pharyngoesophageal sphincter and absence of lower esophageal peristaltic waves, not an underdeveloped pyloric sphincter, also contribute to the reflux of gastric contents.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 590

3. Twenty minutes after birth, a baby begins to move his head from side to side, making eye contact with the mother, and pushes his tongue out several times. The nurse interprets this as:
- A. a good time to initiate breast-feeding.
 - B. the period of decreased responsiveness preceding sleep.
 - C. a sign that the infant is being overstimulated.
 - D. evidence that the newborn is becoming chilled.

Answer: A

Rationale: The newborn is demonstrating behaviors indicating the first period of reactivity, which usually begins at birth and lasts for the first 30 minutes. This is a good time to initiate breastfeeding. Decreased responsiveness occurs from 30 to 120 minutes of age and is characterized by muscle relaxation and diminished responsiveness to outside stimuli. None of the behaviors indicate overstimulation. Chilling would be evidenced by tachypnea, decreased activity, and hypotonia.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 593

4. The nurse institutes measures to maintain thermoregulation based on the understanding that newborns have limited ability to regulate body temperature because they:
- A. have a smaller body surface compared to body mass.
 - B. lose more body heat when they sweat than adults.
 - C. have an abundant amount of subcutaneous fat all over.
 - D. are unable to shiver effectively to increase heat production.

Answer: D

Rationale: Newborns have difficulty maintaining their body heat through shivering and other mechanisms. They have a large body surface area relative to body weight and have limited sweating ability. Additionally, newborns lack subcutaneous fat to provide insulation.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 584

5. A new mother is changing the diaper of her 12-hour-old newborn and asks why the stool is black and sticky. Which response by the nurse would be **most** appropriate?
- A. "You probably took iron during your pregnancy and that is what causes this type of stool."
 - B. "This is meconium stool and is normal for a newborn."

- C. "I'll take a sample and check it for possible bleeding."
- D. "This is unusual, and I need to report this to your pediatrician."

Answer: B

Rationale: Meconium is greenish-black and tarry and usually passed within 12 to 24 hours of birth. This is a normal finding. Iron can cause stool to turn black, but this would not be the case here. The stool is a normal occurrence and does not need to be checked for blood or reported.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 591

6. A client expresses concern that her 2-hour-old newborn is sleepy and difficult to awaken. The nurse explains that this behavior indicates:

- A. normal progression of behavior.
- B. probable hypoglycemia.
- C. physiological abnormality.
- D. inadequate oxygenation.

Answer: A

Rationale: From 30 to 120 minutes of age, the newborn enters the second stage of transition, that of sleep or a decrease in activity. More information would be needed to determine if hypoglycemia, a physiologic abnormality, or inadequate oxygenation was present.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 594

7. After the birth of a newborn, which action would the nurse do **first** to assist in thermoregulation?

- A. Dry the newborn thoroughly.
- B. Put a hat on the newborn's head.
- C. Check the newborn's temperature.
- D. Wrap the newborn in a blanket.

Answer: A

Rationale: Drying the newborn immediately after birth using warmed blankets is essential to prevent heat loss through evaporation. Then the nurse would place a cap on the baby's head and wrap the newborn. Assessing the newborn's temperature would occur once these measures were initiated to prevent heat loss.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 585

8. Assessment of a newborn reveals rhythmic spontaneous movements. The nurse interprets this as indicating:

- A. habituation.
- B. motor maturity.
- C. orientation.
- D. social behaviors.

Answer: B

Rationale: Motor maturity is evidenced by rhythmic, spontaneous movements. Habituation is manifested by the newborn's ability to respond to the environment appropriately. Orientation involves the newborn's response to new stimuli, such as turning the head to a sound. Social behaviors involve cuddling and snuggling into the arms of a parent.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 595

9. When teaching new parents about the sensory capabilities of their newborn, which sense would the nurse identify as being the least mature?

- A. hearing
- B. touch
- C. taste
- D. vision

Answer: D

Rationale: Vision is the least mature sense at birth. Hearing is well developed at birth, evidenced by the newborn's response to noise by turning. Touch is evidenced by the newborn's ability to respond to tactile stimuli and pain. A newborn can distinguish between sweet and sour by 72 hours of age.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 593

10. The nurse places a warmed blanket on the scale when weighing a newborn to minimize heat loss via which mechanism?

- A. evaporation

- B. conduction
- C. convection
- D. radiation

Answer: B

Rationale: Using a warmed cloth diaper or blanket to cover any cold surface, such as a scale, that touches a newborn directly helps to prevent heat loss through conduction. Drying a newborn and promptly changing wet linens, clothes, or diapers help reduce heat loss via evaporation. Keeping the newborn out of a direct cool draft, working inside an isolette as much as possible, and minimizing the opening of portholes help prevent heat loss via convection. Keeping cribs and isolettes away from outside walls, cold windows, and air conditioners and using radiant warmers while transporting newborns and performing procedures will help reduce heat loss via radiation.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 585

11. A nurse is assessing a newborn. Which finding would alert the nurse to the possibility of respiratory distress in a newborn?

- A. symmetrical chest movements
- B. periodic breathing
- C. respirations of 40 breaths/minute
- D. sternal retractions

Answer: D

Rationale: Sternal retractions, cyanosis, tachypnea, expiratory grunting, and nasal flaring are signs of respiratory distress in a newborn. Symmetrical chest movements and a respiratory rate between 30 to 60 breaths/minute are typical newborn findings. Some newborns may demonstrate periodic breathing (cessation of breathing lasting 5 to 10 seconds without changes in color or heart rate) in the first few days of life.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 583

12. The nurse is teaching a group of parents about the similarities and differences between newborn skin and adult skin. Which statement by the group indicates that additional teaching is needed?

- A. "The newborn's skin and that of an adult are similar in thickness."
- B. "The newborn's sweat glands function fully, just like those of an adult."
- C. "Skin development in the newborn is not complete at birth."
- D. "The newborn has fewer fibrils connecting the dermis and epidermis."

Answer: B

Rationale: The newborn has sweat glands, like an adult, but full adult functioning is not present until the second or third year of life. The newborn and adult epidermis is similar in thickness and lipid composition, but skin development is not complete at birth. Fewer fibrils connect the dermis and epidermis in the newborn when compared with the adult.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 592

13. When describing the neurologic development of a newborn to parents, the nurse would explain that it occurs in which fashion?

- A. head-to-toe
- B. lateral-to-medial
- C. outward-to-inward
- D. distal-caudal

Answer: A

Rationale: Neurologic development follows a cephalocaudal (head-to-toe) and proximal-distal (center to outside) pattern.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 592

14. The nurse is assessing the respirations of several newborns. The nurse would notify the health care provider for the newborn with which respiratory rate at rest?

- A. 38 breaths per minute
- B. 46 breaths per minute
- C. 54 breaths per minute
- D. 68 breaths per minute

Answer: D

Rationale: After respirations are established in the newborn, they are shallow and irregular, ranging from 30 to 60 breaths per minute, with short periods of apnea (less than 15 seconds). Thus a newborn with a respiratory rate below 30 or above 60 breaths per minute would require further evaluation.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential
Reference: p. 584

15. A new mother asks the nurse, "Why has my baby lost weight since he was born?" The nurse integrates knowledge of which cause when responding to the new mother?

- A. insufficient calorie intake
- B. shift of water from extracellular space to intracellular space
- C. increase in stool passage
- D. overproduction of bilirubin

Answer: A

Rationale: Normally, term newborns lose 5% to 10% of their birth weight as a result of insufficient caloric intake within the first week after birth, shifting of intracellular water to extracellular space, and insensible water loss. Stool passage and bilirubin have no effect on weight loss.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 590

16. The nurse observes the stool of a newborn who is being bottle-fed. The newborn is 2 days old. What would the nurse expect to find?

- A. greenish black, tarry stool
- B. yellowish-brown, seedy stool
- C. yellow-gold, stringy stool
- D. yellowish-green, pasty stool

Answer: D

Rationale: The milk stools of the formula-fed newborn vary depending on the type of formula ingested. They may be yellow, yellow-green, or greenish and loose, pasty, or formed in consistency, and they have an unpleasant odor. After breast-feedings are initiated, a transitional stool develops, which is greenish brown to yellowish brown, thinner in consistency, and seedy in appearance. Meconium stool is greenish black and tarry. The last development in the stool pattern is the milk stool. Milk stools of the breast-fed newborn are yellow-gold, loose, and stringy to pasty in consistency, and typically sour-smelling.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 591

17. The nurse observes the stool of a newborn who has begun to breastfeed. Which finding would the nurse expect?

- A. greenish black, tarry stool
- B. yellowish-brown, seedy stool
- C. yellow-gold, stringy stool
- D. yellowish-green, pasty stool

Answer: B

Rationale: After feedings are initiated, a transitional stool develops, which is greenish brown to yellowish brown, thinner in consistency, and seedy in appearance. Meconium stool is greenish black and tarry. The last development in the stool pattern is the milk stool. Milk stools of the breastfed newborn are yellow-gold, loose, and stringy to pasty in consistency, and typically sour-smelling. The milk stools of the formula-fed newborn vary depending on the type of formula ingested. They may be yellow, yellow-green, or greenish and loose, pasty, or formed in consistency, and they have an unpleasant odor.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 591

18. A nurse is assessing a newborn who is about 4½ hours old. The nurse would expect this newborn to exhibit which behavior? Select all that apply.

- A. sleeping
- B. interest in environmental stimuli
- C. passage of meconium
- D. difficulty arousing the newborn
- E. spontaneous Moro reflexes

Answer: B, C

Rationale: The newborn is in the second period of reactivity, which begins as the newborn awakens and shows an interest in environmental stimuli. This period lasts 2 to 8 hours in the normal newborn (Boxwell, 2010). Heart and respiratory rates increase. Peristalsis also increases. Thus, it is not uncommon for the newborn to pass meconium or void during this period. In addition, motor activity and muscle tone increase in conjunction with an increase in muscular coordination. Spontaneous Moro reflexes are noted during the first period of reactivity. Sleeping and difficulty arousing the newborn reflect the period of decreased responsiveness.

Question format: Multiple Select

Chapter 17: Newborn Adaptation

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 594

19. A nurse is assessing a newborn and observes the newborn moving his head and eyes toward a loud sound. The nurse interprets this as which behavior?

- A. habituation

- B. motor maturity
- C. social behavior
- D. orientation

Answer: D

Rationale: Orientation refers to the response of newborns to stimuli. It reflects newborns' response to auditory and visual stimuli, demonstrated by their movement of head and eyes to focus on that stimulus. Habituation is the newborn's ability to process and respond to visual and auditory stimuli—that is, how well and appropriately he or she responds to the environment. Habituation is the ability to block out external stimuli after the newborn has become accustomed to the activity. Motor maturity depends on gestational age and involves evaluation of posture, tone, coordination, and movements. These activities enable newborns to control and coordinate movement. When stimulated, newborns with good motor organization demonstrate movements that are rhythmic and spontaneous. Social behaviors include cuddling and snuggling into the arms of the parent when the newborn is held.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 594

20. A newborn is experiencing cold stress. Which findings would the nurse expect to assess?

Select all that apply.

- A. respiratory distress
- B. decreased oxygen needs
- C. hypoglycemia
- D. metabolic alkalosis
- E. jaundice

Answer: A, C, E

Rationale: Cold stress in the newborn can lead to the following problems if not reversed: depleted brown fat stores, increased oxygen needs, respiratory distress, increased glucose consumption leading to hypoglycemia, metabolic acidosis, jaundice, hypoxia, and decreased surfactant production.

Question format: Multiple Select

Chapter 17: Newborn Adaptation

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 588

21. A group of nurses are reviewing information about the changes in the newborn's lungs that must occur to maintain respiratory function. The nurses demonstrate understanding of this information when they identify which event as occurring **first**?

- A. expansion of the lungs

- B. increased pulmonary blood flow
- C. initiation of respiratory movement
- D. redistribution of cardiac output

Answer: C

Rationale: Before the newborn's lungs can maintain respiratory function, the following events must occur: respiratory movement must be initiated; lungs must expand, functional residual capacity must be established, pulmonary blood flow must increase, and cardiac output must be redistributed.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 583

22. A nurse is reviewing the laboratory test results of a newborn. Which result would the nurse identify as a cause for concern?

- A. hemoglobin 19 g/dL
- B. platelets 75,000/ μ L
- C. white blood cells 20,000/mm³
- D. hematocrit 52%

Answer: B

Rationale: Normal newborn platelets range from 150,000 to 350,000/ μ L. Normal hemoglobin ranges from 17 to 23g/dL, and normal hematocrit ranges from 46% to 68%. Normal white blood cell count ranges from 10,000 to 30,000/mm³.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 583

23. A nurse is preparing a class on newborn adaptations for a group of soon-to-be parents. When describing the change from fetal to newborn circulation, which information would the nurse include? Select all that apply.

- A. Decrease in right atrial pressure leads to closure of the foramen ovale.
- B. Increase in oxygen levels leads to a decrease in systemic vascular resistance.
- C. Onset of respirations leads to a decrease in pulmonary vascular resistance.
- D. Increase in pressure in the left atrium results from increases in pulmonary blood flow.
- E. Closure of the ductus venosus eventually forces closure of the ductus arteriosus.

Answer: A, C, D, E

Rationale: When the umbilical cord is clamped, the first breath is taken, and the lungs begin to function. As a result, systemic vascular resistance increases and blood return to the heart via the inferior vena cava decreases. Concurrently with these changes, there is a rapid decrease in pulmonary vascular resistance and an increase in pulmonary blood flow (Boxwell, 2010). The foramen ovale functionally closes with a decrease in pulmonary vascular resistance, which leads to a decrease in right-sided heart pressures. An increase in systemic pressure, after clamping of the cord, leads to an increase in left-sided heart pressures. Ductus arteriosus, ductus venosus, and umbilical vessels that were vital during fetal life are no longer needed.

Question format: Multiple Select

Chapter 17: Newborn Adaptation

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 579

24. A nurse is preparing a presentation about ways to minimize heat loss in the newborn. Which measure would the nurse include to prevent heat loss through convection?

- A. placing a cap on a newborn's head
- B. working inside an isolette as much as possible.
- C. placing the newborn skin-to-skin with the mother
- D. using a radiant warmer to transport a newborn

Answer: B

Rationale: To prevent heat loss by convection, the nurse would keep the newborn out of direct cool drafts (open doors, windows, fans, air conditioners) in the environment, work inside an isolette as much as possible and minimize opening portholes that allow cold air to flow inside, and warm any oxygen or humidified air that comes in contact with the newborn. Placing a cap on the newborn's head would help minimize heat loss through evaporation. Placing the newborn skin-to-skin with the mother helps to prevent heat loss through conduction. Using a radiant warmer to transport a newborn helps minimize heat loss through radiation.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 585

25. After teaching an in-service program to a group of nurses working in newborn nursery about a neutral thermal environment, the nurse determines that the teaching was successful when the group identifies which process as the newborn's primary method of heat production?

- A. convection
- B. nonshivering thermogenesis
- C. cold stress
- D. bilirubin conjugation

Answer: B

Rationale: The newborn's primary method of heat production is through nonshivering thermogenesis, a process in which brown fat (adipose tissue) is oxidized in response to cold exposure. Convection is a mechanism of heat loss. Cold stress results with excessive heat loss that requires the newborn to use compensatory mechanisms to maintain core body temperature. Bilirubin conjugation is a mechanism by which bilirubin in the blood is eliminated.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 587

26. While observing the interaction between a newborn and the mother, the nurse notes the newborn nestling into the arms of the mother. The nurse identifies this as which behavior?

- A. habituation
- B. self-quieting ability
- C. social behaviors
- D. orientation

Answer: C

Rationale: Social behaviors include cuddling and snuggling into the arms of the parent when the newborn is held. Self-quieting ability refers to newborns' ability to quiet and comfort themselves, such as by hand-to-mouth movements and sucking, alerting to external stimuli and motor activity. Habituation is the newborn's ability to process and respond to visual and auditory stimuli—that is, how well and appropriately he or she responds to the environment. Habituation is the ability to block out external stimuli after the newborn has become accustomed to the activity. Orientation refers to the response of newborns to stimuli, becoming more alert when sensing a new stimulus in their environment.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 594

27. When explaining how a newborn adapts to extrauterine life, the nurse would describe which body systems as undergoing the **most** rapid changes?

- A. gastrointestinal and hepatic
- B. urinary and hematologic
- C. respiratory and cardiovascular
- D. neurological and integumentary

Answer: C

Rationale: Although all the body systems of the newborn undergo changes, respiratory gas exchange along with circulatory modifications must occur immediately to sustain extrauterine life.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 578

28. A nurse is teaching a group of new parents about their newborns' sensory capabilities. The nurse would identify which sense as being well-developed at birth?

A. hearing

B. touch

C. taste

D. vision

Answer: A

Rationale: Hearing is well developed at birth, evidenced by the newborn's response to noise by turning. Vision is the least mature sense at birth. Touch is evidenced by the newborn's ability to respond to tactile stimuli and pain. A newborn can distinguish between sweet and sour by 72 hours of age.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 593

29. The nurse dries the neonate thoroughly and promptly changes wet linens. The nurse does so to minimize heat loss via which mechanism?

A. evaporation

B. conduction

C. convection

D. radiation

Answer: A

Rationale: Drying a newborn and promptly changing wet linens, clothes, or diapers help reduce heat loss via evaporation. Keeping the newborn out of a direct cool draft, working inside an isolette as much as possible, and minimizing the opening of portholes help prevent heat loss via convection. Using a warmed cloth diaper or blanket to cover any cold surface, such as a scale, that touches a newborn directly helps to prevent heat loss through conduction. Keeping cribs and isolettes away from outside walls, cold windows, and air conditioners and using radiant warmers while transporting newborns and performing procedures will help reduce heat loss via radiation.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 585

30. A nurse is teaching a new mother about her newborn's immune status. The nurse determines that the teaching was successful when the mother states which immunoglobulin has crossed the placenta?

- A. IgA
- B. IgG
- C. IgM
- D. IgE

Answer: B

Rationale: IgG is the major immunoglobulin and the most abundant, making up about 80% of all circulating antibodies. It is found in serum and interstitial fluid. It is the only class able to cross the placenta, with active placental transfer beginning at approximately 20 to 22 weeks' gestation. No other immunoglobulin crosses the placenta.

Question format: Multiple Choice

Chapter 17: Newborn Adaptation

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 591

Chapter 18

1. Prior to discharging a 24-hour-old newborn, the nurse assesses the newborn's respiratory status. What would the nurse expect to assess?
 - A. respiratory rate 45 breaths/minute, irregular
 - B. costal breathing pattern
 - C. nasal flaring, rate 65 breaths/minute
 - D. crackles on auscultation

Answer: A

Rationale: Typically, respirations in a 24-hour-old newborn are symmetric, slightly irregular, shallow, and unlabored at a rate of 30 to 60 breaths/minute. The breathing pattern is primarily diaphragmatic. Nasal flaring, rates above 60 breaths per minute, and crackles suggest a problem.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 610

2. The nurse encourages the mother of a healthy newborn to put the newborn to the breast immediately after birth for which reason?
 - A. to aid in maturing the newborn's sucking reflex
 - B. to encourage the development of maternal antibodies
 - C. to facilitate maternal–infant bonding
 - D. to enhance the clearing of the newborn's respiratory passages

Answer: C

Rationale: Breastfeeding can be initiated immediately after birth. This immediate mother–newborn contact takes advantage of the newborn's natural alertness and fosters bonding. This contact also reduces maternal bleeding and stabilizes the newborn's temperature, blood glucose level, and respiratory rate. It is not associated with maturing the sucking reflex, encouraging the development of maternal antibodies, or aiding in clearing of the newborn's respiratory passages.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Reference: p. 640

3. When making a home visit, the nurse observes a newborn sleeping on his back in a bassinet. In one corner of the bassinet is some soft bedding material, and at the other end is a bulb syringe. The nurse determines that the mother needs additional teaching for which reason?
 - A. The newborn should not be sleeping on his back.

- B. Soft bedding material should not be in areas where infants sleep.
- C. The bulb syringe should not be kept in the bassinet.
- D. This newborn should be sleeping in a crib.

Answer: B

Rationale: The nurse should instruct the mother to remove all fluffy bedding, quilts, stuffed animals, and pillows from the crib to prevent suffocation. Newborns and infants should be placed on their backs to sleep. Having the bulb syringe nearby in the bassinet is appropriate. Although a crib is the safest sleeping location, a bassinet is appropriate initially.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Analyze

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Reference: p. 631

4. Assessment of a newborn reveals a heart rate of 180 beats per minute. To determine whether this finding is a common variation rather than a sign of distress, what else does the nurse need to know?

- A. How many hours old is this newborn?
- B. How long ago did this newborn eat?
- C. What was the newborn's birthweight?
- D. Is acrocyanosis present?

Answer: A

Rationale: The typical heart rate of a newborn ranges from 110 to 160 beats per minute with wide fluctuation during activity and sleep. Typically heart rate is assessed every 30 minutes until stable for 2 hours after birth. The time of the newborn's last feeding and his birthweight would have no effect on his heart rate. Acrocyanosis is a common normal finding in newborns.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 610

5. When assessing a newborn 1 hour after birth, the nurse measures an axillary temperature of 95.8° F (35.4° C), an apical pulse of 114 beats per minute, and a respiratory rate of 60 breaths per minute. The nurse would identify which area as the **priority**?

- A. hypothermia
- B. impaired parenting
- C. deficient fluid volume
- D. risk for infection

Answer: A

Rationale: The newborn's heart rate is slightly below the accepted range of 120 to 160 beats per minute; the respiratory rate is at the high end of the accepted range of 30 to 60 breaths per minute. However, the newborn's temperature is significantly below the accepted range of 97.7 to 99.7? (36.5 to 37.6?). Therefore, the priority problem area is hypothermia. There is no information to suggest impaired parenting. Additional information is needed to determine if there is deficient fluid volume or a risk for infection.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 602

6. The nurse places a newborn with jaundice under the phototherapy lights in the nursery to achieve which goal?

- A. Prevent cold stress.
- B. Increase surfactant levels in the lungs.
- C. Promote respiratory stability.
- D. Decrease the serum bilirubin level.

Answer: D

Rationale: Jaundice reflects elevated serum bilirubin levels; phototherapy helps to break down the bilirubin for excretion. Phototherapy has no effect on body temperature, surfactant levels, or respiratory stability.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 636

7. During a physical assessment of a newborn, the nurse observes bluish markings across the newborn's lower back. The nurse interprets this finding as:

- A. milia.
- B. Mongolian spots.
- C. stork bites.
- D. birth trauma.

Answer: B

Rationale: Mongolian spots are blue or purple splotches that appear on the lower back and buttocks of newborns. Milia are unopened sebaceous glands frequently found on a newborn's nose. Stork bites are superficial vascular areas found on the nape of the neck and eyelids and between the eyes and upper lip. Birth trauma would be manifested by bruising, swelling, and possible deformity.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 612

8. While making rounds in the nursery, the nurse sees a 6-hour-old baby girl gagging and turning bluish. What would the nurse do **first**?

- A. Alert the primary care provider stat, and turn the newborn to her right side.
- B. Administer oxygen via facial mask by positive pressure.
- C. Lower the newborn's head to stimulate crying.
- D. Aspirate the oral and nasal pharynx with a bulb syringe.

Answer: D

Rationale: The nurse's first action would be to suction the oral and nasal pharynx with a bulb syringe to maintain airway patency. Turning the newborn to her right side will not alleviate the blockage due to secretions. Administering oxygen via positive pressure is not indicated at this time. Lowering the newborn's head would be inappropriate.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 638

9. While performing a physical assessment of a newborn boy, the nurse notes diffuse edema of the soft tissues of his scalp that crosses suture lines. The nurse documents this finding as:

- A. molding.
- B. microcephaly.
- C. caput succedaneum.
- D. cephalhematoma.

Answer: C

Rationale: Caput succedaneum is localized edema on the scalp, a poorly demarcated soft tissue swelling that crosses the suture lines. Molding refers to the elongated shape of the fetal head as it accommodates to the passage through the birth canal. Microcephaly refers to a head circumference that is 2 standard deviations below average or less than 10% of normal parameters for gestational age. Cephalhematoma is a localized effusion of blood beneath the periosteum of the skull.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 614

10. Assessment of a newborn reveals uneven gluteal (buttocks) skin creases and a "clunk" when the Ortolani maneuver is performed. What would the nurse suspect?

- A. slipping of the periosteal joint
- B. developmental hip dysplasia
- C. normal newborn variation
- D. overriding of the pelvic bone

Answer: B

Rationale: A "clunk" indicates the femoral head hitting the acetabulum as the head reenters the area. This, along with uneven gluteal creases, suggests developmental hip dysplasia. These findings are not a normal variation and are not associated with slipping of the periosteal joint or overriding of the pelvic bone.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 621

11. A nurse is assessing a newborn's reflexes. The nurse strokes the lateral sole of the newborn's foot from the heel to the ball of the foot to elicit which reflex?

- A. Babinski
- B. tonic neck
- C. stepping
- D. plantar grasp

Answer: A

Rationale: The Babinski reflex is elicited by stroking the lateral sole of the newborn's foot from the heel toward and across the ball of the foot. The tonic neck reflex is tested by having the newborn lie on his back and then turn his head to one side. The stepping reflex is elicited by holding the newborn upright and inclined forward with the soles of the feet on a flat surface. The plantar grasp reflex is elicited by placing a finger against the area just below the newborn's toes.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 621

12. The nurse administers vitamin K intramuscularly to the newborn based on which rationale?

- A. Stop Rh sensitization.
- B. Increase erythropoiesis.
- C. Enhance bilirubin breakdown.
- D. Promote blood clotting.

Answer: D

Rationale: Vitamin K promotes blood clotting by increasing the synthesis of prothrombin by the liver. Rho(D) immune globulin prevents Rh sensitization. Erythropoietin stimulates erythropoiesis. Phototherapy enhances bilirubin breakdown.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Reference: p. 606

13. The nurse is assessing the skin of a newborn and notes a rash on the newborn's face and chest. The rash consists of small papules and is scattered with no pattern. The nurse interprets this finding as:

- A. harlequin sign.
- B. nevus flammeus.
- C. erythema toxicum.
- D. port wine stain.

Answer: C

Rationale: Erythema toxicum (newborn rash) is a benign, idiopathic, generalized, transient rash that occurs in up to 70% of all newborns during the first week of life. It consists of small papules or pustules on the skin resembling flea bites. The rash is common on the face, chest, and back. One of the chief characteristics of this rash is its lack of pattern. It is caused by the newborn's eosinophils reacting to the environment as the immune system matures. Harlequin sign refers to the dilation of blood vessels on only one side of the body, giving the newborn the appearance of wearing a clown suit. It gives a distinct midline demarcation, which is described as pale on the nondependent side and red on the opposite, dependent side. Nevus flammeus or port wine stain is a capillary angioma located directly below the dermis. It is flat with sharp demarcations and is purple-red. This skin lesion is made up of mature capillaries that are congested and dilated.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 614

14. A nurse is conducting a refresher program for a group of nurses working in the newborn nursery. After teaching the group about variations in newborn head size and appearance, the nurse determines that the teaching was successful when the group identifies which variation as normal? Select all that apply.

- A. cephalhematoma
- B. molding
- C. closed fontanel
- D. caput succedaneum
- E. posterior fontanel diameter 1.5 cm

Answer: A, B, D

Rationale: Normal variations in newborn head size and appearance include cephalhematoma, molding, and caput succedaneum. Microcephaly, closed fontanel, or a posterior fontanel diameter greater than 1 cm are considered abnormal.

Question format: Multiple Select

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 614

15. The nurse is assessing a newborn's eyes. Which findings would the nurse identify as normal?

Select all that apply.

- A. slow blink response
- B. able to track object to midline
- C. transient deviation of the eyes
- D. involuntary repetitive eye movement
- E. absent red reflex

Answer: B, C, D

Rationale: Assessment of the eyes should reveal a rapid blink reflex, ability to track objects to the midline, transient strabismus (deviation or wandering of the eyes independently), searching nystagmus (involuntary repetitive eye movement), and a red reflex.

Question format: Multiple Select

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 617

16. Assessment of a newborn's head circumference reveals that it is 34 cm. The nurse would suspect that this newborn's chest circumference would be:

- A. 30 cm.
- B. 32 cm.
- C. 34 cm.
- D. 36 cm.

Answer: B

Rationale: The newborn's chest should be round, symmetric, and 2 to 3 cm smaller than the head circumference. Therefore, this newborn's chest circumference of 31 to 32 cm would be normal.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 610

17. The nurse is auscultating a newborn's heart and places the stethoscope at the point of maximal impulse at which location?

- A. just superior to the nipple, at the midsternum
- B. lateral to the midclavicular line at the fourth intercostal space
- C. at the fifth intercostal space to the left of the sternum
- D. directly adjacent to the sternum at the second intercostals space

Answer: B

Rationale: The point of maximal impulse (PMI) in a newborn is a lateral to midclavicular line located at the fourth intercostal space.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 618

18. The nurse is inspecting the external genitalia of a male newborn. Which finding would alert the nurse to a possible problem?

- A. limited rugae
- B. large scrotum
- C. palpable testes in scrotal sac
- D. negative engorgement

Answer: A

Rationale: The scrotum usually appears relatively large and should be pink in white neonates and dark brown in neonates of color. Rugae should be well formed and should cover the scrotal sac.

There should not be bulging, edema(engorgement), or discoloration. Testes should be palpable in the scrotal sac and feel firm and smooth and be of equal size on both sides of the scrotal sac.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 619

19. When assessing a newborn's reflexes, the nurse strokes the newborn's cheek, and the newborn turns toward the side that was stroked and begins sucking. The nurse documents which reflex as being positive?

- A. palmar grasp reflex
- B. tonic neck reflex
- C. Moro reflex
- D. rooting reflex

Answer: D

Rationale: The rooting reflex is elicited by stroking the newborn's cheek. The newborn should turn toward the side that was stroked and should begin to make sucking movements. The palmar grasp reflex is elicited by placing a finger on the newborn's open palm. The baby's hand will close around the finger. Attempting to remove the finger causes the grip to tighten. The tonic neck reflex is elicited by having the newborn lie on the back and turning the head to one side. The arm toward which the baby is facing should extend straight away from the body with the hand partially open, whereas the arm on the side away from the face is flexed and the fist is clenched tightly. Reversing the direction to which the face is turned reverses the position. The Moro reflex is elicited by placing the newborn on his or her back, supporting the upper body weight of the supine newborn by the arms using a lifting motion without lifting the newborn off the surface. The arms are released suddenly, the newborn will throw the arms outward and flex the knees, and then the arms return to the chest. The fingers also spread to form a C.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 621

20. A nurse is teaching new parents about bathing their newborn. The nurse determines that the teaching was successful when the parents make which statement?

- A. "We can put a tiny bit of lotion on his skin, and then rub it in gently."
- B. "We should avoid using any kind of baby powder."
- C. "We need to bathe him at least four to five times a week."
- D. "We should clean his eyes after washing his face and hair."

Answer: B

Rationale: Powders should not be used, because they can be inhaled, causing respiratory distress. If the parents want to use oils and lotions, have them apply a small amount onto their hand first, away from the newborn; this warms the lotion. Then the parents should apply the lotion or oil sparingly. Parents need to be instructed that a bath two or three times weekly is sufficient for the first year because too frequent bathing may dry the skin. The eyes are cleaned first and only with plain water; then the rest of the face is cleaned with plain water.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 625

21. A new mother who is breastfeeding her newborn asks the nurse, "How will I know if my baby is drinking enough?" Which response by the nurse would be **most** appropriate?

- A. "If he seems content after feeding, that should be a sign."
- B. "Make sure he drinks at least 5 minutes on each breast."
- C. "He should wet between 6 to 10 diapers each day."
- D. "If his lips are moist, then he's okay."

Answer: C

Rationale: Soaking 6 to 10 diapers a day indicates adequate hydration. Contentedness after feeding is not an indicator for adequate hydration. Typically a newborn wakes up 8 to 12 times per day for feeding. As the infant gets older, the time on the breast increases. Moist mucous membranes help to suggest adequate hydration, but this is not the best indicator.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 639

22. A nurse is teaching a postpartum client and her partner about caring for their newborn's umbilical cord site. Which statement by the parents indicates a need for additional teaching?

- A. "We can put him in the tub to bathe him once the cord falls off and is healed."
- B. "The cord stump should change from brown to yellow."
- C. "Exposing the stump to the air helps it to dry."
- D. "We need to call the primary care provider if we notice a funny odor."

Answer: B

Rationale: The cord stump should change color from yellow to brown or black. Therefore the parents need additional teaching if they state the color changes from brown to yellow. Tub baths are avoided until the cord has fallen off and the area is healed. Exposing the stump to the air helps it to dry. The parents should notify their primary care provider if there is any bleeding, redness, drainage, or foul odor from the cord stump.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 627

23. While changing a female newborn's diaper, the nurse observes a mucus-like, slightly bloody vaginal discharge. Which action would the nurse do **next**?

- A. Document this as pseudo menstruation.
- B. Notify the primary care provider immediately.
- C. Obtain a culture of the discharge.
- D. Inspect for engorgement.

Answer: A

Rationale: The nurse should assess pseudomenstruation, a vaginal discharge composed of mucus mixed with blood, which may be present during the first few weeks of life. This discharge requires no treatment. The discharge is a normal finding and thus does not need to be reported immediately. It is not an indication of infection. The female genitalia normally will be engorged, so assessing for engorgement is not indicated.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 620

24. A nurse is describing the advantages and disadvantages of circumcision to a group of expectant parents. Which statement by the parents indicates effective teaching?

- A. "Sexually transmitted infections are more common in circumcised males."
- B. "The rate of penile cancer is less for circumcised males."
- C. "Urinary tract infections are more easily treated in circumcised males."
- D. "Circumcision is a risk factor for acquiring HIV infection."

Answer: B

Rationale: The risk for penile cancer appears to be slightly lower for males who are circumcised. However, penile cancer is rare and other risk factors such as genital warts and HPV infection seem to play a larger role. Sexually transmitted infections are less common in circumcised males, but the risk is believed to be related more to behavioral factors than circumcision status.

Circumcised males have a 50% lower risk of acquiring HIV infection. Urinary tract infections are slightly less common in circumcised boys. However, rates are low in both circumcised and uncircumcised boys and are easily treated without long-term sequelae.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 628

25. A newborn is scheduled to undergo a screening test for phenylketonuria (PKU). The nurse prepares to obtain the blood sample from the newborn's:

- A. finger.
- B. heel.
- C. scalp vein.
- D. umbilical vein.

Answer: B

Rationale: Screening tests for genetic and inborn errors of metabolism require a few drops of blood taken from the newborn's heel. The finger, scalp vein, or umbilical vein are inappropriate sites for the blood sample.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 633

26. Assessment of a newborn reveals transient tachypnea. The nurse reviews the newborn's medical record. Which factor in the newborn's history would the nurse identify as playing a role in this condition?

- A. vaginal birth
- B. shortened labor
- C. central nervous system depressant during labor
- D. maternal hypertension

Answer: C

Rationale: Transient tachypnea of the newborn occurs when the fetal liquid in the lungs is removed slowly or incompletely. This can be due to the lack of thoracic squeezing that occurs during a cesarean birth or diminished respiratory effort if the mother received central nervous system depressant medication. Prolonged labor, macrosomia of the fetus, and maternal asthma also have been associated with this condition.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 635

27. A nurse is providing teaching to a new mother about her newborn's nutritional needs. Which suggestions would the nurse include in the teaching? Select all that apply.

- A. Supplement with iron if the woman is breastfeeding.
- B. Provide supplemental water intake with feedings.
- C. Feed the newborn every 2 to 4 hours during the day.
- D. Burp the newborn frequently throughout each feeding.
- E. Use feeding time for promoting closeness.

Answer: C, D, E

Rationale: Most newborns are on demand feeding schedules and are allowed to feed when they awaken. When they go home, mothers are encouraged to feed their newborns every 2 to 4 hours during the day and only when the newborn awakens during the night for the first few days after birth. Newborns swallow air during feedings, which causes discomfort and fussiness. Parents can prevent this by burping them frequently throughout the feeding. Feeding is also more than an opportunity to get nutrients into the newborn. It is also a time for closeness and sharing. Iron supplementation is recommended for infants who are bottle-fed. Fluid requirements for the newborn and infant do range from 100 to 150 mL/kg daily. This requirement can be met through breast or bottle feedings. Thus, additional water supplementation is not necessary.

Question format: Multiple Select

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 639

28. The nurse completes the initial assessment of a newborn. Which finding would lead the nurse to suspect that the newborn is experiencing difficulty with oxygenation?

- A. respiratory rate of 54 breaths/minute
- B. abdominal breathing
- C. nasal flaring
- D. acrocyanosis

Answer: C

Rationale: Nasal flaring is a sign of respiratory difficulty in the newborn. A rate of 54 breaths/minute, diaphragmatic/abdominal breathing, and acrocyanosis are normal findings.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 601

29. Just after birth, a newborn's axillary temperature is 94°F (34.4°C). What action would be **most** appropriate?

- A. Assess the newborn's gestational age.
- B. Rewarm the newborn gradually.
- C. Observe the newborn every hour.
- D. Notify the primary care provider if the temperature goes lower.

Answer: B

Rationale: A newborn's temperature is typically maintained at 97.7° F to 99.7° F (36.5° C to 37.5° C). Since this newborn's temperature is significantly lower, the nurse should institute measures to rewarm the newborn gradually. Assessment of gestational age is completed regardless of the newborn's temperature. Observation would be inappropriate because lack of action may lead to a further lowering of the temperature. The nurse should notify the primary care provider of the newborn's current temperature since it is outside normal parameters.

Question format: Multiple Choice

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 608

30. A new parent is talking with the nurse about feeding the newborn. The parent has chosen to use formula. The parent asks, "How can I make sure that my baby is getting what is needed?" Which response(s) by the nurse would be appropriate? Select all that apply.

- A. "Make sure to use an iron-fortified formula until your baby is about 1 year old."
- B. "Start giving your baby fluoride supplements now so your baby develops strong teeth."
- C. "Since you are not breastfeeding, your baby needs a baby multivitamin each day."
- D. "Your baby gets enough fluid with formula, so you do not need to give extra water."
- E. "It is important to give your baby vitamin D each day."

Answer: A, D, E

Rationale: Fluid requirements for the newborn and infant range from 100 to 150 mL/kg daily. This requirement can be met through breastfeeding or bottle feeding. Additional water supplementation is not necessary. Adequate carbohydrates, fats, protein, and vitamins are achieved through consumption of breast milk or formula. Iron-fortified formula is recommended for all infants who are not breastfed from birth to 1 year of age. The breastfed infant draws on iron reserves for the first 6 months and then needs iron-rich foods or supplementation added at 6 months of age. All infants (breastfed and bottle fed) should receive a daily supplement of 400 International Units of vitamin D starting within the first few days of life to prevent rickets and vitamin D deficiency. It is also recommended that fluoride supplementation be given to infants not receiving fluoridated water after the age of 6 months.

Question format: Multiple Select

Chapter 18: Nursing Management of the Newborn

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 637

Chapter 19

1. After teaching a woman who has had an evacuation for gestational trophoblastic disease (hydatidiform mole or molar pregnancy) about her condition, which statement indicates that the nurse's teaching was successful?
- A. "I will be sure to avoid getting pregnant for at least 1 year."
 - B. "My intake of iron will have to be closely monitored for 6 months."
 - C. "My blood pressure will continue to be increased for about 6 more months."
 - D. "I won't use my birth control pills for at least a year or two."

Answer: A

Rationale: After evacuation of trophoblastic tissue (hydatidiform mole), long-term follow-up is necessary to make sure any remaining trophoblastic tissue does not become malignant. Serial hCG levels are monitored closely for 1 year, and the client is urged to avoid pregnancy for 1 year because it can interfere with the monitoring of hCG levels. Iron intake and blood pressure are not important aspects of follow up after evacuation of a hydatidiform mole. Use of a reliable contraceptive is strongly recommended so that pregnancy is avoided.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 667

2. A client is diagnosed with gestational hypertension and is receiving magnesium sulfate. The nurse determines that the medication is at a therapeutic level based on which finding?
- A. urinary output of 20 mL per hour
 - B. respiratory rate of 10 breaths/minute
 - C. deep tendon reflexes 2+
 - D. difficulty in arousing

Answer: C

Rationale: With magnesium sulfate, deep tendon reflexes of 2+ would be considered normal and therefore a therapeutic level of the drug. Urinary output of less than 30 mL, a respiratory rate of less than 12 breaths/minute, and a diminished level of consciousness would indicate magnesium toxicity.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 689

3. Upon entering the room of a client who has had a spontaneous abortion, the nurse observes the client crying. Which response by the nurse would be **most** appropriate?

- A. "Why are you crying?"
- B. "Will a pill help your pain?"
- C. "I'm sorry you lost your baby."
- D. "A baby still wasn't formed in your uterus."

Answer: C

Rationale: Telling the client that the nurse is sorry for the loss acknowledges the loss to the woman, validates her feelings, and brings the loss into reality. Asking why the client is crying is ineffective at this time. Offering a pill for the pain ignores the client's feelings. Telling the client that the baby was not formed is inappropriate and discounts any feelings or beliefs that the client has.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 661

4. A nurse is reviewing a client's history and physical examination findings. Which information would the nurse identify as contributing to the client's risk for an ectopic pregnancy?

- A. use of oral contraceptives for 5 years
- B. ovarian cyst 2 years ago
- C. recurrent pelvic infections
- D. heavy, irregular menses

Answer: C

Rationale: In the general population, most cases of ectopic pregnancy are the result of tubal scarring secondary to pelvic inflammatory disease. Oral contraceptives, ovarian cysts, and heavy, irregular menses are not considered risk factors for ectopic pregnancy.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 663

5. A client is suspected of having a ruptured ectopic pregnancy. Which assessment would the nurse identify as the **priority**?

- A. hemorrhage
- B. jaundice
- C. edema
- D. infection

Answer: A

Rationale: With a ruptured ectopic pregnancy, the woman is at high risk for hemorrhage. Jaundice, edema, and infection are not associated with a ruptured ectopic pregnancy.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 663

6. It is determined that a client's blood Rh is negative and her partner's is Rh positive. To help prevent Rh isoimmunization, the nurse would expect to administer Rho(D) immune globulin at which time?

- A. at 32 weeks' gestation and immediately before discharge
- B. 24 hours before birth and 24 hours after birth
- C. in the first trimester and within 2 hours of birth
- D. at 28 weeks' gestation and again within 72 hours after birth

Answer: D

Rationale: To prevent isoimmunization, the woman should receive Rho(D) immune globulin at 28 weeks and again within 72 hours after birth.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 693

7. A woman pregnant with twins comes to the clinic for an evaluation. While assessing the client, the nurse would be especially alert for signs and symptoms for which potential problem?

- A. oligohydramnios
- B. preeclampsia
- C. post-term labor
- D. chorioamnionitis

Answer: B

Rationale: Women with multiple gestations are at high risk for preeclampsia, preterm labor, polyhydramnios, hyperemesis gravidarum, anemia, and antepartal hemorrhage. There is no association between multiple gestations and the development of chorioamnionitis.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Reference: p. 695

8. A client comes to the clinic for an evaluation. The client is at 22 weeks' gestation. After reviewing a client's history, which factor would the nurse identify as placing her at risk for preeclampsia?

- A. Her mother had preeclampsia during pregnancy.
- B. Client has a twin sister.
- C. Her sister-in-law had gestational hypertension.
- D. This is the client's second pregnancy.

Answer: A

Rationale: A family history of preeclampsia, such as a mother or sister, is considered a risk factor for the client. Having a twin sister or having a sister-in-law with gestational hypertension would not increase the client's risk. If the client had a history of preeclampsia in her first pregnancy, then she would be at risk in her second pregnancy.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 683

9. A client with hyperemesis gravidarum is admitted to the facility after being cared for at home without success. What would the nurse expect to include in the client's plan of care?

- A. clear liquid diet
- B. total parenteral nutrition
- C. nothing by mouth
- D. administration of labetalol

Answer: C

Rationale: Typically, on admission, the woman with hyperemesis has oral food and fluids withheld to rest the gut and receives parenteral fluids to rehydrate and reduce the symptoms. Once the condition stabilizes, oral intake is gradually increased. Total parenteral nutrition may be used if the client's condition does not improve with several days of bed rest, gut rest, IV fluids, and antiemetics. Labetalol is an antihypertensive agent that may be used to treat gestational hypertension, not hyperemesis.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Reference: p. 680

10. A nurse suspects that a client is developing HELLP syndrome. The nurse notifies the health care provider based on which finding?

- A. hyperglycemia
- B. elevated platelet count
- C. disseminated intravascular coagulation (DIC)

D. elevated liver enzymes

Answer: D

Rationale: HELLP is an acronym for hemolysis, elevated liver enzymes, and low platelets. Hyperglycemia is not a part of this syndrome. HELLP may increase the woman's risk for DIC but it is not an assessment finding.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 691

11. A client with severe preeclampsia is receiving magnesium sulfate as part of the treatment plan. To ensure the client's safety, which compound would the nurse have readily available?

- A. calcium gluconate
- B. potassium chloride
- C. ferrous sulfate
- D. calcium carbonate

Answer: A

Rationale: The woman is at risk for magnesium toxicity. The antidote for magnesium sulfate is calcium gluconate, and this should be readily available in case the woman has signs and symptoms of magnesium toxicity.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Nursing Process

Reference: p. 686

12. A nurse is conducting an assessment of a woman who has experienced PROM. Which amniotic fluid finding would lead the nurse to suspect infection as the cause of a client's PROM?

- A. yellow-green fluid
- B. blue color on Nitrazine testing
- C. ferning
- D. foul odor

Answer: D

Rationale: A foul odor of the amniotic fluid indicates infection. Yellow-green fluid would suggest meconium. A blue color on Nitrazine testing and ferning indicate the presence of amniotic fluid.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 697

13. The nurse is reviewing the laboratory test results of a pregnant client. Which finding would alert the nurse to the development of HELLP syndrome?

- A. hyperglycemia
- B. elevated platelet count
- C. leukocytosis
- D. elevated liver enzymes

Answer: D

Rationale: HELLP is an acronym for hemolysis, elevated liver enzymes, and low platelets.

Hyperglycemia or leukocytosis is not a part of this syndrome.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 691

14. While assessing a pregnant woman, the nurse suspects that the client may be at risk for hydramnios. Which information would the nurse use to support this suspicion? Select all that apply.

- A. history of diabetes
- B. reports of shortness of breath
- C. identifiable fetal parts on abdominal palpation
- D. difficulty obtaining fetal heart rate
- E. fundal height below that for expected gestational age

Answer: A, B, D

Rationale: Factors such as maternal diabetes or multiple gestations place the woman at risk for hydramnios. In addition, there is a discrepancy between fundal height and gestational age, such that a rapid growth of the uterus is noted. Shortness of breath may result from overstretching of the uterus due to the increased amount of amniotic fluid. Often, fetal parts are difficult to palpate and fetal heart rate is difficult to obtain because of the excess fluid present.

Question format: Multiple Select

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 694

15. A nurse is conducting an in-service program for a group of nurses working at the women's health facility about the causes of spontaneous abortion. The nurse determines that the teaching

was successful when the group identifies which condition as the **most** common cause of first trimester abortions?

- A. maternal disease
- B. cervical insufficiency
- C. fetal genetic abnormalities
- D. uterine fibroids

Answer: C

Rationale: The causes of spontaneous abortion are varied and often unknown. The most common cause for first-trimester abortions is fetal genetic abnormalities, usually unrelated to the mother. Chromosomal abnormalities are more likely causes in first trimester, and maternal disease is more likely in the second trimester. Those occurring during the second trimester are more likely related to maternal conditions, such as cervical insufficiency, congenital, or acquired anomaly of the uterine cavity (uterine septum or fibroids), hypothyroidism, diabetes mellitus, chronic nephritis, use of crack cocaine, inherited and acquired thrombophilias, lupus, polycystic ovary syndrome, severe hypertension, and acute infection such as rubella virus, cytomegalovirus, herpes simplex virus, bacterial vaginosis, and toxoplasmosis.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 662

16. A pregnant woman is admitted with premature rupture of the membranes. The nurse is assessing the woman closely for possible infection. Which findings would lead the nurse to suspect that the woman is developing an infection? Select all that apply.

- A. fetal bradycardia
- B. abdominal tenderness
- C. elevated maternal pulse rate
- D. decreased C-reactive protein levels
- E. cloudy malodorous fluid

Answer: B, C, E

Rationale: Possible signs of infection associated with premature rupture of membranes include elevation of maternal temperature and pulse rate, abdominal/uterine tenderness, fetal tachycardia over 160 bpm, elevated white blood cell count and C-reactive protein levels, and cloudy, foul-smelling amniotic fluid.

Question format: Multiple Select

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 698

17. A nurse is teaching a pregnant woman with preterm prelabor rupture of membranes about caring for herself after she is discharged home (which is to occur later this day). Which statement by the woman indicates a need for additional teaching?

- A. "I need to keep a close eye on how active my baby is each day."
- B. "I need to call my doctor if my temperature increases."
- C. "It's okay for my husband and me to have sexual intercourse."
- D. "I can shower, but I shouldn't take a tub bath."

Answer: C

Rationale: The woman with preterm prelabor rupture of membranes should monitor her baby's activity by performing fetal kick counts daily, check her temperature and report any increases to the health care provider, not insert anything into her vagina or vaginal area, such as tampons or vaginal intercourse, and avoid sitting in a tub bath.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 697

18. A nurse is assessing a pregnant woman with gestational hypertension. Which finding would lead the nurse to suspect that the client has developed severe preeclampsia?

- A. urine protein 300 mg/24 hours
- B. blood pressure 150/96 mm Hg
- C. mild facial edema
- D. hyperreflexia

Answer: D

Rationale: Severe preeclampsia is characterized by blood pressure over 160/110 mm Hg, urine protein levels greater than 500 mg/24 hours, and hyperreflexia. Mild facial edema is associated with mild preeclampsia.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 683

19. A nurse suspects that a pregnant client may be experiencing a placental abruption based on assessment of which finding? Select all that apply.

- A. dark red vaginal bleeding
- B. insidious onset
- C. absence of pain
- D. rigid uterus
- E. absent fetal heart tones

Answer: A, D, E

Rationale: Assessment findings associated with a placental abruption include a sudden onset with concealed or visible dark red bleeding, constant pain or uterine tenderness on palpation, firm to rigid uterine tone, and fetal distress or absent fetal heart tones.

Question format: Multiple Select

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 677

20. The health care provider prescribes PGE2 for a woman to help evacuate the uterus following a spontaneous abortion. Which action would be **most** important for the nurse to do?

- A. Use clean technique to administer the drug.
- B. Keep the gel cool until ready to use.
- C. Maintain the client supine for 30 minutes after administration.
- D. Administer intramuscularly into the deltoid area.

Answer: C

Rationale: When PGE2 is prescribed, the gel should come to room temperature before administering it. Sterile technique should be used, and the client should remain supine for 30 minutes after administration. Rho(D) immune globulin is administered intramuscularly into the deltoid area.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 664

21. A nurse is reviewing an article about preterm prelabor rupture of membranes. Which factors would the nurse expect to find placing a woman at high risk for this condition? Select all that apply.

- A. high body mass index
- B. urinary tract infection
- C. low socioeconomic status
- D. single gestations
- E. smoking

Answer: B, C, E

Rationale: High-risk factors associated with prelabor rupture of membranes (PROM) include low socioeconomic status, multiple gestation, low body mass index, tobacco use, preterm labor history, placenta previa, abruptio placenta, urinary tract infection, vaginal bleeding at any time in pregnancy, cerclage, and amniocentesis.

Question format: Multiple Select

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 697

22. A woman with placenta previa is being treated with expectant management. The woman and fetus are stable. The nurse is assessing the woman for possible discharge home. Which statement by the woman would suggest to the nurse that home care might be inappropriate?

- A. "My mother lives next door and can drive me here if necessary."
- B. "I have a toddler and preschooler at home who need my attention."
- C. "I know to call my health care provider right away if I start to bleed again."
- D. "I realize the importance of following the instructions for my care."

Answer: B

Rationale: Having a toddler and preschooler at home needing attention suggest that the woman would have difficulty maintaining bed rest at home. Therefore, expectant management at home may not be appropriate. Expectant management is appropriate if the mother and fetus are both stable, there is no active bleeding, the client has readily available access to reliable transportation, and can comprehend instructions.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 672

23. A woman with hyperemesis gravidarum asks the nurse about suggestions to minimize nausea and vomiting. Which suggestion would be **most** appropriate for the nurse to make?

- A. "Make sure that anything around your waist is quite snug."
- B. "Try to eat three large meals a day with less snacking."
- C. "Drink fluids in between meals rather than with meals."
- D. "Lie down for about an hour after you eat."

Answer: C

Rationale: Suggestions to minimize nausea and vomiting include avoiding tight waistbands to minimize pressure on the abdomen, eating small frequent meals throughout the day, separating fluids from solids by consuming fluids in between meals; and avoiding lying down or reclining for at least 2 hours after eating.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Physiological Integrity: Basic Care and Comfort

Reference: p. 682

24. A woman with gestational hypertension develops eclampsia and experiences a seizure. Which intervention would the nurse identify as the **priority**?

- A. fluid replacement
- B. oxygenation
- C. control of hypertension
- D. birth of the fetus

Answer: B

Rationale: As with any seizure, the priority is to clear the airway and maintain adequate oxygenation both to the mother and the fetus. Fluids and control of hypertension are addressed once the airway and oxygenation are maintained. Delivery of fetus is determined once the seizures are controlled and the woman is stable.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 686

25. A woman is receiving magnesium sulfate as part of her treatment for severe preeclampsia. The nurse is monitoring the woman's serum magnesium levels. The nurse determines that the drug is at a therapeutic level based on which result?

- A. 3.3 mEq/L
- B. 6.1 mEq/L
- C. 8.4 mEq/L
- D. 10.8 mEq/L

Answer: B

Rationale: Although exact levels may vary among agencies, serum magnesium levels ranging from 4 to 7 mEq/L are considered therapeutic, whereas levels more than 8 mEq/dL are generally considered toxic.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 690

26. A nurse is teaching a woman with mild preeclampsia about important areas that she needs to monitor at home. The nurse determines that the teaching was successful based on which statements by the woman? Select all that apply.

- A. "I should check my blood pressure twice a day."
- B. "I will weigh myself once a week."
- C. "I should complete a fetal kick count each day."
- D. "I will check my urine for protein four times a day."
- E. "I'll call my health care provider if I have burning when I urinate."

Answer: A, C, E

Rationale: The client should take her blood pressure twice daily, check and record weight daily, perform urine dipstick checks for protein twice daily, record the number of fetal kicks daily, and notify her health care provider if she experiences burning on urination.

Question format: Multiple Select

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 687

27. A client comes to the emergency department with moderate vaginal bleeding. She says, "I have had to change my pad about every 2 hours and it looks like I may have passed some tissue and clots." The woman reports that she is 9 weeks' pregnant. Further assessment reveals the following:

- Cervical dilation
- Strong abdominal cramping
- Low human chorionic gonadotropin (hCG) levels
- Ultrasound positive for products of conception

The nurse suspects that the woman is experiencing which type of spontaneous abortion?

- A. Threatened
- B. Inevitable
- C. Incomplete
- D. Complete

Answer: B

Rationale: Based on the assessment findings, the woman is likely experiencing an inevitable abortion characterized by vaginal bleeding, rupture of membranes, cervical dilation, strong abdominal cramping, possible passage of products of conception, and ultrasound and hCG levels indicating pregnancy loss. A threatened abortion is characterized by slight vaginal bleeding, no cervical dilation or change in cervical consistency, mild abdominal cramping, closed cervical os, and no passage of fetal tissue. An incomplete abortion is characterized by intense abdominal cramping, heavy vaginal bleeding and cervical dilation with passage of some products of conception. A complete abortion is characterized by a history of vaginal bleeding and abdominal pain along with passage of tissue and subsequent decrease in pain and decrease in bleeding.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 663

28. A pregnant client with preeclampsia is being treated with intravenous magnesium sulfate. The nurse assesses the client's deep tendon reflexes and grades them as 4+. The nurse notifies the

health care provider about this finding, describing them using which term to ensure accurate communication?

- A. Absent
- B. Average
- C. Brisk
- D. Clonus

Answer: D

Rationale: The National Institute of Neurological Disorders and Stroke, a division of the National Institutes of Health, published a scale in the early 1990s that, though subjective, is used widely today. It grades reflexes from 0 to 4+. Grades 2+ and 3+ are considered normal, and grades 0 which indicates an absent reflex and 4 which indicates clonus may indicate pathology. Because these are subjective assessments, to improve communication of reflex results, condensed descriptor categories such as absent, average, brisk, or clonus should be used rather than numeric codes. A 4+ grade indicates clonus which is the presence of rhythmic involuntary contractions, most often at the foot or ankle. Sustained clonus confirms central nervous system involvement.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Communication and Documentation

Reference: p. 690

29. A client who has experienced an incomplete abortion is prescribed mifepristone to assist in removing the retained products of conception. Which medication would the nurse expect to administer if prescribed before administering mifepristone?

- A. Opioid analgesic for relief of cramping
- B. Antiemetic to minimize nausea
- C. Vitamin K to reduce bleeding
- D. Diuretic to promote fluid loss

Answer: B

Rationale: For the client receiving mifepristone, the nurse would anticipate administering an antiemetic beforehand to reduce nausea and vomiting. Acetaminophen would be useful for pain relief, not an opioid. Vitamin K or a diuretic would not be appropriate when administering mifepristone. Vitamin K would be used to counteract bleeding such as that associated with heparin administration. A diuretic would be appropriate to promote fluid excretion with fluid overload.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Nursing Process

Reference: p. 664

30. A client at 33 weeks' gestation comes to the emergency department with vaginal bleeding. Assessment reveals the following:

- Onset of slight vaginal bleeding at 29 weeks with spontaneous cessation
- Recent onset of bright red vaginal bleeding, more than with previous episode
- No uterine contractions at present
- Fetal heart rate within normal range
- Uterus soft and nontender

Based on the assessment findings, which condition would the nurse likely suspect?

- A. Placental abruption
- B. Placenta previa
- C. Ruptured ectopic pregnancy
- D. Polyhydramnios

Answer: B

Rationale: The assessment findings suggest placenta previa, a bleeding condition that occurs during the last two trimesters of pregnancy. It is characterized by slight bright red vaginal bleeding initially that stops spontaneously and then recurs later in amounts greater than the initial episode; absence of pain/contractions; soft, relaxed uterine tone; and a fetal heart rate within normal parameters. Placental abruption is characterized by a sudden onset with concealed or visible dark vaginal bleeding, uterine tenderness and pain, with a firm or rigid uterus and fetal distress. The hallmark of ectopic pregnancy is abdominal pain with spotting within 6 to 8 weeks after a missed menstrual period. If ectopic rupture or hemorrhage occurs before treatment begins, symptoms may worsen and include severe, sharp, and sudden pain in the lower abdomen as the tube tears open and the embryo is expelled into the pelvic cavity; feelings of faintness; referred pain to the shoulder area, indicating bleeding into the abdomen caused by phrenic nerve irritation; hypotension; marked abdominal tenderness with distention; and hypovolemic shock. Polyhydramnios is initially suspected when uterine enlargement, maternal abdominal girth, and fundal height are larger than expected for the fetus's gestational age. With polyhydramnios, there is a discrepancy between fundal height and gestational age, or a rapid growth of the uterus is noted. Shortness of breath and uterine contractions from overstretching may occur. Often the fetal parts and heart rate are difficult to obtain because of the excess fluid present.

Question format: Multiple Choice

Chapter 19: Nursing Management of Pregnancy at Risk: Pregnancy-Related Complications

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 677

Chapter 20

1. The nurse is teaching a pregnant woman with type 1 diabetes about her diet during pregnancy. Which client statement indicates that the nurse's teaching was successful?
- A. "I'll basically follow the same diet that I was following before I became pregnant."
 - B. "Because I need extra protein, I'll have to increase my intake of milk and meat."
 - C. "Pregnancy affects insulin production, so I'll need to make adjustments in my diet."
 - D. "I'll adjust my diet and insulin based on the results of my urine tests for glucose."

Answer: C

Rationale: In pregnancy, placental hormones cause insulin resistance at a level that tends to parallel growth of the fetoplacental unit. Nutritional management focuses on maintaining balanced glucose levels. Thus, the woman will probably need to make adjustments in her diet. Protein needs increase during pregnancy, but this is unrelated to diabetes. Blood glucose monitoring results typically guide therapy.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 705

2. A pregnant woman with diabetes at 10 weeks' gestation has a glycosylated hemoglobin (HbA1c) level of 13%. At this time the nurse should be **most** concerned about which possible fetal outcome?
- A. congenital anomalies
 - B. incompetent cervix
 - C. placenta previa
 - D. placental abruption (abruptio placentae)

Answer: A

Rationale: A HbA1c level of 13% indicates poor glucose control. This, in conjunction with the woman being in the first trimester, increases the risk for congenital anomalies in the fetus. Elevated glucose levels are not associated with incompetent cervix, placenta previa, or placental abruption (abruptio placentae).

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 708

3. A nurse is conducting a review class for a group of perinatal nurses working at the local clinic. The clinic sees a high population of women who are HIV positive. After discussing the recommendations for antiretroviral therapy with the group, the nurse determines that the teaching was successful when the group identifies which rationale as the underlying principle for the therapy?

- A. reduction in viral loads in the blood
- B. treatment of opportunistic infections
- C. adjunct therapy to radiation and chemotherapy
- D. can cure acute HIV/AIDS infections

Answer: A

Rationale: Drug therapy is the mainstay of treatment and is important in reducing the viral load as much as possible. Antiretroviral agents do not treat opportunistic infections and are not adjunctive therapy. There is no cure for HIV/AIDS.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 742

4. Assessment of a pregnant woman and her fetus reveals tachycardia and hypertension. There is also evidence suggesting vasoconstriction. The nurse would question the woman about use of which substance?

- A. marijuana
- B. alcohol
- C. heroin
- D. cocaine

Answer: D

Rationale: Cocaine use produces vasoconstriction, tachycardia, and hypertension in both the mother and fetus. The effects of marijuana are not yet fully understood. Alcohol ingestion would lead to cognitive and behavioral problems in the newborn. Heroin is a central nervous system depressant.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 756

5. When teaching a class of pregnant women about the effects of substance use during pregnancy, the nurse would include which effect?

- A. low-birthweight infants

- B. excessive weight gain
- C. higher pain tolerance
- D. longer gestational periods

Answer: A

Rationale: Substance use during pregnancy is associated with low birth weight infants, preterm labor, abortion, intrauterine growth restriction, abruptio placentae, neurobehavioral abnormalities, and long-term childhood developmental consequences. Excessive weight gain, higher pain tolerance, and longer gestational periods are not associated with substance use.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 752

6. A client who is HIV-positive is in her second trimester and remains asymptomatic. She voices concern about her newborn's risk for the infection. Which statement by the nurse would be **most** appropriate?

- A. "You'll probably have a cesarean birth to prevent exposing your newborn."
- B. "Antibodies cross the placenta and provide immunity to the newborn."
- C. "Wait until after the infant is born, and then something can be done."
- D. "Antiretroviral medications are available to help reduce the risk of transmission."

Answer: D

Rationale: Drug therapy is the mainstay of treatment for pregnant women infected with HIV. The goal of therapy is to reduce the viral load as much as possible; this reduces the risk of transmission to the fetus. Decisions about the method of birth should be based on the woman's viral load, duration of ruptured membranes, progress of labor, and other pertinent clinical factors. The newborn is at risk for HIV because of potential perinatal transmission. Waiting until after the infant is born may be too late.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Reference: p. 741

7. When preparing a schedule of follow-up visits for a pregnant woman with chronic hypertension, which schedule would be **most** appropriate?

- A. monthly visits until 32 weeks, then bi-monthly visits
- B. bi-monthly visits until 28 weeks, then weekly visits
- C. monthly visits until 20 weeks, then bi-monthly visits
- D. bi-monthly visits until 36 weeks, then weekly visits

Answer: B

Rationale: For the woman with chronic hypertension, antepartum visits typically occur every 2 weeks until 28 weeks' gestation and then weekly to allow for frequent maternal and fetal surveillance.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Reference: p. 722

8. A woman with a history of asthma comes to the clinic for evaluation for pregnancy. The woman's pregnancy test is positive. When reviewing the woman's medication therapy regimen for asthma, which medication would the nurse identify as problematic for the woman now that she is pregnant?

- A. ipratropium
- B. albuterol
- C. salmeterol
- D. Prednisone

Answer: D

Rationale: Oral corticosteroids such as prednisone are not preferred for the long-term treatment of asthma during pregnancy. Inhaled steroids are the choice for maintenance medications to reduce inflammation that leads to bronchospasm. Common ones prescribed include beclomethasone and salmeterol. Rescue agents such as albuterol or ipratropium provide immediate symptomatic relief by reducing acute bronchospasm.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 724

9. A pregnant woman is diagnosed with iron-deficiency anemia and is prescribed an iron supplement. After teaching her about her prescribed iron supplement, which statement indicates successful teaching?

- A. "I should take my iron with milk."
- B. "I should avoid drinking orange juice."
- C. "I need to eat foods high in fiber."
- D. "I'll call the primary care provider if my stool is black and tarry."

Answer: C

Rationale: Iron supplements can lead to constipation, so the woman needs to increase her intake of fluids and high-fiber foods. Milk inhibits absorption and should be discouraged. Vitamin C-containing fluids such as orange juice are encouraged because they promote absorption. Ideally the woman should take the iron on an empty stomach to improve absorption, but many women cannot tolerate the gastrointestinal discomfort it causes. In such cases, the woman should take it with meals. Iron typically causes the stool to become black and tarry; there is no need for the woman to notify her primary care provider.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 729

10. The nurse is assessing a newborn of a woman who is suspected of abusing alcohol. Which newborn finding would provide additional evidence to support this suspicion?

- A. wide, large eyes
- B. thin upper lip
- C. protruding jaw
- D. elongated nose

Answer: B

Rationale: Newborn characteristics suggesting fetal alcohol spectrum disorder include thin upper lip, small head circumference, small eyes, receding jaw, and short nose. Other features include a low nasal bridge, short palpebral fissures, flat midface, epicanthal folds, and minor ear abnormalities.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 752

11. After teaching a group of nurses working at the women's health clinic about the impact of pregnancy on the older woman, which statement by the group indicates that the teaching was successful?

- A. "The majority of women who become pregnant over age 35 experience complications."
- B. "Women over the age of 35 who become pregnant require a specialized type of assessment."
- C. "Women over age 35 and are pregnant have an increased risk for spontaneous abortions."
- D. "Women over age 35 are more likely to have a substance use disorder."

Answer: C

Rationale: Whether childbearing is delayed by choice or by chance, women starting a family at age 35 or older are not doing so without risk. Women in this age group may already have chronic

health conditions that can put the pregnancy at risk. In addition, numerous studies have shown that increasing maternal age is a risk factor for infertility and spontaneous abortions, gestational diabetes, chronic hypertension, postpartum hemorrhage, preeclampsia, preterm labor and birth, multiple pregnancy, genetic disorders and chromosomal abnormalities, placenta previa, fetal growth restriction, low Apgar scores, and surgical births (Dillion et al. 2019). However, even though increased age implies increased complications, most women today who become pregnant after age 34, have healthy pregnancies and healthy newborns. Nursing assessment of the pregnant woman over age 35 is the same as that for any pregnant woman. Women of this age have the same risk for a substance use disorder as any other age group.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 749

12. A nurse is conducting an in-service presentation to a group of perinatal nurses about sexually transmitted infections and their effect on pregnancy. The nurse determines that the teaching was successful when the group identifies which infection as being responsible for ophthalmia neonatorum?

- A. syphilis
- B. gonorrhea
- C. chlamydia
- D. HPV

Answer: B

Rationale: Infection with gonorrhea during pregnancy can cause ophthalmia neonatorum in the newborn from birth through an infected birth canal. Infection with syphilis can cause congenital syphilis in the neonate. Infection with chlamydia can lead to conjunctivitis or pneumonia in the newborn. Exposure to HPV during birth is associated with laryngeal papillomas.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Analyze

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Reference: p. 734

13. A nurse is preparing a presentation for a group of young adult pregnant women about common infections and their effect on pregnancy. When describing the infections, which infection would the nurse include as the **most** common congenital and perinatal viral infection in the world?

- A. rubella
- B. hepatitis B
- C. cytomegalovirus
- D. parvovirus B19

Answer: C

Rationale: Although rubella, hepatitis B, and parovirus B19 can affect pregnant women and their fetuses, cytomegalovirus (CMV) is the most common congenital and perinatal viral infection in the world. CMV is the leading cause of congenital infection, with morbidity and mortality at birth and sequelae. Each year approximately 1% to 7% of pregnant women acquire a primary CMV infection. Of these, about 30% to 40% transmits infection to their fetuses.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 734

14. A pregnant woman asks the nurse, "I'm a big coffee drinker. Will the caffeine in my coffee hurt my baby?" Which response by the nurse would be **most** appropriate?

- A. "The caffeine in coffee has been linked to birth defects."
- B. "Caffeine has been shown to restrict growth in the fetus."
- C. "Caffeine is a stimulant and needs to be avoided completely."
- D. "If you keep your intake to less than 200 mg/day, you should be okay."

Answer: D

Rationale: The effect of caffeine intake during pregnancy on fetal growth and development is still unclear. A recent study found that caffeine intake of no more than 200 mg/day during pregnancy does not affect pregnancy duration and the condition of the newborn. Birth defects have not been linked to caffeine consumption, but maternal coffee consumption decreases iron absorption and may increase the risk of anemia during pregnancy. It is not known if there is a correlation between high caffeine intake and miscarriage due to lack of sufficient studies.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 754

15. A neonate born to a mother who was abusing heroin is exhibiting signs and symptoms of withdrawal. Which signs would the nurse assess? Select all that apply.

- A. low whimpering cry
- B. hypertonicity
- C. lethargy
- D. excessive sneezing
- E. overly vigorous sucking
- F. tremors

Answer: B, D, F

Rationale: Signs and symptoms of withdrawal, or neonatal abstinence syndrome, include: irritability, hypertonicity, excessive and often high-pitched crying, vomiting, diarrhea, feeding disturbances, respiratory distress, disturbed sleeping, excessive sneezing and yawning, nasal stuffiness, diaphoresis, fever, poor sucking, tremors, and seizures.

Question format: Multiple Select

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 755

16. A nurse has been invited to speak at a local high school about adolescent pregnancy. When developing the presentation, the nurse would incorporate information related to which aspects? Select all that apply.

- A. peer pressure to become sexually active
- B. rise in teen birth rates over the years.
- C. Asian Americans as having the highest teen birth rate
- D. loss of self-esteem as a major impact
- E. about half occurring within a year of first sexual intercourse

Answer: A, D

Rationale: Adolescent pregnancy has emerged as one of the most significant social problems facing our society. Early pregnancies among adolescents have major health consequences for mothers and their infants. The latest estimates show that approximately 1 million teenagers become pregnant each year in the United States, accounting for 13% of all U.S. births, but the rates have been declining in the last several years. Teen birth rates in the United States have declined but remain high, especially among African American and Hispanic teenagers and adolescents in southern states. The most important impact lies in the psychosocial area as it contributes to a loss of self-esteem, a destruction of life projects, and the maintenance of the circle of poverty. Moreover, about half of all teen pregnancies occur within 6 months of first having sexual intercourse. About one in four teen mothers under age 18 have a second baby within 2 years after the birth of the first baby.

Question format: Multiple Select

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 747

17. A nurse is counseling a pregnant woman with rheumatoid arthritis about medications that can be used during pregnancy. The nurse would emphasize the need to avoid which medication at this time?

- A. hydroxychloroquine

- B. nonsteroidal anti-inflammatory drugs
- C. glucocorticoid
- D. methotrexate

Answer: D

Rationale: Methotrexate is contraindicated during pregnancy. For rheumatoid arthritis, medications are limited to hydroxychloroquine, glucocorticoids, and NSAIDS.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 733

18. A nurse is preparing a teaching program for a group of pregnant women about preventing infections during pregnancy. When describing measures for preventing cytomegalovirus infection, which measure would the nurse include as a **priority**?

- A. frequent handwashing
- B. immunization
- C. prenatal screening
- D. antibody titer screening

Answer: A

Rationale: Most women are asymptomatic and do not know they have been exposed to CMV. Prenatal screening for CMV infection is not routinely performed. Since there is no therapy that prevents or treats CMV infections, nurses are responsible for educating and supporting childbearing-age women at risk for CMV infection. Stressing the importance of good handwashing and use of sound hygiene practices can help to reduce transmission of the virus. There is no immunization for CMV. Antibody titer levels would be useful for identifying women at risk for rubella.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Reference: p. 735

19. A pregnant woman comes to the clinic for her first evaluation. The woman is screened for hepatitis B (HBV) and tests positive. The nurse would anticipate administering which agent?

- A. HBV immune globulin
- B. HBV vaccine
- C. acylcovir
- D. valacyclovir

Answer: A

Rationale: If a woman tests positive for HBV, expect to administer HBV immune globulin. The newborn will also receive HBV vaccine within 12 hours of birth. Acyclovir or valacyclovir would be used to treat herpes simplex virus infection.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 737

20. After teaching a pregnant woman with iron deficiency anemia about nutrition, the nurse determines that the teaching was successful when the woman identifies which foods as being good sources of iron in her diet? Select all that apply.

- A. dried fruits
- B. peanut butter
- C. meats
- D. milk
- E. white bread

Answer: A, B, C

Rationale: Foods high in iron include meats, green leafy vegetables, legumes, dried fruits, whole grains, peanut butter, bean dip, whole-wheat fortified breads, and cereals.

Question format: Multiple Select

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 729

21. A pregnant woman with gestational diabetes comes to the clinic for a fasting blood glucose level. When reviewing the results, the nurse determines that the woman is achieving good glucose control based on which result?

- A. 88 mg/dL
- B. 100 mg/dL
- C. 110 mg/dL
- D. 120 mg/dL

Answer: A

Rationale: For a pregnant woman with diabetes, the ADA and ACOG recommend maintaining a fasting blood glucose level below 95 mg/dL, with postprandial levels below 140 mg/dL at 1 hour, below 120 mg/dL at 2 hours.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 708

22. A nurse is conducting a program for pregnant women with gestational diabetes about reducing complications. The nurse determines that the teaching was successful when the group identifies which factor as being **most** important in helping to reduce complications associated with pregnancy and diabetes?

- A. stability of the woman's emotional and psychological status
- B. degree of blood glucose control achieved during the pregnancy
- C. reduction in retinopathy risk by frequent ophthalmologic evaluations
- D. control of blood urea nitrogen (BUN) levels for optimal kidney function

Answer: B

Rationale: Therapeutic management for the woman with diabetes focuses on tight glucose control, thereby minimizing the risks to the mother, fetus, and neonate. The woman's emotional and psychological status is highly variable and may or may not affect the pregnancy. Evaluating for long-term diabetic complications such as retinopathy or nephropathy, as evidenced by laboratory testing such as BUN levels, is an important aspect of preconception care to ensure that the mother enters the pregnancy in an optimal state.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 709

23. A nurse is providing care to several pregnant women at different weeks of gestation. The nurse would expect to screen for group B streptococcus infection in the client who is at:

- A. 16 weeks' gestation.
- B. 28 weeks' gestation.
- C. 32 weeks' gestation.
- D. 36 weeks' gestation.

Answer: D

Rationale: Pregnant women between 36 and 37 weeks' gestation should be universally screened for GBS infection during a prenatal visit and if positive, receive appropriate intrapartum antibiotic prophylaxis.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 739

24. A woman with a history of systemic lupus erythematosus comes to the clinic for evaluation. The woman tells the nurse that she and her partner would like to have a baby but that they are afraid her lupus will be a problem. Which response would be **most** appropriate for the nurse to make?

- A. "It's probably not a good idea for you to get pregnant since you have lupus."
- B. "Be sure that your lupus is stable or in remission for 6 months before getting pregnant."
- C. "Your lupus will not have any effect on your pregnancy whatsoever."
- D. "If you get pregnant, we'll have to add quite a few medications to your normal treatment plan."

Answer: B

Rationale: The time at which the nurse comes in contact with the woman in her childbearing life cycle will determine the focus of the assessment. If the woman is considering pregnancy, it is recommended that she postpone conception until the disease has been stable or in remission for 6 months. Active disease at time of conception and history of renal disease increase the likelihood of a poor pregnancy outcome (Cunningham et al., 2018). In particular, if pregnancy is planned during periods of inactive or stable disease, the result is often giving birth to healthy full-term babies without increased risks of pregnancy complications. Nonetheless, pregnancies with most autoimmune diseases are still classified as high risk because of the potential for major complications. Preconception counseling should include the medical and obstetric risks of spontaneous abortion, stillbirth, fetal death, fetal growth restriction, preeclampsia, preterm labor, and neonatal death and the need for more frequent visits for monitoring the condition. Treatment of SLE in pregnancy is generally limited to NSAIDs (e.g., ibuprofen), prednisone, and an antimalarial agent, hydroxychloroquine. During pregnancy in the woman with SLE, the goal is to keep drug therapy to a minimum.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 731

25. A nurse is conducting a presentation for a group of pregnant women about measures to prevent toxoplasmosis. The nurse determines that additional teaching is needed when the group identifies which measure as preventive?

- A. washing raw fruits and vegetables before eating them
- B. cooking all meat to an internal temperature of 125° F (52° C)
- C. wearing gardening gloves when working in the soil
- D. avoiding contact with a cat's litter box

Answer: B

Rationale: Meats should be cooked to an internal temperature of 160° F (71° C). Other measures to prevent toxoplasmosis include peeling or thoroughly washing all raw fruits and vegetables before eating them, wearing gardening gloves when in contact with outdoor soil, and avoiding the emptying or cleaning of a cat's litter box.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 740

26. A pregnant client with iron-deficiency anemia is prescribed an iron supplement. After teaching the woman about using the supplement, the nurse determines that more teaching is needed based on which client statement?

- A. "Taking the iron supplement with food will help with the side effects."
- B. "I will need to avoid coffee and tea when I take this supplement."
- C. "I will take the iron with milk instead of orange or grapefruit juice."
- D. "If I happen to miss a dose, I will take it as soon as I remember."

Answer: C

Rationale: The pregnant client should take the iron supplement with vitamin C-containing fluids such as orange juice, which will promote absorption, rather than milk, which can inhibit iron absorption. Taking iron on an empty stomach improves its absorption, but many women cannot tolerate the gastrointestinal discomfort it causes. In such cases, the woman is advised to take it with meals. The woman also needs instruction about adverse effects, which are predominantly gastrointestinal and include gastric discomfort, nausea, vomiting, anorexia, diarrhea, metallic taste, and constipation. Taking the iron supplement with meals and increasing intake of fiber and fluids helps overcome the most common side effects. If the woman misses a dose, she should take a dose as soon as she remembers.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Teaching/Learning

Reference: p. 729

27. A client in her first trimester comes to the clinic for an evaluation. Assessment reveals reports of fatigue, anorexia, and frequent upper respiratory infections. The client's skin is pale and the client is slightly tachycardic. The client also reports drinking about 6 cups of coffee on average each day. A diagnosis of iron-deficiency anemia is suspected. The client is scheduled for laboratory testing and the results are as follows:

- Hemoglobin 11.5 g/dL (115 g/L)
- Hematocrit 35% (0.35)

- Serum iron 32 µg/dL (5.73 µmol/L)
- Serum ferritin 90 ng/dL (90 µg/L)

Which laboratory finding would the nurse correlate with the suspected diagnosis?

- A. Hemoglobin
- B. Hematocrit
- C. Serum iron level
- D. Serum ferritin level

Answer: D

Rationale: Laboratory tests for iron-deficiency anemia usually reveal low hemoglobin (less than 11 g/dL or 110 g/L), low hematocrit (less than 35% or 0.35), low serum iron (less than 30 µg/dL or 5.37 µmol/L), microcytic and hypochromic cells, and low serum ferritin (less than 100 ng/dL or 100 µg/L). The client's hemoglobin, hematocrit, and serum iron levels are borderline low normal, but the client's serum ferritin is below 100 ng/dL (100 µg/L), helping to support the diagnosis.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 728

28. A young adult woman comes to the clinic for a routine check-up. During the visit, the woman who works in a day care facility tells the nurse that she and her partner are considering having a baby. "We are concerned that I might be exposed to common childhood illnesses." The woman undergoes testing and finds out that she is not immune from chickenpox. Based on this information, which information would the nurse give to the client?

- A. "You will need to be vaccinated now and wait at least 1 month before getting pregnant."
- B. "It is very likely that you will need to quit your job if you do get pregnant."
- C. "Because chickenpox is so rare nowadays, there is nothing to worry about."
- D. "You will need to take a leave of absence during winter and spring months."

Answer: A

Rationale: Preconception counseling is important for preventing chickenpox (varicella). A major component of counseling involves determining the woman's varicella immunity. Vaccination is the cornerstone of prevention. The vaccine is administered if needed. Varicella vaccine is a live attenuated viral vaccine. It should be administered to all adolescents and adults 13 years of age and older who do not have evidence of varicella immunity. Therefore, the woman should be vaccinated now before she becomes pregnant and then wait at least 1 month before getting pregnant. The varicella vaccine is contraindicated for pregnant women because the effects of the vaccine on the fetus are unknown. There is no need for the woman to quit her job once she is immunized nor does she need to take a leave of absence during the winter and spring months when the incidence is highest. Chickenpox does occur and is highly contagious. Maternal

varicella can be transmitted to the fetus through the placenta, leading to congenital varicella syndrome if the mother is infected during the first half of pregnancy via an ascending aorta.
Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Integrated Process: Nursing Process

Reference: p. 738

29. A nurse is obtaining a medication history from a pregnant client with a history of systemic lupus erythematosus (SLE). Which medication(s) would the nurse expect the woman to report to be currently using? Select all that apply.

- A. Ibuprofen
- B. Hydroxychloroquine
- C. Methotrexate
- D. Leflunomide
- E. Prednisone

Answer: A, B, E

Rationale: Treatment of SLE in pregnancy is generally limited to NSAIDs like ibuprofen, prednisone, and an antimalarial agent, hydroxychloroquine. Methotrexate and leflunomide are used to treat rheumatoid arthritis but are contraindicated for use in pregnancy because of the potential for fetal toxicity.

Question format: Multiple Select

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Nursing Process

Reference: p. 731

30. The nurse reviews the medical record of a woman who has come to the clinic for an evaluation. The client has a history of mitral valve prolapse and is listed as risk class II. During the visit, the woman states, "We want to have a baby, but I know I am at higher risk. But what is my risk, really?" Which response by the nurse would be appropriate?

- A. "If you do get pregnant, you will need to be seen by a cardiologist every other month for monitoring."
- B. "Your risk during pregnancy is small, but you should see your cardiologist first before getting pregnant."
- C. "Your heart disease would put too much strain on your heart if you were to get pregnant."
- D. "Your pregnancy would be uneventful, but you would need specialized care for labor and birth."

Answer: B

Rationale: Typically, a woman with class I or II cardiac disease can go through a pregnancy without major complications. For class I disease, there is no detectable increased risk of maternal mortality and no increase or a mild increase in morbidity. For class II disease, there is a small increased risk of maternal mortality or moderate increase in morbidity and cardiac consultation should occur every trimester. It is best to have the woman see her cardiologist before becoming pregnant. A woman with class III disease needs frequent visits with the cardiac care team throughout pregnancy. There is a significantly increased risk of maternal mortality or severe morbidity and cardiologist consult should occur every other month with prenatal care and delivery occurring at an appropriate level hospital. A woman with class IV disease is typically advised to avoid pregnancy.

Question format: Multiple Choice

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 717

31. A pregnant woman with chronic hypertension is entering her second trimester. The nurse is providing anticipatory guidance to the woman about measures to promote a healthy outcome. The nurse determines that the teaching was successful based on which client statement(s)? Select all that apply.

- A. "I will need to schedule follow-up appointments every 2 weeks until I reach 32 weeks' gestation."
- B. "I should try to lie down and rest on my left side for about an hour each day."
- C. "I will start doing daily counts of my baby's activity at about 24 weeks' gestation."
- D. "I will need to have an ultrasound at each visit beginning at 28 weeks' gestation."
- E. "I should take my blood pressure frequently at home and report any high readings."

Answer: B, C, E

Rationale: The woman with chronic hypertension will be seen more frequently (every 2 weeks until 28 weeks' gestation and then weekly until birth) to monitor her blood pressure and to assess for any signs of preeclampsia. At approximately 24 weeks' gestation, the woman will be instructed to document fetal movement. At this same time, serial ultrasounds will be prescribed to monitor fetal growth and amniotic fluid volume. The woman should also have daily periods of rest (1 hour) in the left lateral recumbent position to maximize placental perfusion and use home blood pressure monitoring devices frequently (daily checks would be preferred), reporting any elevations.

Question format: Multiple Select

Chapter 20: Nursing Management of the Pregnancy at Risk: Selected Health Conditions and Vulnerable Populations

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Teaching/Learning

Reference: p. 722

Chapter 21

1. After spontaneous rupture of membranes, the nurse notices a prolapsed cord. The nurse immediately places the woman in which position?

- A. supine
- B. side-lying
- C. sitting
- D. knee-chest

Answer: D

Rationale: Pressure on the cord needs to be relieved. Therefore, the nurse would position the woman in a modified Sims, Trendelenburg, or knee-chest position. Supine, side-lying, or sitting would not provide relief of cord compression.

Question format: Multiple Choice

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 796

2. A primigravida whose labor was initially progressing normally is now experiencing a decrease in the frequency and intensity of her contractions. The nurse would assess the woman for which condition?

- A. a low-lying placenta
- B. fetopelvic disproportion
- C. contraction ring
- D. uterine bleeding

Answer: B

Rationale: The woman is experiencing dystocia most likely due to hypotonic uterine dysfunction and fetopelvic disproportion associated with a large fetus. A low-lying placenta, contraction ring, or uterine bleeding would not be associated with a change in labor pattern.

Question format: Multiple Choice

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 773

3. Which assessment finding will alert the nurse to be on the lookout for possible placental abruption during labor?

- A. macrosomia
- B. gestational hypertension
- C. gestational diabetes

D. low parity

Answer: B

Rationale: Risk factors for placental abruption include preeclampsia, gestational hypertension, seizure activity, uterine rupture, trauma, smoking, cocaine use, coagulation defects, previous history of abruption, intimate partner violence, and placental pathology. Macrosomia, gestational diabetes, and low parity are not considered risk factors.

Question format: Multiple Choice

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 797

4. A woman in labor is experiencing hypotonic uterine dysfunction. Assessment reveals no fetopelvic disproportion. Which group of medications would the nurse expect to administer?

- A. sedatives
- B. tocolytics
- C. uterine stimulants
- D. corticosteroids

Answer: C

Rationale: For hypotonic labor, a uterine stimulant such as oxytocin may be prescribed once fetopelvic disproportion is ruled out. Sedatives might be helpful for the woman with hypertonic uterine contractions to promote rest and relaxation. Tocolytics would be ordered to control preterm labor. Corticosteroids may be given to enhance fetal lung maturity for women experiencing preterm labor.

Question format: Multiple Choice

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 770

5. A woman gave birth to a newborn via vaginal birth with the use of a vacuum extractor. The nurse would be alert for which possible effect in the newborn?

- A. asphyxia
- B. clavicular fracture
- C. cephalhematoma
- D. central nervous system injury

Answer: C

Rationale: Use of forceps or a vacuum extractor poses the risk of tissue trauma, such as ecchymoses, facial and scalp lacerations, facial nerve injury, cephalhematoma, and caput

succedaneum. Asphyxia may be related to numerous causes, but it is not associated with use of a vacuum extractor. Clavicular fracture is associated with shoulder dystocia. Central nervous system injury is not associated with the use of a vacuum extractor.

Question format: Multiple Choice

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 799-800

6. A pregnant client undergoing labor induction is receiving an oxytocin infusion. Which finding would require immediate intervention?

- A. fetal heart rate of 150 beats/minute
- B. contractions every 2 minutes, lasting 45 seconds
- C. uterine resting tone of 14 mm Hg
- D. urine output of 20 mL/hour

Answer: D

Rationale: Oxytocin can lead to water intoxication. Therefore, a urine output of 20 mL/hour is below acceptable limits of 30 mL/hour and requires intervention. FHR of 150 beats/minute is within the accepted range of 120 to 160 beats/minute. Contractions should occur every 2 to 3 minutes, lasting 40 to 60 seconds. A uterine resting tone greater than 20 mm Hg would require intervention.

Question format: Multiple Choice

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 792

7. A woman with a history of crack cocaine use disorder is admitted to the labor and birth area. While caring for the client, the nurse notes a sudden onset of fetal bradycardia. Inspection of the abdomen reveals an irregular wall contour. The client also reports acute abdominal pain that is continuous. Which condition would the nurse suspect?

- A. amniotic fluid embolism
- B. shoulder dystocia
- C. uterine rupture
- D. umbilical cord prolapse

Answer: C

Rationale: Uterine rupture is associated with crack cocaine use disorder. Generally, the first and most reliable sign is sudden fetal distress accompanied by acute abdominal pain, vaginal bleeding, hematuria, irregular wall contour, and loss of station in the fetal presenting part.

Amniotic fluid embolism often is manifested with a sudden onset of respiratory distress.

Shoulder dystocia is noted when continued fetal descent is obstructed after the fetal head is

delivered. Umbilical cord prolapse is noted as the protrusion of the cord alongside or ahead of the presenting part of the fetus.

Question format: Multiple Choice

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 797

8. A woman receives magnesium sulfate as treatment for preterm labor. The nurse assesses and maintains the infusion at the prescribed rate based on which finding?

- A. Respiratory rate-16 breaths/minute
- B. Decreased fetal heart rate variability
- C. Urine output 22 mL/hour
- D. Absent deep tendon reflexes

Answer: B

Rationale: A respiratory rate of 16 breaths per minute is appropriate and within acceptable parameters to continue the infusion. When administering magnesium sulfate, the nurse would immediately report decreased fetal heart rate variability, a urine output less than 30 mL/hour, and decreased or absent deep tendon reflexes.

Question format: Multiple Choice

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Nursing Process

Reference: p. 781

9. The nurse is reviewing the physical examination findings for a client who is to undergo labor induction. Which finding would indicate to the nurse that a woman's cervix is ripe in preparation for labor induction?

- A. posterior position
- B. firm
- C. closed
- D. shortened

Answer: D

Rationale: A ripe cervix is shortened, centered (anterior), softened, and partially dilated. An unripe cervix is long, closed, posterior, and firm.

Question format: Multiple Choice

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 787

10. A woman with preterm labor is receiving magnesium sulfate. Which finding would require the nurse to intervene immediately?

- A. respiratory rate of 16 breaths per minute
- B. 1+ deep tendon reflexes
- C. urine output of 45 mL/hour
- D. alert level of consciousness

Answer: B

Rationale: Diminished deep tendon reflexes (1+) suggest magnesium toxicity, which requires immediate intervention. Additional signs of magnesium toxicity include a respiratory rate less than 12 breaths/minute, urine output less than 30 mL/hour, and a decreased level of consciousness.

Question format: Multiple Choice

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 781

11. After teaching a couple about what to expect with their planned cesarean birth, which statement indicates the need for additional teaching?

- A. "Holding a pillow against my incision will help me when I cough."
- B. "I'm going to have to wait a few days before I can start breastfeeding."
- C. "I guess the nurses will be getting me up and out of bed rather quickly."
- D. "I'll probably have a tube in my bladder for about 24 hours or so."

Answer: B

Rationale: Typically, breastfeeding is initiated early as soon as possible after birth to promote bonding. The woman may need to use alternate positioning techniques to reduce incisional discomfort. Splinting with pillows helps to reduce the discomfort associated with coughing. Early ambulation is encouraged to prevent respiratory and cardiovascular problems and promote peristalsis. An indwelling urinary catheter is typically inserted to drain the bladder. It usually remains in place for approximately 24 hours.

Question format: Multiple Choice

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 800

12. When describing the stages of labor to a pregnant woman, which of the following would the nurse identify as the major change occurring during the first stage?

- A. Regular contractions
- B. Cervical dilation
- C. Fetal movement through the birth canal
- D. Placental separation

Answer: B

Rationale: The primary change occurring during the first stage of labor is progressive cervical dilation. Contractions occur during the first and second stages of labor. Fetal movement through the birth canal is the major change during the second stage of labor. Placental separation occurs during the third stage of labor.

Question format: Multiple Choice

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 768

13. The nurse is providing care to several pregnant women who may be scheduled for labor induction. The nurse identifies the woman with which Bishop score as having the **best** chance for a successful induction and vaginal birth?

- A. 11
- B. 7
- C. 5
- D. 3

Answer: A

Rationale: The Bishop score helps identify women who would be most likely to achieve a successful induction. The duration of labor is inversely correlated with the Bishop score: a score over 8 indicates a successful vaginal birth. Therefore the woman with a Bishop score of 11 would have the greatest chance for success. Bishop scores of less than 6 usually indicate that a cervical ripening method should be used prior to induction.

Question format: Multiple Choice

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 787

14. A nurse is reviewing the medical record of a pregnant client. The nurse suspects that the client may be at risk for dystocia based on which factors? Select all that apply.

- A. plan for pudendal block anesthetic use
- B. multiparity
- C. short maternal stature
- D. Body mass index 30.2
- E. breech fetal presentation

Answer: C, D, E

Rationale: Risk factors for dystocia may include maternal short stature, obesity, hydramnios, uterine abnormalities, fetal malpresentation, cephalopelvic disproportion, overstimulation with oxytocin, maternal exhaustion, ineffective pushing, excessive size fetus, poor maternal positioning in labor, and maternal anxiety and fear

Question format: Multiple Select

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 768

15. A nurse is preparing an inservice education program for a group of nurses about dystocia involving problems with the passenger. Which problem would the nurse likely include as the **most common**?

- A. macrosomia
- B. breech presentation
- C. persistent occiput posterior position
- D. multifetal pregnancy

Answer: C

Rationale: Common problems involving the passenger include occiput posterior position, breech presentation, multifetal pregnancy, excessive size (macrosomia) as it relates to cephalopelvic disproportion (CPD), and structural anomalies. Of these, persistent occiput posterior is the most common malposition, occurring in about 15% of laboring women.

Question format: Multiple Choice

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 775

16. A nurse is conducting a review course on tocolytic therapy for perinatal nurses. After teaching the group, the nurse determines that the teaching was successful when they identify which drugs as being used for tocolysis? Select all that apply.

- A. nifedipine
- B. magnesium sulfate
- C. dinoprostone
- D. misoprostol
- E. indomethacin

Answer: A, B, E

Rationale: Medications most commonly used for tocolysis include magnesium sulfate (which reduces the muscle's ability to contract), indomethacin (a prostaglandin synthetase inhibitor), and nifedipine (a calcium channel blocker). These drugs are used "off label": this means they are effective for this purpose but have not been officially tested and developed for this purpose by the FDA. Dinoprostone and misoprostol are used to ripen the cervix.

Question format: Multiple Select

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 783

17. A nurse is teaching a pregnant woman at risk for preterm labor about what to do if she experiences signs and symptoms. The nurse determines that the teaching was successful when the woman makes which statement?

- A. "I'll sit down to rest for 30 minutes."
- B. "I'll try to move my bowels."
- C. "I'll lie down with my legs raised."
- D. "I'll drink several glasses of water."

Answer: D

Rationale: If the woman experiences any signs and symptoms of preterm labor, she should stop what she is doing and rest for 1 hour, empty her bladder, lie down on her side, drink two to three glasses of water, feel her abdomen and note the hardness of the contraction, and call her health care provider and describe the contraction.

Question format: Multiple Choice

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 784

18. A nurse is describing the risks associated with post-term pregnancies as part of an inservice presentation. The nurse determines that more teaching is needed when the group identifies which factor as an underlying reason for problems in the fetus?

- A. aging of the placenta
- B. increased amniotic fluid volume
- C. meconium aspiration
- D. cord compression

Answer: B

Rationale: Fetal risks associated with a post-term pregnancy include macrosomia, shoulder dystocia, brachial plexus injuries, low Apgar scores, postmaturity syndrome (loss of subcutaneous fat and muscle and meconium staining), and cephalopelvic disproportion. As the placenta ages, its perfusion decreases and it becomes less efficient at delivering oxygen and nutrients to the fetus. Amniotic fluid volume also begins to decline after 38 weeks' gestation, possibly leading to oligohydramnios, subsequently resulting in fetal hypoxia and an increased risk of cord compression because the cushioning effect offered by adequate fluid is no longer present. Hypoxia and oligohydramnios predispose the fetus to aspiration of meconium, which is released by the fetus in response to a hypoxic insult (Norwitz, 2019). All of these issues can compromise fetal well-being and lead to fetal distress.

Question format: Multiple Choice

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 785

19. A nurse is explaining to a group of nurses new to the labor and birth unit about methods used for cervical ripening. The group demonstrates understanding of the information when they identify which method as a mechanical one?

- A. herbal agents
- B. laminaria
- C. membrane stripping
- D. amniotomy

Answer: B

Rationale: Laminaria is a hygroscopic dilator that is used as a mechanical method for cervical ripening. Herbal agents are a nonpharmacologic method. Membrane stripping and amniotomy are considered surgical methods.

Question format: Multiple Choice

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 788

20. The nurse notifies the obstetrical team immediately because the nurse suspects that the pregnant woman may be exhibiting signs and symptoms of amniotic fluid embolism. When reporting this suspicion, which finding(s) would the nurse include in the report? Select all that apply.

- A. significant difficulty breathing
- B. hypertension
- C. tachycardia
- D. pulmonary edema
- E. bleeding with bruising

Answer: A, C, D, E

Rationale: Anaphylactoid syndrome of pregnancy (ASP), also known as amniotic fluid embolism, is an unforeseeable, life-threatening complication of childbirth. The etiology of ASP remains an enigmatic, devastating obstetric condition associated with significant maternal and newborn morbidity and mortality. It is a rare and often fatal event characterized by the sudden onset of hypotension, cardiopulmonary collapse, hypoxia, and coagulopathy. ASP should be suspected in any pregnant women with an acute onset of dyspnea, hypotension, and DIC. By knowing how to intervene, the nurse can promote a better chance of survival for both the mother and her newborn.

Question format: Multiple Select

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

21. A nurse is conducting an in-service program for a group of labor and birth unit nurses about cesarean birth. The group demonstrates understanding of the information when they identify which conditions as appropriate indications? Select all that apply.

- A. active genital herpes infection
- B. placenta previa
- C. previous cesarean birth
- D. prolonged labor
- E. fetal distress

Answer: A, B, C, E

Rationale: The leading indications for cesarean birth are previous cesarean birth, breech presentation, dystocia, and fetal distress. Examples of specific indications include active genital herpes, fetal macrosomia, fetopelvic disproportion, prolapsed umbilical cord, placental abnormality (placenta previa or placental abruption), previous classic uterine incision or scar, gestational hypertension, diabetes, positive human immunodeficiency virus (HIV) status, and dystocia. Fetal indications include malpresentation (nonvertex presentation), congenital anomalies (fetal neural tube defects, hydrocephalus, abdominal wall defects), and fetal distress.

Question format: Multiple Select

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 800

22. A pregnant woman is receiving misoprostol to ripen her cervix and induce labor. The nurse assesses the woman closely for which effect?

- A. uterine hyperstimulation
- B. headache
- C. blurred vision
- D. hypotension

Answer: A

Rationale: A major adverse effect of the obstetric use of misoprostol is hyperstimulation of the uterus, which may progress to uterine tetany with marked impairment of uteroplacental blood flow, uterine rupture (requiring surgical repair, hysterectomy, and/or salpingo-oophorectomy), or amniotic fluid embolism. Headache, blurred vision, and hypotension are associated with magnesium sulfate.

Question format: Multiple Choice

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 789

23. A nurse is teaching a woman about measures to prevent preterm labor in future pregnancies because the woman just experienced preterm labor with her most recent pregnancy. The nurse determines that the teaching was successful based on which statement by the woman?
- A. "I'll make sure to limit the amount of long distance traveling I do."
 - B. "Stress isn't a problem that is related to preterm labor."
 - C. "Separating pregnancies by about a year should be helpful."
 - D. "I'll need extra iron in my diet so I have extra for the baby."

Answer: A

Rationale: Appropriate measures to reduce the risk for preterm labor include: avoiding travel for long distances in cars, trains, planes or buses; achieving adequate iron store through balanced nutrition (excess iron is not necessary); waiting for at least 18 months between pregnancies, and using stress management techniques for stress.

Question format: Multiple Choice

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Reference: p. 784

24. A pregnant woman at 31-weeks' gestation calls the clinic and tells the nurse that she is having contractions sporadically. Which instructions would be **most** appropriate for the nurse to give the woman? Select all that apply.

- A. "Walk around the house for the next half hour."
- B. "Drink two or three glasses of water."
- C. "Lie down on your back."
- D. "Try emptying your bladder."
- E. "Stop what you are doing and rest."

Answer: B, D, E

Rationale: Appropriate instructions for the woman who may be experiencing preterm labor include having the client stop what she is doing and rest for an hour, empty her bladder, lie down on her left side, and drink two to three glasses of water.

Question format: Multiple Select

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 784

25. A pregnant client has received dinoprostone. Following administration of this medication, the nurse assesses the client and determines that the client is experiencing an adverse effect of the medication based on which client report? Select all that apply.

- A. headache

- B. nausea
- C. diarrhea
- D. tachycardia
- E. hypotension

Answer: A, B, C

Rationale: Adverse effects associated with dinoprostone include headache, nausea and vomiting, and diarrhea. Tachycardia and hypotension are not associated with this drug.

Question format: Multiple Select

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 789

26. A nurse is reading a journal article about cesarean births and the indications for them. Place the indications for cesarean birth below in the proper sequence from most frequent to least frequent. All options must be used.

- A. Labor dystocia
- B. Abnormal fetal heart rate tracing
- C. Fetal malpresentation
- D. Multiple gestation
- E. Suspected macrosomia

Answer: A, B, C, D, E

Rationale: The most common indications for primary cesarean births include, in order of frequency: labor dystocia as the labor does not progress, abnormal fetal heart rate tracing indicating fetal distress, fetal malpresentation making a difficult progression of labor, multiple gestation , and suspected macrosomia.

Question format: Drag and Drop

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 768

27. A nurse is taking a history on a woman who is at 20 weeks' gestation. The woman reports that she feels some heaviness in her thighs since yesterday. The nurse suspects that the woman may be experiencing preterm labor based on which additional assessment findings? Select all that apply.

- A. dull low backache
- B. viscous vaginal discharge
- C. dysuria
- D. constipation
- E. occasional cramping

Answer: A, B, C

Rationale: Symptoms of preterm labor are often subtle and may include change or increase in vaginal discharge with mucus, water, or blood in it; pelvic pressure; low, dull backache; nausea, vomiting or diarrhea, and heaviness or aching in the thighs. Constipation is not known to be a sign of preterm labor. Preterm labor is assessed when there are more than six contractions per hour. Occasional asymptomatic cramping can be normal.

Question format: Multiple Select

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 780

28. A pregnant client at 24 weeks' gestation comes to the clinic for an evaluation. The client called the clinic earlier in the day stating that she had not felt the fetus moving since yesterday evening. Further assessment reveals absent fetal heart tones. Intrauterine fetal demise is suspected. The nurse would expect to prepare the client for which testing to confirm the suspicion?

- A. Ultrasound
- B. Amniocentesis
- C. Human chorionic gonadotropin (hCG) level
- D. Triple marker screening

Answer: A

Rationale: A client experiencing an intrauterine fetal demise (IUFD) is likely to seek care when she notices that the fetus is not moving or when she experiences contractions, loss of fluid, or vaginal bleeding. History and physical examination frequently are of limited value in the diagnosis of fetal death, since many times the only history tends to be recent absence of fetal movement and no fetal heart beat heard. An inability to obtain fetal heart sounds on examination suggests fetal demise, but an ultrasound is necessary to confirm the absence of fetal cardiac activity. Once fetal demise is confirmed, induction of labor or expectant management is offered to the client. An amniocentesis, hCG level, or triple marker screening would not be used to confirm IUFD.

Question format: Multiple Choice

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 794

29. A 32-year-old black woman in her second trimester has come to the clinic for an evaluation. While interviewing the client, she reports a history of fibroids and urinary tract infection. The client states, "I know smoking is bad and I have tried to stop, but it is impossible. I have cut down quite a bit though, and I do not drink alcohol." Complete blood count results reveal a low red blood cell count, low hemoglobin, and low hematocrit. When planning this client's care,

which factor(s) would the nurse identify as increasing the client's risk for preterm labor? Select all that apply.

- A. African heritage
- B. Maternal age
- C. History of fibroids
- D. Cigarette smoking
- E. History of urinary tract infections
- F. Complete blood count results

Answer: A, C, D, E, F

Rationale: For this client, risk factors associated with preterm labor and birth would include African heritage, cigarette smoking, uterine abnormalities, such as fibroids, urinary tract infection, and possible anemia based on her complete blood count results. Maternal age extremes (younger than 16 years and older than 35 years) are also a risk factor but do not apply to this client.

Question format: Multiple Select

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 782

30. A pregnant client at 30 weeks' gestation calls the clinic because she thinks that she may be in labor. To determine if the client is experiencing labor, which question(s) would be appropriate for the nurse to ask? Select all that apply.

- A. "Are you feeling any pressure or heaviness in your pelvis?"
- B. "Are you having contractions that come and go, off and on?"
- C. "Have you noticed any fluid leaking from your vagina?"
- D. "Are you having problems with heartburn?"
- E. "Have you been having any nausea or vomiting?"

Answer: A, B, C, E

Rationale: Frequently, women are unaware that uterine contractions, effacement, and dilation are occurring, thus making early intervention ineffective in arresting preterm labor and preventing the birth of a premature newborn. The nurse should ask the client about any signs/symptoms, being alert for subtle symptoms of preterm labor, which may include: a change or increase in vaginal discharge with mucous, water, or blood in it; pelvic pressure (pushing-down sensation); low dull backache; menstrual-like cramps; urinary tract infection symptoms; feeling of pelvic pressure or fullness; gastrointestinal upset like nausea, vomiting, and diarrhea; general sense of discomfort or unease; heaviness or aching in the thighs; uterine contractions with or without pain; more than six contractions per hour; intestinal cramping with or without diarrhea.

Contractions also must be persistent, such that four contractions occur every 20 minutes or eight contractions occur in 1 hour. A report of heartburn is unrelated to preterm labor.

Question format: Multiple Select

Chapter 21: Nursing Management of Labor and Birth at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 784

Chapter 22

1. Review of a primiparous woman's labor and birth record reveals a prolonged second stage of labor and extended time in the stirrups. Based on an interpretation of these findings, the nurse would be especially alert for which condition?
- A. retained placental fragments
 - B. hypertension
 - C. thrombophlebitis
 - D. uterine subinvolution

Answer: C

Rationale: The woman is at risk for thrombophlebitis due to the prolonged second stage of labor, necessitating an increased amount of time in bed, and venous pooling that occurs when the woman's legs are in stirrups for a long period of time. These findings are unrelated to retained placental fragments, which would lead to uterine subinvolution, or hypertension.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 818-819

2. The nurse is conducting a class for postpartum women about mood disorders. The nurse describes a transient, self-limiting mood disorder that affects mothers after birth. The nurse determines that the women understood the description when they identify the condition as postpartum:

- A. depression.
- B. psychosis.
- C. bipolar disorder.
- D. blues.

Answer: D

Rationale: Postpartum blues are manifested by mild depressive symptoms of anxiety, irritability, mood swings, tearfulness, increased sensitivity, feelings of being overwhelmed, and fatigue. They are usually self-limiting and require no formal treatment other than reassurance and validation of the woman's experience as well as assistance in caring for herself and her newborn. Postpartum depression is a major depressive episode associated with birth. Postpartum psychosis is at the severe end of the continuum of postpartum emotional disorders. Bipolar disorder refers to a mood disorder typically involving episodes of depression and mania.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Reference: p. 828

3. A woman who is 2 weeks postpartum calls the clinic and says, "My left breast hurts." After further assessment on the phone, the nurse suspects the woman has mastitis. In addition to pain, the nurse would question the woman about which symptom?

- A. an inverted nipple on the affected breast
- B. no breast milk in the affected breast
- C. an ecchymotic area on the affected breast
- D. hardening of an area in the affected breast

Answer: D

Rationale: Mastitis is characterized by a tender, hot, red, painful area on the affected breast. An inverted nipple is not associated with mastitis. With mastitis, the breast is distended with milk, the area is inflamed (not ecchymotic), and there is breast tenderness.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 822

4. A nurse is developing a program to help reduce the risk of late postpartum hemorrhage in clients in the labor and birth unit. Which measure would the nurse emphasize as part of this program?

- A. administering broad-spectrum antibiotics
- B. inspecting the placenta after delivery for intactness
- C. manually removing the placenta at birth
- D. applying pressure to the umbilical cord to remove the placenta

Answer: B

Rationale: After the placenta is expelled, a thorough inspection is necessary to confirm its intactness because tears or fragments left inside may indicate an accessory lobe or placenta accreta. These can lead to profuse hemorrhage because the uterus is unable to contract fully. Administering antibiotics would be appropriate for preventing infection, not postpartum hemorrhage. Manual removal of the placenta or excessive traction on the umbilical cord can lead to uterine inversion, which in turn would result in hemorrhage.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Reference: p. 809

5. A multipara client develops thrombophlebitis after birth. Which assessment findings would lead the nurse to intervene immediately?

- A. dyspnea, diaphoresis, hypotension, and chest pain

- B. dyspnea, bradycardia, hypertension, and confusion
- C. weakness, anorexia, change in level of consciousness, and coma
- D. pallor, tachycardia, seizures, and jaundice

Answer: A

Rationale: Sudden unexplained shortness of breath and reports of chest pain along with diaphoresis and hypotension suggest pulmonary embolism, which requires immediate action. Other signs and symptoms include tachycardia, apprehension, hemoptysis, syncope, and sudden change in the woman's mental status secondary to hypoxemia. Anorexia, seizures, and jaundice are unrelated to a pulmonary embolism.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 819

6. A client experienced prolonged labor with prolonged premature rupture of membranes. The nurse would be alert for which condition in the mother and the newborn?

- A. infection
- B. hemorrhage
- C. trauma
- D. hypovolemia

Answer: A

Rationale: Although hemorrhage, trauma, and hypovolemia may be problems, the prolonged labor with the prolonged premature rupture of membranes places the client at high risk for a postpartum infection. The rupture of membranes removes the barrier of amniotic fluid, so bacteria can ascend.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Reference: p. 824

7. When assessing the postpartum woman, the nurse uses indicators other than pulse rate and blood pressure for postpartum hemorrhage because:

- A. these measurements may not change until after the blood loss is large.
- B. the body's compensatory mechanisms activate and prevent any changes.
- C. they relate more to change in condition than to the amount of blood lost.
- D. maternal anxiety adversely affects these vital signs.

Answer: A

Rationale: The typical signs of hemorrhage do not appear in the postpartum woman until as much as 1,800 to 2,100 ml of blood has been lost. In addition, accurate determination of actual blood loss is difficult because of blood pooling inside the uterus and on perineal pads, mattresses, and the floor.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 809-810

8. A nurse is assessing a postpartum client. Which finding would cause the nurse the **greatest** concern?

- A. leg pain on ambulation with mild ankle edema
- B. calf pain with dorsiflexion of the foot
- C. perineal pain with swelling along the episiotomy
- D. sharp, stabbing chest pain with shortness of breath

Answer: D

Rationale: Sharp, stabbing chest pain with shortness of breath suggests pulmonary embolism, an emergency that requires immediate action. Leg pain on ambulation with mild edema suggests superficial venous thrombosis. Calf pain on dorsiflexion of the foot may indicate deep vein thrombosis or a strained muscle or contusion. Perineal pain with swelling along the episiotomy might be a normal finding or suggest an infection. Of the conditions, pulmonary embolism is the most urgent.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 818-819

9. A woman who is experiencing postpartum hemorrhage is extremely apprehensive and diaphoretic. The woman's extremities are cool and her capillary refill time is increased. Based on this assessment, the nurse suspects that the client is experiencing approximately how much blood loss?

- A. 20%
- B. 30%
- C. 40%
- D. 60%

Answer: D

Rationale: The client's assessment indicated mild shock, which is associated with a 20% blood loss. Moderate shock occurs with a blood loss of 30 to 40%. Severe shock is associated with a blood loss greater than 40%.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 810

10. A postpartum client is prescribed medication therapy as part of the treatment plan for postpartum hemorrhage. Which medication would the nurse expect to administer in this situation?

- A. Magnesium sulfate
- B. methylergonovine
- C. Indomethacin
- D. nifedipine

Answer: B

Rationale: Methylergonovine, along with oxytocin and carboprost are drugs used to manage postpartum hemorrhage. Magnesium sulfate, indomethacin, and nifedipine are used to control preterm labor.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 816

11. A client is experiencing postpartum hemorrhage, and the nurse begins to massage her fundus. Which action would be **most** appropriate for the nurse to do when massaging the woman's fundus?

- A. Place the hands on the sides of the abdomen to grasp the uterus.
- B. Use an up-and-down motion to massage the uterus.
- C. Wait until the uterus is firm to express clots.
- D. Continue massaging the uterus for at least 5 minutes.

Answer: C

Rationale: The uterus must be firm before attempts to express clots are made because application of firm pressure on an uncontracted uterus could lead to uterine inversion. One hand is placed on the fundus and the other hand is placed on the area above the symphysis pubis. Circular motions are used for massage. There is no specified amount of time for fundal massage. Uterine tissue responds quickly to touch, so it is important not to overmassage the fundus.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 815

12. After teaching a woman with a postpartum infection about care after discharge, which client statement indicates the need for additional teaching?

- A. "I need to call my doctor if my temperature goes above 100.4° F (38° C)."
- B. "When I put on a new pad, I'll start at the back and go forward."
- C. "If I have chills or my discharge has a strange odor, I'll call my doctor."
- D. "I'll point the spray of the peri-bottle so it the water flows front to back."

Answer: B

Rationale: The woman needs additional teaching when she states that she should apply the perineal pad starting at the back and going forward. The pad should be applied using a front-to-back motion. Notifying the health care provider of a temperature above 100.4° F (38° C), aiming the peri-bottle spray so that the flow goes from front to back, and reporting danger signs such as chills or lochia with a strange odor indicate effective teaching.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 821

13. A nurse is making a home visit to a postpartum client. Which finding would lead the nurse to suspect that a woman is experiencing postpartum psychosis?

- A. delirium
- B. feelings of guilt
- C. sadness
- D. insomnia

Answer: A

Rationale: Postpartum psychosis is at the severe end of the continuum of postpartum emotional disorders. It is manifested by depression that escalates to delirium, hallucinations, anger toward self and infant, bizarre behavior, mania, and thoughts of hurting herself and the infant. Feelings of guilt, sadness, and insomnia are associated with postpartum depression.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 830

14. A nurse is reviewing a journal article on the causes of postpartum hemorrhage. Which condition would the nurse most likely find as the **most** common cause?

- A. labor augmentation
- B. uterine atony
- C. cervical or vaginal lacerations
- D. uterine inversion

Answer: B

Rationale: The most common cause of postpartum hemorrhage is uterine atony, failure of the uterus to contract and retract after birth. The uterus must remain contracted after birth to control bleeding from the placental site. Labor augmentation is a risk factor for postpartum hemorrhage. Lacerations of the birth canal and uterine inversion may cause postpartum hemorrhage, but these are not the most common cause.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 809

15. A postpartum woman is diagnosed with endometritis. The nurse interprets this as an infection involving which area? Select all that apply.

- A. endometrium
- B. decidua
- C. myometrium
- D. broad ligament
- E. ovaries
- F. fallopian tubes

Answer: A, B, C

Rationale: Endometritis is an infectious condition that involves the endometrium, decidua, and adjacent myometrium of the uterus. Extension of endometritis can result in parametritis, which involves the broad ligament and possibly the ovaries and fallopian tubes, or septic pelvic thrombophlebitis.

Question format: Multiple Select

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 821

16. A group of nurses are reviewing information about mastitis and its causes in an effort to develop a teaching program on prevention for postpartum women. The nurses demonstrate understanding of the information when they focus the teaching on ways to minimize risk of exposure to which organism?

- A. E. coli
- B. S. aureus
- C. Proteus
- D. Klebsiella

Answer: B

Rationale: The most common infectious organism that causes mastitis is *S. aureus*, which comes from the breast-feeding infant's mouth or throat. *E. coli* is another, less common cause. *E. coli*, *Proteus*, and *Klebsiella* are common causes of urinary tract infections.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 822

17. A home health care nurse is assessing a postpartum woman who was discharged 2 days ago. The woman tells the nurse that she has a low-grade fever and feels "lousy." Which finding would lead the nurse to suspect endometritis? Select all that apply.

- A. lower abdominal tenderness
- B. urgency
- C. flank pain
- D. breast tenderness
- E. anorexia

Answer: A, E

Rationale: Manifestations of endometritis include lower abdominal tenderness or pain on one or both sides, elevated temperature, foul-smelling lochia, anorexia, nausea, fatigue and lethargy, leukocytosis, and elevated sedimentation rate. Urgency and flank pain would suggest a urinary tract infection. Breast tenderness may be related to engorgement or suggest mastitis.

Question format: Multiple Select

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 821

18. A postpartum client comes to the clinic for her routine 6-week visit. The nurse assesses the client and suspects that she is experiencing subinvolution based on which finding?

- A. nonpalpable fundus
- B. moderate lochia serosa
- C. bruising on arms and legs
- D. fever

Answer: B

Rationale: Subinvolution is usually identified at the woman's postpartum examination 4 to 6 weeks after birth. The clinical picture includes a postpartum fundal height that is higher than expected, with a boggy uterus; the lochia fails to change colors from red to serosa to alba within a few weeks. Normally, at 4 to 6 weeks, lochia alba or no lochia would be present and the fundus would not be palpable. Thus evidence of lochia serosa suggests subinvolution. Bruising would suggest a coagulopathy. Fever would suggest an infection.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 810-811

19. Assessment of a postpartum client reveals a firm uterus with bright-red bleeding and a localized bluish bulging area just under the skin at the perineum. The woman also reports significant pelvic pain and is experiencing problems with voiding. The nurse suspects which condition?

- A. hematoma
- B. laceration
- C. bladder distention
- D. uterine atony

Answer: A

Rationale: The woman most likely has a hematoma based on the findings: firm uterus with bright-red bleeding; localized bluish bulging area just under the skin surface in the perineal area; severe perineal or pelvic pain; and difficulty voiding. A laceration would involve a firm uterus with a steady stream or trickle of unclotted bright-red blood in the perineum. Bladder distention would be palpable along with a soft, boggy uterus that deviates from the midline. Uterine atony would be noted by an uncontracted uterus.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 811

20. A postpartum woman is prescribed oxytocin to stimulate the uterus to contract. Which action would be **most** important for the nurse to do?

- A. Administer the drug as an IV bolus injection.
- B. Give as a vaginal or rectal suppository.
- C. Piggyback the IV infusion into a primary line.
- D. Withhold the drug if the woman is hypertensive.

Answer: C

Rationale: When giving oxytocin, it should be diluted in a liter of IV solution and the infusion set up to be piggy-backed into a primary line to ensure that the medication can be discontinued readily if hyperstimulation or adverse effects occur. It should never be given as an IV bolus injection. Oxytocin may be given if the woman is hypertensive. Oxytocin is not available as a vaginal or rectal suppository.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 816

21. Assessment of a postpartum woman experiencing postpartum hemorrhage reveals mild shock. Which finding would the nurse expect to assess? Select all that apply.

- A. diaphoresis
- B. tachycardia
- C. oliguria
- D. cool extremities
- E. confusion

Answer: A, D

Rationale: Signs and symptoms of mild shock include diaphoresis, increased capillary refill, cool extremities, and maternal anxiety. Tachycardia and oliguria suggest moderate shock. Confusion suggests severe shock.

Question format: Multiple Select

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 810

22. A nurse is providing a refresher class for a group of postpartum nurses. The nurse reviews the risk factors associated with postpartum hemorrhage. The group demonstrates understanding of the information when they identify which risk factors associated with uterine tone? Select all that apply.

- A. rapid labor
- B. retained blood clots
- C. hydramnios
- D. operative birth
- E. fetal malposition

Answer: A, C

Rationale: Risk factors associated with uterine tone include hydramnios, rapid or prolonged labor, oxytocin use, maternal fever, or prolonged rupture of membranes. Retained blood clots are a risk factor associated with tissue retained in the uterus. Fetal malposition and operative birth are risk factors associated with trauma of the genital tract.

Question format: Multiple Select

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 810

23. A nurse is massaging a postpartum client's fundus and places the nondominant hand on the area above the symphysis pubis based on the understanding that this action:

- A. determines that the procedure is effective.

- B. helps support the lower uterine segment.
- C. aids in expressing accumulated clots.
- D. prevents uterine muscle fatigue.

Answer: B

Rationale: The nurse places the nondominant hand on the area above the symphysis pubis to help support the lower uterine segment. The hand, usually the dominant hand that is placed on the fundus, helps to determine uterine firmness (and thus the effectiveness of the massage).

Applying gentle downward pressure on the fundus helps to express clots. Overmassaging the uterus leads to muscle fatigue.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 815

24. A nurse is developing a plan of care for a woman who is at risk for thromboembolism. Which measure would the nurse include as the **most** cost-effective method for prevention?

- A. prophylactic heparin administration
- B. compression stockings
- C. early ambulation
- D. warm compresses

Answer: C

Rationale: Although compression stockings and prophylactic heparin administration may be appropriate, the most cost-effective preventive method is early ambulation. It is also the easiest method. Warm compresses are used to treat superficial venous thrombosis.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Reference: p. 820

25. A postpartum woman who developed deep vein thrombosis is being discharged on anticoagulant therapy. After teaching the woman about this treatment, the nurse determines that additional teaching is needed when the woman makes which statement?

- A. "I will use a soft toothbrush to brush my teeth."
- B. "I can take ibuprofen if I have any pain."
- C. "I need to avoid drinking any alcohol."
- D. "I will call my health care provider if my stools are black and tarry."

Answer: B

Rationale: Individuals receiving anticoagulant therapy need to avoid use of any over-the-counter products containing aspirin or aspirin-like derivatives such as NSAIDs (ibuprofen) to reduce the risk for bleeding. Using a soft toothbrush and avoiding alcohol are appropriate measures to reduce the risk for bleeding. Black, tarry stools should be reported to the health care provider.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Reference: p. 821

26. The nurse is developing a discharge teaching plan for a postpartum woman who has developed a postpartum infection. Which measures would the nurse **most** likely include in this teaching plan? Select all that apply.

- A. taking the prescribed antibiotic until it is finished
- B. checking temperature once a week
- C. washing hands before and after perineal care
- D. handling perineal pads by the edges
- E. directing peribottle to flow from back to front

Answer: A, C, D

Rationale: Teaching should address taking the prescribed antibiotic until finished to ensure complete eradication of the infection; checking temperature daily and notifying the practitioner if it is above 100.4° F (38° C); washing hands thoroughly before and after eating, using the bathroom, touching the perineal area, or providing newborn care; handling perineal pads by the edges and avoiding touching the inner aspect of the pad that is against the body; and directing peribottle so that it flows from front to back.

Question format: Multiple Select

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 821

27. A nurse is assessing a postpartum client who is at home. Which statement by the client would lead the nurse to suspect that the client may be developing postpartum depression?

- A. "I just feel so overwhelmed and tired."
- B. "I'm feeling so guilty and worthless lately."
- C. "It's strange, one minute I'm happy, the next I'm sad."
- D. "I keep hearing voices telling me to take my baby to the river."

Answer: B

Rationale: Indicators for postpartum depression include feelings related to restlessness, worthlessness, guilt, hopeless, and sadness along with loss of enjoyment, low energy level, and loss of libido. The statements about being overwhelmed and fatigued and changing moods suggest postpartum blues. The statement about hearing voices suggests postpartum psychosis.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Reference: p. 828

28. As part of an in-service program to a group of home health care nurses who care for postpartum women, a nurse is describing postpartum depression. The nurse determines that the teaching was successful when the group identifies that this condition becomes evident at which time after birth of the newborn?

- A. in the first week
- B. within the first 2 weeks
- C. in approximately 1 month
- D. within the first 6 weeks

Answer: D

Rationale: PPD usually has a gradual onset and becomes evident within the first 6 weeks postpartum. Postpartum blues typically manifests in the first week postpartum. Postpartum psychosis usually appears about 3 months after birth of the newborn.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Reference: p. 828-829

29. A nurse suspects that a client may be developing disseminated intravascular coagulation. The woman has a history of placental abruption (abruptio placentae) during birth. Which finding would help to support the nurse's suspicion?

- A. severe uterine pain
- B. board-like abdomen
- C. appearance of petechiae
- D. inversion of the uterus

Answer: C

Rationale: A complication of abruptio placentae is disseminated intravascular coagulation (DIC), which is manifested by petechiae, ecchymoses, and other signs of impaired clotting. Severe uterine pain, a board-like abdomen, and uterine inversion are not associated with DIC and placental abruption.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 812

30. On a follow-up visit to the clinic, a nurse suspects that a postpartum client is experiencing postpartum psychosis. Which finding would **most** likely lead the nurse to suspect this condition?

- A. delusional beliefs
- B. feelings of anxiety
- C. sadness
- D. insomnia

Answer: A

Rationale: Postpartum psychosis is at the severe end of the continuum of postpartum emotional disorders. It is manifested by depression that escalates to delirium, hallucinations, delusional beliefs, anger toward self and infant, bizarre behavior, mania, and thoughts of hurting herself and the infant. Feelings of anxiety, sadness, and insomnia are associated with postpartum depression.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 830

31. A nurse is assessing a client who gave birth vaginally about 4 hours ago. The client tells the nurse that she changed her perineal pad about an hour ago. On inspection, the nurse notes that the pad is now saturated. The uterus is firm and approximately at the level of the umbilicus. Further inspection of the perineum reveals an area, bluish in color and bulging just under the skin surface. Which action would the nurse do **next**?

- A. Apply warm soaks to the area.
- B. Notify the health care provider.
- C. Massage the uterine fundus.
- D. Encourage the client to void.

Answer: B

Rationale: The client is experiencing postpartum hemorrhage secondary to a perineal hematoma. The nurse needs to notify the health care provider about these findings to prevent further hemorrhage. Applying warm soaks to the area would do nothing to control the bleeding. With a perineal hematoma, the uterus is firm, so massaging the uterus or encouraging the client to void would not be appropriate.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 821

32. A nurse is providing education to a woman who is experiencing postpartum hemorrhage and is to receive a uterotonic agent. The nurse determines that additional teaching is needed when the woman identifies which drug as possibly being prescribed as treatment?

- A. oxytocin

- B. methylergonovine
- C. carboprost
- D. magnesium sulfate

Answer: D

Rationale: Magnesium sulfate is used during labor as a tocolytic agent to slow or halt preterm labor. It is not used to treat postpartum hemorrhage. Oxytocin, methylergonovine, and carboprost are drugs used to manage postpartum hemorrhage.

Question format: Multiple Choice

Chapter 22: Nursing Management of the Postpartum Woman at Risk

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Nursing Process

Reference: p. 816

Chapter 23

1. The nurse is teaching a group of parents who have preterm newborns about the differences between a full-term newborn and a preterm newborn. Which characteristic would the nurse describe as associated with a preterm newborn but not a term newborn?
 - A. fewer visible blood vessels through the skin
 - B. more subcutaneous fat in the neck and abdomen
 - C. well-developed flexor muscles in the extremities
 - D. greater body surface area in proportion to weight

Answer: D

Rationale: Preterm newborns have large body surface areas compared to weight, which allows an increased transfer of heat from their bodies to the environment. Preterm newborns often have thin transparent skin with numerous visible veins, minimal subcutaneous fat, and poor muscle tone.

Question format: Multiple Choice

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Teaching/Learning

Reference: p. 855

2. A nurse is assessing a postterm newborn. Which finding would the nurse correlate with this gestational age variation?
 - A. moist, supple, plum skin appearance
 - B. abundant lanugo and vernix
 - C. thin umbilical cord
 - D. absence of sole creases

Answer: C

Rationale: A postterm newborn typically exhibits a thin umbilical cord; dry, cracked, wrinkled skin; limited vernix and lanugo; and creases covering the entire soles of the feet.

Question format: Multiple Choice

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 847

3. The parents of a preterm newborn being cared for in the neonatal intensive care unit (NICU) are coming to visit for the first time. The newborn is receiving mechanical ventilation,

intravenous fluids and medications and is being monitored electronically by various devices.

Which action by the nurse would be **most** appropriate?

- A. Suggest that the parents stay for just a few minutes to reduce their anxiety.
- B. Reassure them that their newborn is progressing well.
- C. Encourage the parents to touch their preterm newborn.
- D. Discuss the care they will be giving the newborn upon discharge.

Answer: C

Rationale: The NICU environment can be overwhelming. Therefore, the nurse should address their reactions and explain all the equipment being used. On entering the NICU, the nurse should encourage the parents to touch, interact, and hold their newborn. Doing so helps to acquaint the parents with their newborn, promotes self-confidence, and fosters parent–newborn attachment. The parents should be allowed to stay for as long as they feel comfortable. Reassurance, although helpful, may be false reassurance at this time. Discussing discharge care can be done later once the newborn's status improves and plans for discharge are initiated.

Question format: Multiple Choice

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Integrated Process: Caring

Reference: p. 857

4. Rapid assessment of a newborn indicates the need for resuscitation. The newborn has copious secretions. The newborn is dried and placed under a radiant warmer. Which action would the nurse do **next**?

- A. Intubate with an appropriate-sized endotracheal tube.
- B. Give chest compressions at a rate of 80 times per minute.
- C. Administer epinephrine intravenously.
- D. Clear the airway with a bulb syringe.

Answer: D

Rationale: After placing the newborn's head in a neutral position, the nurse would clear the airway with a bulb syringe or suction. This is followed by assessment of breathing and bagging if needed, placing a pulse oximeter, ventilating the newborn, assessing the heart rate and giving chest compressions if needed, and then administering epinephrine and/or volume expansion if needed.

Question format: Multiple Choice

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 852-853

5. The nurse prepares to assess a newborn who is considered to be large-for-gestational-age (LGA). Which characteristic would the nurse correlate with this gestational age variation?

- A. strong, brisk motor skills
- B. difficulty in arousing to a quiet alert state
- C. birthweight of 7 lb, 14 oz (3,572 g)
- D. wasted appearance of extremities

Answer: B

Rationale: LGA newborns typically are more difficult to arouse to a quiet alert state. They have poor motor skills, have a large body that appears plump and full-sized, and usually weigh more than 8 lb, 13 oz (3,997 g) at term.

Question format: Multiple Choice

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Understand

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 846

6. A preterm newborn has received large concentrations of oxygen therapy during a 3-month stay in the NICU. As the newborn is prepared to be discharged home, the nurse anticipates a referral for which specialist?

- A. ophthalmologist
- B. nephrologist
- C. cardiologist
- D. neurologist

Answer: A

Rationale: Use of large concentrations of oxygen and sustained oxygen saturations higher than 95% while on supplemental oxygen have been associated with the development of retinopathy of prematurity (ROP) and further respiratory complications in the preterm newborn (Martin & Deakins, 2020). For these reasons, oxygen should be used judiciously to prevent the development of further complications. A guiding principle for oxygen therapy is it should be targeted to levels appropriate to the condition, gestational age, and postnatal age of the newborn. As a result, an ophthalmology consult for follow-up after discharge is essential for preterm infants who have received extensive oxygen. Although referrals to other specialists may be warranted depending on the newborn's status, there is no information to suggest that any would be needed.

Question format: Multiple Choice

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 854

7. A nurse is developing the plan of care for a small-for-gestational-age newborn. Which action would the nurse determine as a **priority**?

- A. Preventing hypoglycemia with early feedings
- B. Observing for newborn reflexes
- C. Promoting bonding between the parents and the newborn
- D. Monitoring vital signs every 2 hours

Answer: A

Rationale: The nurse must consider the implications of a small-for-gestational-age newborn. With the loss of the placenta at birth, the newborn must now assume control of glucose homeostasis. This is achieved by early oral intermittent feedings. Observing for newborn reflexes, promoting bonding, and monitoring vital signs, although important, are not the priority for this newborn.

Question format: Multiple Choice

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 842

8. The nurse is providing care to a newborn who was born at 36 weeks' gestation. Based on the nurse's understanding of gestational age, the nurse identifies this newborn as:

- A. preterm.
- B. late preterm.
- C. term.
- D. postterm.

Answer: B

Rationale: Gestational age is typically measured in weeks: a newborn born before completion of 37 weeks is classified as a preterm newborn, and one born after completion of 42 weeks is classified as a postterm newborn. An infant born from the first day of the 38th week through 42 weeks is classified as a term newborn. The late preterm newborn (near term) is one who is born between 34 weeks and 36 weeks, 6 days of gestation.

Question format: Multiple Choice

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 847

9. Which intervention would be **most** appropriate for the nurse to do when assisting parents who have experienced the loss of their preterm newborn?

- A. Avoid using the terms "death" or "dying."
- B. Provide opportunities for them to hold the newborn.

- C. Refrain from initiating conversations with the parents.
- D. Quickly refocus the parents to a more pleasant topic.

Answer: B

Rationale: When dealing with grieving parents, nurses should provide them with opportunities to hold the newborn if they desire. In addition, the nurse should provide the parents with as many memories as possible, encouraging them to see, touch, dress, and take pictures of the newborn. These interventions help to validate the parents' sense of loss, relive the experience, and attach significance to the meaning of loss. The nurse should use appropriate terminology, such as "dying," "died," and "death," to help the parents accept the reality of the death. Nurses need to demonstrate empathy and to respect the parents' feelings, responding to them in helpful and supportive ways. Active listening and allowing the parents to vent their frustrations and anger help validate the parents' feelings and facilitate the grieving process.

Question format: Multiple Choice

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Integrated Process: Caring

Reference: p. 847

10. A nurse is reviewing the maternal history of a large-for-gestational-age (LGA) newborn. Which factor, if noted in the maternal history, would the nurse identify as possibly contributing to the birth of this newborn?

- A. substance use disorder
- B. diabetes
- C. preeclampsia
- D. infection

Answer: B

Rationale: Maternal factors that increase the chance of having an LGA newborn include maternal diabetes mellitus or glucose intolerance, multiparity, prior history of a macrosomic infant, postdate gestation, maternal obesity, male fetus, and genetics. Substance use disorder is associated with small-for-gestational-age (SGA) newborns and preterm newborns. A maternal history of preeclampsia and infection would be associated with preterm birth.

Question format: Multiple Choice

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 846

11. A nurse is assessing a preterm newborn. Which finding would alert the nurse to suspect that a preterm newborn is in pain?

- A. bradycardia

- B. oxygen saturation level of 94%
- C. decreased muscle tone
- D. sudden high-pitched cry

Answer: D

Rationale: The nurse should suspect pain if the newborn exhibits a sudden high-pitched cry, oxygen desaturation, tachycardia, and increased muscle tone.

Question format: Multiple Choice

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Apply

Client Needs: Physiological Integrity: Basic Care and Comfort

Integrated Process: Nursing Process

Reference: p. 858

12. A 22-year-old woman experiencing homelessness arrives at a walk-in clinic seeking pregnancy confirmation. The nurse notes on assessment her uterus suggests 12 weeks' gestation, a blood pressure of 110/70 mm Hg, and a BMI of 17.5. The client admits to using cocaine a few times. The client has been pregnant before and indicates she "loses them early." What characteristic(s) place the client in the high-risk pregnancy category? Select all that apply.

- A. BMI 17.5
- B. blood pressure 110/70 mm Hg
- C. prenatal history
- D. homelessness
- E. age
- F. prenatal care

Answer: A, C, D, F

Rationale: The key to identifying a newborn with special needs related to birthweight or gestational age variation is an awareness of the factors that could place a newborn at risk. These factors are similar to those that would suggest a high-risk pregnancy and include maternal nutrition (malnutrition or overweight), substandard living conditions or low socioeconomic status, maternal age of less than 20 or more than 35 years, lack of prenatal care, and history of previous preterm birth.

Question format: Multiple Select

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 840

13. A neonate born at 40 weeks' gestation, weighing 2300 grams (5 lb, 1 oz) is admitted to the newborn nursery for observation only. What is the nurse's **first** observation about the infant?

- A. The neonate is average for its gestational age.
- B. The neonate is small for its gestational age.

- C. The neonate is large for its gestational age.
- D. The neonate is fetal growth restricted.

Answer: B

Rationale: Small for gestational age (SGA) describes newborns that typically weigh less than 2,500 g (5 lb, 8 oz) at term due to less growth than expected in utero. A newborn is also classified as SGA if his or her birthweight is at or below the 10th percentile as correlated with the number of weeks of gestation. In some SGA newborns, the rate of growth does not meet the expected growth pattern. These infants are considered to have fetal growth restriction resulting in pathology.

Question format: Multiple Choice

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 840-841

14. A thin newborn has a respiratory rate of 80 breaths/min, nasal flaring with sternal retractions, a heart rate of 120 beats/min, temperature of 36° C (96.8° F) and persisting oxygen saturation of <87%. The nurse interprets these findings as:

- A. cardiac distress.
- B. respiratory alkalosis.
- C. bronchial pneumonia.
- D. respiratory distress.

Answer: D

Rationale: Ineffective breathing pattern related to immature respiratory system and respiratory distress as evidenced by tachypnea, nasal flaring, sternal retractions, and/or oxygen saturation less than 87 %. These assessment findings do not indicate bronchial pneumonia respiratory alkalosis or cardiac distress at this time.

Question format: Multiple Choice

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Understand

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 852-853

15. A one-day-old neonate born at 32 weeks' gestation is in the neonatal intensive care unit under a radiant overhead warmer. The nurse assesses the morning axilla temperature as 95 degrees F (35 degrees C). What could explain the assessment finding?

- A. Conduction heat loss is a problem in the baby.
- B. The supply of brown adipose tissue is not developed.
- C. Axillary temperatures are not accurate.
- D. This is a normal temperature.

Answer: B

Rationale: Typically newborns use nonshivering thermogenesis for heat production by metabolizing their own brown adipose tissue. However, this preterm newborn has an inadequate supply of brown fat because he or she left the uterus early before the supply was adequate. Conduction heat loss allows an increased transfer of heat from their bodies to the environment, but there is nothing to substantiate conduction heat loss. Axillary temperatures are accurate and the mode of taking temperatures for neonates.

Question format: Multiple Choice

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Understand

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 855

16. A 42-year-old woman is 26 weeks' pregnant. She lives at a shelter for female victims of intimate partner violence. Her blood pressure is 170/90 mm Hg, the fetal heart rate is 140 bpm, TORCH studies are positive, and she is bleeding vaginally. What findings put her at risk of giving birth to a small-for-gestational-age (SGA) infant? Select all that apply.

- A. the age of the client
- B. living in a shelter for victims of intimate partner violence
- C. vaginal bleeding
- D. fetal heart rate
- E. blood pressure
- F. positive test for TORCH

Answer: A, B, C, E, F

Rationale: Some factors contributing to the birth of SGA newborns include maternal age of 20 or 35 years old, low socioeconomic status, and preeclampsia with increased blood pressure. The vaginal bleeding indicates placental problems, and she tests positive for sexually transmitted diseases by TORCH group infections.

Question format: Multiple Select

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 840

17. A term neonate has been admitted to the observational newborn nursery with the diagnosis of being small for gestational age. Which factors would predispose the neonate to this diagnosis? Select all that apply.

- A. The mother had chronic placental abruption.
- B. At birth the placenta was noted to be decreased in weight.
- C. On assessment the placenta had areas of infarction.

- D. At birth the placenta was a shiny Schultz presentation.
- E. Placental talipes was present at birth.

Answer: A, B, C, D

Rationale: Placental factors that can contribute to a small for gestational age infant include chronic placental abruption, infarction on surface of placenta, and a decreased placental weight. A shiny Schultz placenta is a normal description because the fetal side of the placenta comes out first, which is shiny. Placenta talipes does not exist.

Question format: Multiple Select

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 841

18. A small-for-gestational age infant is admitted to the observational care unit with the nursing diagnosis of ineffective thermoregulation related to lack of fat stores as evidenced by persistent low temperatures. Which are appropriate nursing interventions? Select all that apply.

- A. Assess the axillary temperature every hour.
- B. Review maternal history.
- C. Assess environment for sources of heat loss.
- D. Bathe the neonate with warmer water.
- E. Minimize kangaroo care.
- F. Encourage skin-to-skin contact.

Answer: A, B, C, F

Rationale: Proper care to promote thermoregulation include assessing the axillary temperature every hour, reviewing the maternal history to identify risk factors contributing to problem, assessing the environment for sources of heat loss, avoiding bathing and exposing newborn to prevent cold stress, and encouraging kangaroo care (mother or father holds preterm infant underneath clothing skin-to-skin and upright between breasts) to provide warmth.

Question format: Multiple Select

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 842

19. A couple has just given birth to a baby who has low Apgar scores due to asphyxia from prolonged cord compression. The neonatologist has given a poor prognosis to the newborn, who is not expected to live. Which interventions are appropriate at this time? Select all that apply.

- A. Advise the parents that the hospital can make the arrangements.
- B. Offer to pray with the family if appropriate.
- C. Leave the parents to talk through their next steps.

- D. Initiate spiritual comfort by calling the hospital clergy, if appropriate.
- E. Respect variations in the family's spiritual needs and readiness.

Answer: B, D, E

Rationale: When assisting the parents to cope with a perinatal loss, the nurse must respect variations in the family's spiritual needs and readiness. The nurse will also initiate spiritual comfort by calling the hospital clergy, if appropriate, and can offer to pray with the family, if appropriate.

Question format: Multiple Select

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Integrated Process: Caring

Reference: p. 863

20. A neonate is born at 42 weeks' gestation weighing 4.4 kg (9 lb, 7 oz) with satisfactory Apgar scores. Two hours later birth the neonate's blood sugar indicates hypoglycemia. Which symptoms would the baby demonstrate? Select all that apply.

- A. poor sucking
- B. respiratory distress
- C. weak cry
- D. jitteriness
- E. blood glucose >40 mg/dl

Answer: A, B, C, D

Rationale: Some of the common problems associated with newborns experiencing a variation in gestational age, such as a postterm newborn, are respiratory distress, jitteriness, feeble sucking, weak cry, and a blood glucose of 40 mg/dl.

Question format: Multiple Select

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Understand

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 846

21. A premature, 36-week-gestation neonate is admitted to the observational nursery and placed under bili-lights with evidence of hyperbilirubinemia. Which assessment findings would the neonate demonstrate? Select all that apply.

- A. increased serum bilirubin levels
- B. clay-colored stools
- C. tea-colored urine
- D. cyanosis
- E. Mongolian spots

Answer: A, B, C

Rationale: Hyperbilirubinemia is indicated when the newborn presents with elevated serum bilirubin levels, tea-colored urine, and clay-colored stools. Cyanosis would not be seen in infants in this scenario. Mongolian spots are not associated with newborn jaundice.

Question format: Multiple Select

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Understand

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 862

22. A jaundiced neonate must have heel sticks to assess bilirubin levels. Which assessment findings would indicate that the neonate is in pain? Select all that apply.

- A. There is flaccid muscle tone of the affected limb.
- B. Respiration rate is 52 breaths per minute.
- C. Heart rate is 180 beats per minutes.
- D. Oxygen saturation level is 88%.
- E. The infant has facial grimacing and quivering chin.

Answer: C, D, E

Rationale: Suspect pain if the newborn exhibits a sudden high-pitched cry; facial grimace is noted with furrowing of the brow and quivering of the chin with an increase in muscle tone when disturbed. Oxygen desaturation will be noted with an increase in heart rate. Increase in the normal blood pressure, pulse, and respiration are noted.

Question format: Multiple Select

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Apply

Client Needs: Physiological Integrity: Basic Care and Comfort

Integrated Process: Nursing Process

Reference: p. 858

23. During a neonate resuscitation attempt, the neonatologist has ordered 0.1 mL/kg IV epinephrine (adrenaline) in a 1:10,000 concentration to be given stat. The neonate weighs 3000 grams and is 38 centimeters long. How many milliliters (mL) should the nurse administer? Record your answer using one decimal place.

Answer: 0.3

Rationale: Epinephrine should be given if heart rate is 60 after 30 seconds of compressions and ventilation.

epinephrine: 1:10,000 concentration

0.1 to 0.3 mL/kg IV

3000 grams = 3 kg

$3 \text{ kg} \times 0.1 \text{ mL/kg} = 0.3 \text{ mL}$

Question format: Fill in the Blank

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Nursing Process

Reference: p. 852-853

24. A macrosomic infant in the newborn nursery is being observed for a possible fractured clavicle. For which would the nurse assess? Select all that apply.

- A. facial grimacing with movement
- B. bruising over area
- C. asymmetrical movement
- D. edema present
- E. positive Babinski reflex

Answer: A, B, C, D

Rationale: Birth trauma for LGA newborns would be demonstrated by an obvious deformity, with bruising at the site and edema noted. There would be asymmetrical movement when the newborn moves the limb. Babinski reflex is a neurological test and would be normal to be positive.

Question format: Multiple Select

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 846

25. A set of newborn twins has been admitted to the neonatal intensive care unit with the diagnosis of fetal growth restriction (FGR). Which maternal factors would predispose the newborn to this diagnosis? Select all that apply.

- A. hemoglobin 15 g/dl (150 g/l)
- B. A1C levels of 8% (0.08)
- C. heroin use disorder
- D. blood pressure baseline of 170/90 mm Hg
- E. age 39 years
- F. multiple gestation

Answer: B, C, D, E, F

Rationale: Assessment of the small-for-gestational-age (SGA) or FGR infant begins by reviewing the maternal history to identify risk factors such as maternal age over 30 years, a substance use disorder, hypertension, multiple gestation. Gestational diabetes or diabetes mellitus is also a factor. Normal A1C level is 5.7% (0.57) for a person without diabetes. Hemoglobin is normal for pregnant woman in third trimester.

Question format: Multiple Select

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 841

26. A neonate is admitted to the newborn observation nursery with the possible diagnosis of polycythemia. The nurse would be observing for which findings? Select all that apply.

- A. ruddy skin color
- B. respiratory distress
- C. cyanosis
- D. pink gums and tongue
- E. jitteriness

Answer: A, B, C, E

Rationale: Observe for clinical signs of polycythemia (respiratory distress, cyanosis, jitteriness, jaundice, ruddy skin color, and lethargy) and monitor blood results.

Question format: Multiple Select

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 846

27. A 20-hour-old neonate is suspected of having polycythemia. Which nursing intervention(s) will the nurse utilize to provide care for this neonate? Select all that apply.

- A. Obtain hemoglobin and hematocrit laboratory tests
- B. Provide early feedings to prevent hypoglycemia
- C. Maintain oxygen saturation parameters
- D. Monitor urinary output
- E. Insert a peripheral IV

Answer: A, B, C, D

Rationale: Polycythemia in a neonate is defined as a hematocrit above 65% (0.65) and a hemoglobin level above 20 g/dl (200 g/l). The hematocrit and hemoglobin peak between 6 and 12 hours of life and then start to decrease. If these values do not decrease as expected, then hypoperfusion will occur and polycythemia will develop. In the beginning, the nurse may assess feeding difficulties, hypoglycemia, jitteriness and respiratory distress. As the condition worsens, a ruddy skin color could be seen, cyanosis could develop, the neonate could become lethargic and seizures could develop. Nursing care for this neonate requires obtaining hematocrit and hemoglobin laboratory tests at 2 hours, 12 hours and 24 hours. Feeding should be started to provide fluid, nutrition and prevent hypoglycemia. The oxygen saturation should be monitored. If the levels are below the established parameters from the health care provider, oxygen therapy will be needed. The urine output should be monitored continuously because polycythemia can

cause real failure. A peripheral IV may or may not be needed. This would depend on the neonate's condition and if IV fluids would be required.

Question format: Multiple Select

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 846

28. A client has given birth to a full-term infant weighing 10 pounds 5 ounces (4678 grams).

What priority assessment should be completed by the nurse?

- A. Blood glucose
- B. Temperature control
- C. Feeding difficulty
- D. Perfusion

Answer: A

Rationale: Hypoglycemia is a common concern with a large-for-gestational age (LGA) infant. This infant will deplete the glucose stores very rapidly. Therefore, it is important to assess the glucose level within 30 minutes of birth and to repeat every hour until stable. Hypoglycemia is defined as a glucose level less than 35 to 45 mg/dl (1.94 to 2.50 mmol/l) in the first 4 hours of life, and intervention should occur when the glucose is less than 40 mg/dl (2.22 mmol/l). Intervention should also occur if the blood glucose is less than 45 mg/dl (2.50 mmol/l) at 4 and 24 hours of life respectively. Generally the nurse assesses symptoms of jitteriness, irritability and tachypnea first. These symptoms can progress to temperature instability, lethargy, bradycardia, hyponatremia and seizures.

Question format: Multiple Choice

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 846

29. A client expresses concerns that her grandmothers had complicated pregnancies. What principle(s) should the nurse discuss to allay the fears of the client? Select all that apply.

- A. "We work to ensure that birth of high-risk infants happens in settings where we are able to care for them."
- B. "We will work with you to identify prenatal risk factors early and take actions to reduce their impact."
- C. "We support those at risk of having a preterm birth with the goal of delaying early births."
- D. "We work to ensure care for mothers and infants to reduce infant illnesses, disabilities, and death."
- E. "We allow families to grieve the loss of a newborn, should it occur."

Answer: A, B, C, D

Rationale: The nurse will attempt to allay the client's fears by discussing the actions the facility enacts to promote a healthy birth and infant. This includes ensuring the birth of high-risk infants takes place in settings that have the technological capacity to care for them, identifying risk factors early and taking action to reduce their impact, working to delay the birth of those pregnancies identified at risk of preterm birth, and promoting an overall reduction in infant illness, disability, and death to proper care of the mother and infant. Although allowing a family to grieve in instances of infant death, discussing this factor with the client is likely to create more fear.

Question format: Multiple Select

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Caring

Reference: p. 840

30. A late preterm newborn is being prepared for discharge to home after being in the neonatal intensive care unit for 4 days. The nurse instructs the parents about the care of their newborn and emphasizes warning signs that should be reported to the pediatrician immediately. The nurse determines that additional teaching is needed based on which parental statement?

- A. "We will call 911 if we start to see that our newborn's lips or skin are looking bluish."
- B. "If our newborn's skin turns yellow, it is from the treatments and our newborn is okay."
- C. "If our newborn does not have a wet diaper in 12 hours, we will call our pediatrician."
- D. "We will let the pediatrician know if our newborn's temperature goes above 100.4°F (38°C)."

Answer: B

Rationale: The parents of a preterm newborn need teaching about when to notify their pediatrician or nurse practitioner. These include: displaying a yellow color to the skin (jaundice); having difficulty breathing or turning blue (call for emergency services in this case); having a temperature below 97°F (36.1°C) or above 100.4°F (38°C); and failing to void for 12 hours.

Question format: Multiple Choice

Chapter 23: Nursing Care of the Newborn With Special Needs

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 862

Chapter 24

1. A newborn with severe meconium aspiration syndrome (MAS) is not responding to conventional treatment. Which measure would the nurse anticipate as possibly necessary for this newborn?
- A. extracorporeal membrane oxygenation (ECMO)
 - B. respiratory support with a ventilator
 - C. insertion of a laryngoscope for deep suctioning
 - D. replacement of an endotracheal tube via X-ray

Answer: A

Rationale: If conventional measures are ineffective, then the nurse would need to prepare the newborn for ECMO. Hyperoxygenation, ventilatory support, and direct tracheal suctioning are typically used initially to promote tissue perfusion. However, if these are ineffective, ECMO would be the next step.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 881

2. A nurse is providing care to a newborn. The nurse suspects that the newborn is developing sepsis based on which assessment finding?

- A. increased urinary output
- B. interest in feeding
- C. temperature instability
- D. wakefulness

Answer: C

Rationale: Manifestations of sepsis are typically nonspecific and may include hypothermia (temperature instability), oliguria or anuria, lack of interest in feeding, and lethargy.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 907

3. A nurse is providing care to a newborn who is receiving phototherapy. Which action would the nurse **most** likely include in the plan of care?

- A. keeping the newborn in the supine position
- B. covering the newborn's eyes while under the bililights
- C. ensuring that the newborn is covered or clothed
- D. reducing the amount of fluid intake to 8 ounces daily

Answer: B

Rationale: During phototherapy, the newborn's eyes are covered to protect them from the lights. The newborn is turned every 2 hours to expose all areas of the body to the lights and is kept undressed, except for the diaper area, to provide maximum body exposure to the lights. Fluid intake is increased to allow for added fluid, protein, and calories.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 904-905

4. A newborn has been diagnosed with a group B streptococcal infection shortly after birth. The nurse understands that the newborn **most** likely acquired this infection from which cause?

- A. improper hand washing
- B. contaminated formula
- C. nonsterile catheter insertion
- D. mother's birth canal

Answer: D

Rationale: Most often, a newborn develops a group B streptococcus infection during the birthing process when the newborn comes into contact with an infected birth canal. Improper hand washing, contaminated formula, and nonsterile catheter insertion would most likely lead to a late-onset infection, which typically occurs in the nursery due to horizontal transmission.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 906

5. Which action would be **most** appropriate for the nurse to take when a newborn has an unexpected anomaly at birth?

- A. Show the newborn to the parents as soon as possible while explaining the defect.
- B. Remove the newborn from the birthing area immediately.

- C. Inform the parents that there is nothing wrong at the moment.
- D. Tell the parents that the newborn must go to the nursery immediately.

Answer: A

Rationale: When an anomaly is identified at or after birth, parents need to be informed promptly and given a realistic appraisal of the severity of the condition, the prognosis, and treatment options so that they can participate in all decisions concerning their child. Removing the newborn from the area or telling them that the newborn needs to go to the nursery immediately is inappropriate and would only add to the parents' anxieties and fears. Telling them that nothing is wrong is inappropriate because it violates their right to know.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Caring

Reference: p. 908

6. The nurse prepares to administer a gavage feeding for a newborn with transient tachypnea based on the understanding that this type of feeding is necessary because:
- A. lactase enzymatic activity is not adequate.
 - B. oxygen demands need to be reduced.
 - C. renal solute load must be considered.
 - D. hyperbilirubinemia is likely to develop.

Answer: B

Rationale: For the newborn with transient tachypnea, the newborn's respiratory rate is high, increasing the oxygen demand. Thus, measures are initiated to reduce this demand. Gavage feedings are one way to do so. With transient tachypnea, enzyme activity and kidney function are not affected. This condition typically resolves within 72 hours. The risk for hyperbilirubinemia is not increased.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 876

7. Which information would the nurse include when teaching a new mother about the difference between pathologic and physiologic jaundice?
- A. Physiologic jaundice results in kernicterus.
 - B. Pathologic jaundice appears within 24 hours after birth.
 - C. Both are treated with exchange transfusions of maternal O- blood.

D. Physiologic jaundice requires transfer to the NICU.

Answer: B

Rationale: Pathologic jaundice appears within 24 hours after birth whereas physiologic jaundice commonly appears around the third or fourth days of life. Kernicterus is more commonly associated with pathologic jaundice. An exchange transfusion is used only if the total serum bilirubin level remains elevated after intensive phototherapy. With this procedure, the newborn's blood is removed and replaced with nonhemolyzed red blood cells from a donor. Physiologic jaundice often is treated at home.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Teaching/Learning

Reference: p. 901

8. A nurse is teaching the mother of a newborn experiencing cocaine withdrawal about caring for the neonate at home. The mother stopped using cocaine near the end of her pregnancy. The nurse determines that additional teaching is needed when the mother identifies which action as appropriate for her newborn?

- A. wrapping the newborn snugly in a blanket
- B. waking the newborn every hour
- C. checking the newborn's fontanel
- D. offering a pacifier

Answer: B

Rationale: Stimuli need to be decreased. Waking the newborn every hour would most likely be too stimulating. Measures such as swaddling the newborn tightly and offering a pacifier help to decrease irritable behaviors. A pacifier also helps to satisfy the newborn's need for nonnutritive sucking. Checking the fontanel provides evidence of hydration.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Integrated Process: Teaching/Learning

Reference: p. 896

9. A newborn is suspected of having fetal alcohol syndrome. Which finding would the nurse expect to assess?

- A. bradypnea
- B. hydrocephaly
- C. flattened maxilla

D. hypoactivity

Answer: C

Rationale: A newborn with fetal alcohol syndrome exhibits characteristic facial features such as microcephaly (not hydrocephaly), small palpebral fissures, and abnormally small eyes, flattened or absent maxilla, epicanthal folds, thin upper lip, and missing vertical groove in the median portion of the upper lip. Bradypnea is not typically associated with fetal alcohol syndrome. Fine and gross motor development is delayed, and the newborn shows poor hand-eye coordination but not hypoactivity.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Understand

Client Needs: Psychosocial Integrity

Integrated Process: Nursing Process

Reference: p. 896

10. After teaching the parents of a newborn with periventricular hemorrhage about the disorder and treatment, which statement by the parents indicates that the teaching was successful?

- A. "We'll make sure to cover both of his eyes to protect them."
- B. "Our newborn could develop a learning disability later on."
- C. "Once the bleeding ceases, there won't be any more worries."
- D. "We need to get family members to donate blood for transfusion."

Answer: B

Rationale: Periventricular hemorrhage has long-term sequelae such as seizures, hydrocephalus, periventricular leukomalacia, cerebral palsy, learning disabilities, vision or hearing deficits, and intellectual disability. Covering the eyes is more appropriate for the newborn receiving phototherapy. The bleeding in the brain can lead to serious long-term effects. Blood transfusions are not used to treat periventricular hemorrhage.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Teaching/Learning

Reference: p. 883

11. A newborn has an Apgar score of 6 at 5 minutes. Which action would be the **priority**?

- A. initiating IV fluid therapy
- B. beginning resuscitative measures
- C. promoting kangaroo care
- D. obtaining a blood culture

Answer: B

Rationale: An Apgar score below 7 at 1 or 5 minutes indicates the need for resuscitation. Intravenous fluid therapy and blood cultures may be done once resuscitation is started. Kangaroo care would be appropriate once the newborn is stable.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 874

12. While reviewing a newborn's medical record, the nurse notes that the chest X-ray shows a ground glass pattern. The nurse interprets this as indicative of:

- A. respiratory distress syndrome.
- B. transient tachypnea of the newborn.
- C. asphyxia.
- D. persistent pulmonary hypertension.

Answer: A

Rationale: The chest X-ray of a newborn with RDS reveals a reticular (ground glass) pattern. For TTN, the chest X-ray shows lung overaeration and prominent perihilar interstitial markings and streakings. A chest X-ray for asphyxia would reveal possible structural abnormalities that might interfere with respiration, but the results are highly variable. An echocardiogram would be done to evaluate persistent pulmonary hypertension.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Understand

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 877

13. A newborn is suspected of developing persistent pulmonary hypertension. The nurse would expect to prepare the newborn for which procedure to confirm the suspicion?

- A. chest X-ray
- B. blood cultures
- C. echocardiogram
- D. stool for occult blood

Answer: C

Rationale: An echocardiogram is used to reveal right-to-left shunting of blood to confirm the diagnosis of persistent pulmonary hypertension. Chest X-ray would be most likely used to aid in

the diagnosis of RDS or TTN. Blood cultures would be helpful in evaluating for neonatal sepsis. Stool for occult blood may be done to evaluate for NEC.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 882

14. A preterm newborn is receiving enteral feedings. Which finding would alert the nurse to suspect that the newborn is developing NEC?

- A. irritability
- B. sunken abdomen
- C. clay-colored stools
- D. feeding intolerance

Answer: D

Rationale: The newborn with NEC may exhibit feeding intolerance with lethargy, abdominal distention and tenderness, and bloody stools.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 884-885

15. The nurse frequently assesses the respiratory status of a preterm newborn based on the understanding that the newborn is at increased risk for respiratory distress syndrome because of:

- A. inability to clear fluids.
- B. immature respiratory control center.
- C. deficiency of surfactant.
- D. smaller respiratory passages.

Answer: C

Rationale: A preterm newborn is at increased risk for respiratory distress syndrome (RDS) because of a surfactant deficiency. Surfactant helps to keep the alveoli open and maintain lung expansion. With a deficiency, the alveoli collapse, predisposing the newborn to RDS. An inability to clear fluids can lead to transient tachypnea. Immature respiratory control centers lead to an increased risk for apnea. Smaller respiratory passages led to an increased risk for obstruction.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 877

16. At a preconception counseling class, a client expresses concern and wonders how Healthy People 2030 will improve maternal–infant outcomes. Which response(s) by the nurse is appropriate? Select all that apply.

- A. Healthy People 2030 will reduce the rate of fetal and infant deaths.
- B. Healthy People 2030 will decrease the number of all infant deaths (within 1 year).
- C. Healthy People 2030 will decrease the number of neonatal deaths (within the first year).
- D. Healthy People 2030 will foster early and consistent prenatal care.

Answer: A, B, C, D

Rationale: One of the leading health indicators as identified by Healthy People 2030 refers to decreasing the number of infant deaths. Acquired and congenital conditions account for a significant percentage of infant deaths. Specific objectives include reducing the rate of fetal deaths at 20 or more weeks of gestation through the nursing action of fostering early and consistent prenatal care; reducing the rate of all infant deaths (within 1 year) through the nursing actions of including education to place infants on their backs for naps and sleep to prevent sudden infant death syndrome (SIDS), avoiding exposing newborns to cigarette smoke, and ensuring that infants with birth defects receive health care needed in order to thrive; and reducing the occurrence of fetal alcohol syndrome (FAS) through the nursing actions of counseling girls and women to avoid alcohol use during pregnancy, and participating in programs for at-risk groups, including adolescents, about the effects of substance use, especially alcohol, during pregnancy.

Question format: Multiple Select

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 873

17. A neonate is exhibiting signs of neonatal abstinence syndrome. Which findings would confirm this diagnosis? Select all that apply.

- A. adequate rooting and sucking
- B. frequent sneezing
- C. persistent fever
- D. shrill, high-pitched cry
- E. hypotonic reflexes
- F. frequent yawning

Answer: B, C, D, F

Rationale: Manifestations of neonatal abstinence syndrome include a shrill, high-pitched cry; persistent fever; frequent yawning; and frequent sneezing. Rather than adequate rooting and sucking, these actions will be frantic in a neonate with abstinence syndrome. In addition, these neonates will have hypertonic muscle tone, not hypotonic reflexes.

Question format: Multiple Select

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 898

18. A pregnant woman gives birth to a small for gestational age neonate who is admitted to the neonatal intensive care unit with seizure activity. The neonate appears to have abnormally small eyes and a thin upper lip. The infant is noted to be microcephalic. Based on these findings, which substance would the nurse suspect the woman of using during pregnancy?

- A. alcohol
- B. cocaine
- C. heroin
- D. methamphetamine

Answer: A

Rationale: This child's features match those of fetal alcohol syndrome, including microcephaly, small palpebral (eyelid) fissures, abnormally small eyes, and fetal growth restriction.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 895

19. The nurse is developing a plan of care for a neonate experiencing symptoms of drug withdrawal. What should be included in this plan?

- A. Administer glucose between feedings.
- B. Schedule feedings every 4 to 6 hours.
- C. Swaddle the infant between feedings.
- D. Rock horizontally.

Answer: C

Rationale: Supportive interventions to promote comfort include swaddling, low lighting, gentle handling, quiet environment with minimal stimulation, use of soft voices, pacifiers to promote

"self-soothing," frequent small feedings, and vertical rocking, which will soothe the newborn's neurological system.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 899

20. A neonate born addicted to cocaine is now being treated with medication for acute neonatal abstinence syndrome. Which medication will be prescribed to relieve withdrawal symptoms?

- A. meperidine
- B. adrenalin
- C. naloxone
- D. morphine sulphate

Answer: D

Rationale: Pharmacologic treatment is warranted if conservative measures are not adequate.

Common medications used in the management of newborn withdrawal include an opioid (morphine or methadone) and phenobarbital as a second drug if the opiate does not adequately control symptoms. The other drugs are not used in NAS treatment.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Integrated Process: Nursing Process

Reference: p. 899

21. The pediatrician prescribes morphine sulphate 0.2 mg/kg orally q 4 hour for a neonate suffering from drug withdrawal. The neonate weighs 3,800 grams. How much of drug will the nurse give in 24 hours? Record your answer using two decimal places.

Answer: 4.56

Rationale: 3800 grams = 3.8 kg

3.8 kg/kg x 0.20 mg x 6 doses = 4.56 mg in 24 hours

Question format: Fill in the Blank

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Nursing Process

Reference: p. 899

22. The nurse is admitting a term, large-for-gestational-age neonate weighing 4,610 g (10 lb, 2 oz), born vaginally with a mid-forceps assist, to a 15-year-old primipara. What would the nurse anticipate as a result of the birth?

- A. fracture of the tibia
- B. fracture of the femur
- C. fracture of a rib
- D. midclavicular fracture

Answer: D

Rationale: Trauma to the newborn may result from the use of mechanical forces, such as forceps during birth. Primarily injuries are found in large babies and babies with shoulder dystocia. Associated traumatic injuries include fracture of the clavicle or humerus or subluxations of the shoulder or cervical spine.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 889

23. A 33 weeks' gestation neonate is being assessed for necrotizing enterocolitis (NEC). Which nursing actions would the nurse implement? Select all that apply.

- A. Perform hemoccult tests on stools.
- B. Monitor abdominal girth.
- C. Measure gastric residual before feeds.
- D. Assess bowel sounds before each feed.
- E. Assess urine output.

Answer: A, B, C, D

Rationale: Always keep the possibility of NEC in mind when dealing with preterm newborns, especially when enteral feedings are being administered. Note feeding intolerance, diarrhea, bile-stained emesis, or grossly bloody stools. Perform hemoccult tests on the bloody stool. Assess the neonate's abdomen for distention, tenderness, and visible loops of bowel. Measure the abdominal circumference, noting an increase. Listen to bowel sounds before each feeding. Determine residual gastric volume prior to feeding; when it is elevated, be suspicious for NEC. Assessing urine output is not essential.

Question format: Multiple Select

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 885

24. A 30 weeks' gestation neonate born with low Apgar scores is in the neonatal intensive care unit with respiratory distress syndrome and underwent an exchange transfusion for anemia.

Which factors place the neonate at risk for necrotizing enterocolitis? Select all that apply

- A. preterm birth
- B. respiratory distress syndrome
- C. low Apgar scores
- D. hyperthermia
- E. hyperglycemia
- F. exchange transfusion

Answer: A, B, C, F

Rationale: The predisposing factors for the development of necrotizing enterocolitis include preterm labor, respiratory distress syndrome, exchange transfusion, and low birth weight. Low Apgar scores, hypothermia, and hypoglycemia are also risk factors.

Question format: Multiple Select

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 885

25. A preterm newborn is admitted to the neonatal intensive care with the diagnosis of an omphalocele. What nursing actions would the nurse perform? Select all that apply.

- A. The abdominal contents are protected.
- B. Fluid loss of the neonate will be minimized.
- C. Perfusion to the exposed abdominal contents will be maintained.
- D. Neonatal weight loss will be prevented.
- E. Assessment of hyperbilirubinemia will be monitored.

Answer: A, B, C

Rationale: Nursing management of newborns with omphalocele or gastroschisis focuses on preventing hypothermia, maintaining perfusion to the eviscerated abdominal contents by minimizing fluid loss, and protecting the exposed abdominal contents from trauma and infection. Weight loss at this point is not a priority, and neither is assessing bilirubin.

Question format: Multiple Select

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 911

26. The nurse in the neonatal intensive care unit is caring for a neonate she suspects is at risk for an intraventricular hemorrhage (IVH). Which nursing actions would be **priorities**? Select all that apply.

- A. Maintain fetal flexed position.
- B. Administer fluids slowly.
- C. Assess for bulging fontanel.
- D. Measure head circumference daily.
- E. Assess Moro reflex.
- F. Measure intake and output.

Answer: A, B, C, D

Rationale: Care of the newborn with IVH is primarily supportive. Correct anemia, acidosis, and hypotension with fluids and medications. Administer fluids slowly to prevent fluctuations in blood pressure. Avoid rapid volume expansion to minimize changes in cerebral blood flow. Keep the newborn in a flexed, contained position with the head elevated to prevent or minimize fluctuations in intracranial pressure. Continuously monitor the newborn for signs of hemorrhage, such as changes in the level of consciousness, bulging fontanel, seizures, apnea, and reduced activity level. Also, measuring head circumference daily to assess for expansion in size is essential in identifying complications early. Moro reflex and intake and output are routine and not associated with IVH.

Question format: Multiple Select

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 883-884

27. At the breech forceps birth of a 32 weeks' gestation neonate, the nurse notes oligohydramnios with green thick amniotic fluid. The maternal history reveals a mother of Hispanic ethnicity with marked hypertension, who admits to using cocaine daily. Which factor(s) may contribute to meconium aspiration syndrome (MAS)? Select all that apply.

- A. the preterm pregnancy
- B. the forceps breech birth
- C. maternal cocaine use
- D. maternal hypertension
- E. Hispanic ethnicity
- F. oligohydramnios present

Answer: B, C, D, F

Rationale: The predisposing factors for meconium aspiration syndrome include postterm pregnancy and breech presentation with forceps. Ethnicity (Pacific Islander, Indigenous Australian, Black African) is a factor. Postterm neonates are at risk for MAS, but preterm neonates are not. Exposure to drugs during pregnancy, especially tobacco and cocaine,

predispose the neonate to MAS. Maternal hypertension and oligohydramnios also contribute to MAS.

Question format: Multiple Select

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 880

28. A 2-hour-old neonate born via caesarean birth has begun having a respiratory rate of 110 breaths/min and is in respiratory distress. What intervention(s) is a priority for the nurse to include in this neonate's care? Select all that apply.

- A. Keep the head in a "sniff" position
- B. Administer oxygen
- C. Insert an orogastric tube
- D. Ensure thermoregulation
- E. Obtain an arterial blood gas

Answer: A, B, D

Rationale: This neonate is experiencing manifestations of transient tachypnea of the newborn (TTN). It occurs from delayed clearing of the lungs from fluid, and can be seen in neonates born via cesarean birth, because they have not had the experience of the compression on the thorax during vaginal delivery. This starts within the first 6 hours of life and can last up to 72 hours. The priority interventions for this neonate are oxygen, thermoregulation and minimal stimulation. Keeping the head in a neutral or "sniff" position allows for optimal airway. If the neonate becomes cold, then respiratory distress and/or sepsis can develop. Minimal stimulation conserves the neonate's respiratory and heat requirements. The neonate may need placement of a peripheral IV for hydration and/or a feeding tube for formula or breast milk. The neonate should not be nipple fed until the respirations are under 60 breaths/min. A chest x-ray and an arterial blood gas may be needed also, but they would only be necessary if the neonate is in severe distress. The arterial blood gas results would show mild hypoxemia, a mildly elevated CO₂ level, and a normal pH.

Question format: Multiple Select

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 878-879

29. A newborn infant has been diagnosed with persistent pulmonary hypertension of the newborn (PPHN). In providing care for this newborn what intervention should be the nurse's **priority**?

- A. Measure blood pressure
- B. Obtain arterial blood gases

- C. Monitor oxygen saturation
- D. Suction the newborn

Answer: A

Rationale: PPHN occurs when there is persistent fetal circulation after birth. The pulmonary pressures do not decrease at birth when the newborn begins breathing causing hypoxemia, acidosis and vasoconstriction of the pulmonary artery. This newborn requires much care and possibly extracorporeal membrane oxygenation (ECMO). The nurse should monitor the newborn's blood pressure regularly, because hypotension can occur from ensuing heart failure and the persistent hypoxemia. Vasopressors may be needed for this newborn. The newborn should not be suctioned. Doing so causes more stimulation and worsens respiratory issues. Arterial blood gases will be obtained regularly, but they are not a priority nursing intervention. Oxygen saturation should always be monitored in a newborn with respiratory distress.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 882-883

30. A newborn is exhibiting symptoms of withdrawal and toxicology test have been prescribed. Which type of specimen should the nurse collect to obtain the **most** accurate results?

- A. Meconium
- B. Blood
- C. Urine
- D. Sputum

Answer: A

Rationale: Toxicology screening of a newborn can include testing from blood, urine and meconium. These tests identify which drugs the newborn has been exposed to in utero. A meconium sample can detect which drugs the mother has been using from the second trimester of pregnancy until birth. It is the preferred method of testing. A urine screen identifies only the drugs the mother has used recently. The nurse should be careful not to mix the meconium sample with urine as it alters the results of the test. Blood samples can be taken and they will yield results of current drugs in the newborn's system, but they are invasive and noninvasive testing will provide the same results. If possible, testing on the mother is preferred. This testing provides quick results of what drugs the mother has been exposing the fetus to in utero. This will help in planning and providing care for the drug-exposed newborn. Sputum is not used for toxicology studies.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential
Integrated Process: Nursing Process
Reference: p. 898

31. A neonate is diagnosed with Erb's palsy after birth. The parents are concerned about their neonate's limp arm. The nurse explains the neonate will be scheduled to receive what recommended treatment for this condition **first**?

- A. Physical therapy to the joint and extremity
- B. Nothing but time and let nature take its course
- C. Surgery to correct the joint and muscle alignment
- D. Immobilization of the shoulder and arm

Answer: D

Rationale: Treatment for a neonate with Erb palsy usually involves immobilization of the upper arm across the upper abdomen/chest to protect the shoulder from excessive motion for the first week; then gentle passive range-of-motion exercises are performed daily to prevent contractures. Surgery is not needed to regain function since there is no structural injury. Doing nothing will not help the neonate regain function in the extremity.

Question format: Multiple Choice

Chapter 24: Nursing Management of the Newborn at Risk: Acquired and Congenital Newborn Conditions

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 890

Chapter 25

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 924, Head Circumference

1. The nurse is examining a 10-month-old boy who was born 10 weeks early. Which finding is cause for concern?

- A) The child has doubled his birth weight.
- B) The child exhibits plantar grasp reflex.
- C) The child's head circumference is 49.53 cm.
- D) No primary teeth have erupted yet.

Ans: C

Feedback:

The child's head size is large for his adjusted age (7.5 months), which would be cause for concern. The average head circumference of the full-term newborn is 35 cm (13.5 in). Head circumference increases about 10 cm from birth to 1 year (Levine, 2019). Birth weight doubles by about 4 months of age. Plantar grasp reflex does not disappear until 9 months adjusted age. Primary teeth may not erupt until 8 months adjusted age.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 925, Brain Growth

2.The nurse is teaching a new mother about the drastic growth and developmental changes her infant will experience in the first year of life. Which statement describes a developmental milestone occurring in infancy?

- A) By 6 months of age, the infant's brain weighs half that of the adult brain; at age 12 months, the brain weighs 2.5 times what it did at birth.
- B) Most infants triple their birth weight by 4 to 6 months of age and quadruple their birth weight by the time they are 1 year old.
- C) The head circumference increases rapidly during the first 6 months: the average increase is about 1 in per month.
- D) The heart triples in size over the first year of life; the average pulse rate decreases from 120 to 140 in the newborn to about 100 in the 1-year-old.

Ans: A

Feedback:

By 6 months of age, the infant's brain weighs half that of the adult brain; at age 12 months, the brain weighs 2.5 times what it did at birth. Most infants double their birth weight by 4 to 6 months of age and triple their birth weight by the time they are 1 year old. The head circumference increases rapidly during the first 6 months: the average increase is about 0.6 in (1.5 cm) per month. The heart doubles in size over the first year of life. As the cardiovascular system matures, the average pulse rate decreases from 120 to 140 in the newborn to about 100 in the 1-year-old.

Format: Multiple Select

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 925, Respiratory System

3.The nurse is assessing the respiratory system of a newborn. Which anatomic differences place the infant at risk for respiratory compromise? Select all that apply.

- A) The nasal passages are narrower.
- B) The trachea and chest wall are less compliant.
- C) The bronchi and bronchioles are shorter and wider.
- D) The larynx is more funnel shaped.
- E) The tongue is smaller.
- F) There are significantly fewer alveoli.

Ans: A, D, F

Feedback:

In comparison with the adult, in the infant, the nasal passages are narrower, the trachea and chest wall are more compliant, the bronchi and bronchioles are shorter and narrower, the larynx is more funnel shaped, the tongue is larger, and there are significantly fewer alveoli. These anatomic differences place the infant at higher risk for respiratory compromise. The respiratory system does not reach adult levels of maturity until about 7 years of age.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 926, Table 25.1

4.A new mother shows the nurse that her baby grasps her finger when she touches the baby's palm. How might the nurse respond to this information?

- A) "This is a primitive reflex known as the plantar grasp."
- B) "This is a primitive reflex known as the palmar grasp."
- C) "This is a protective reflex known as rooting."
- D) "This is a protective reflex known as the Moro reflex."

Ans: B

Feedback:

Primitive reflexes are subcortical and involve a whole-body response. Selected primitive reflexes present at birth include Moro, root, suck, asymmetric tonic neck, plantar and palmar grasp, step, and Babinski. During the palmar grasp, the infant reflexively grasps when the palm is touched. The plantar grasp occurs when the infant reflexively grasps with the bottom of the foot when pressure is applied to the plantar surface. The root reflex occurs when the infant's cheek is stroked and the infant turns to that side, searching with mouth. The Moro reflex is displayed when with sudden extension of the head, the arms abduct and move upward and the hands form a "C."

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 927, Table 25.1

5. Which reflex, if found in a 4-month-old infant, would cause the nurse to be concerned?

- A) Plantar grasp
- B) Step
- C) Babinski
- D) Neck righting

Ans: B

Feedback:

Appropriate appearance and disappearance of primitive reflexes, along with the development of protective reflexes, indicates a healthy neurologic system. The step reflex is a primitive reflex that appears at birth and disappears at 4 to 8 weeks of age. The plantar grasp reflex is a primitive reflex that appears at birth and disappears at about the age of 9 months. The Babinski reflex is a primitive reflex that appears at birth and disappears around the age of 12 months. The neck righting reflex is a protective reflex that appears around the age of 4 to 6 months and persists.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 929, Stools

6.A new mother expresses concern to the nurse that her baby is crying and grunting when passing stool. What is the nurse's **best** response to this observation?

- A) "This is normal behavior for infants unless the stool passed is hard and dry."
- B) "This is normal behavior for infants due to the immaturity of the gastrointestinal system."
- C) "This indicates a blockage in the intestine and must be reported to the health care provider."
- D) "This is normal behavior for infants unless the stool passed is black or green."

Ans: A

Feedback:

Due to the immaturity of the gastrointestinal system, newborns and young infants often grunt, strain, or cry while attempting to have a bowel movement. This is not of concern unless the stool is hard and dry. Stool color and texture may change depending on the foods that the infant is ingesting. Iron supplements may cause the stool to appear black or very dark green.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 931, Take Note!

7.The neonatal nurse assesses newborns for iron deficiency anemia. Which newborn is at **highest** risk for this disorder?

- A) A postterm newborn
- B) A term newborn with jaundice
- C) A newborn born to a diabetic mother
- D) A premature newborn

Ans: D

Feedback:

Maternal iron stores are transferred to the fetus throughout the last trimester of pregnancy. Infants born prematurely miss all or at least a portion of this iron store transfer, placing them at increased risk for iron deficiency anemia compared with term infants. An infant having jaundice, having been born to a mother with diabetes, or having been born postterm does not significantly place the infant at risk for iron deficiency anemia.

Format: Multiple Select

Client Needs: Health Promotion and Maintenance

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 932, Table 25.3

8.The nurse caring for newborns knows that infants exhibit phenomenal increases in their gross motor skills over the first 12 months of life. Which statements accurately describe the typical infant's achievement of these milestones? Select all that apply.

- A) At 1 month, the infant lifts and turns the head to the side in the prone position.
- B) At 2 months, the infant rolls from supine to prone to back again.
- C) At 6 months, the infant pulls to stand up.
- D) At 7 months, the infant sits alone with some use of hands for support.
- E) At 9 months, the infant crawls with the abdomen off the floor.
- F) At 12 months, the infant walks independently.

Ans: A, D, E, F

Feedback:

At 1 month, the infant lifts and turns the head to the side in the prone position. At 7 months, the infant sits alone with some use of hands for support. At 9 months, the infant crawls with the abdomen off the floor. At 12 months, the infant walks independently. At 4 months, the infant lifts the head and looks around. At 10 months, the infant pulls to stand up.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 934, Take Note!

9.The nurse is teaching a new mother about the development of sensory skills in her newborn. What would alert the mother to a sensory deficit in her child?

- A) The newborn's eyes wander and occasionally are crossed.
- B) The newborn does not respond to a loud noise.
- C) The newborn's eyes focus on near objects.
- D) The newborn becomes more alert with stroking when drowsy.

Ans: B

Feedback:

Though hearing should be fully developed at birth, the other senses continue to develop as the infant matures. The newborn should respond to noises. Sight, smell, taste, and touch all continue to develop after birth. The newborn's eyes wander and occasionally cross, and the newborn is nearsighted, preferring to view objects at a distance of 8 to 15 in. Holding, stroking, rocking, and cuddling calm infants when they are upset and make them more alert when they are drowsy.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 934, Communication and Language Development

10. The nurse is assessing a 4-month-old boy during a scheduled visit. Which findings might suggest a developmental problem?

- A) The child does not babble.
- B) The child does not vocally respond to voices.
- C) The child never squeals or yells.
- D) The child does not say dada or mama.

Ans: B

Feedback:

The fact that the child does not vocally respond to voices might suggest a developmental problem. At 4 to 5 months of age, most children are making simple vowel sounds, laughing aloud, doing raspberries, and vocalizing in response to voices. The child is too young to babble, squeal, yell, or say dada or mama.

Format: Multiple Select

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 937, Social and Emotional Development

11. The nurse observes an infant interacting with his parents. What are normal social behavioral developments for this age group? Select all that apply.

- A) Around 5 months, the infant may develop stranger anxiety.
- B) Around 2 months, the infant exhibits a first real smile.
- C) Around 3 months, the infant smiles widely and gurgles when interacting with the caregiver.
- D) Around 3 months, the infant will mimic the parent's facial movements, such as sticking out the tongue.
- E) Around 3 to 6 months of age, the infant may enjoy socially interactive games such as patty-cake and peek-a-boo.
- F) Separation anxiety may also start in the last few months of infancy.

Ans: B, C, D, F

Feedback:

The infant exhibits a first real smile at age 2 months. By about 3 months of age, the infant will start an interaction with a caregiver by smiling widely and possibly gurgling. The 3- to 4-month-old will also mimic the parent's facial movements, such as widening the eyes and sticking out the tongue. Separation anxiety may also start in the last few months of infancy. Around the age of 8 months, the infant may develop stranger anxiety. At 6 to 8 months of age, the infant may enjoy socially interactive games such as patty-cake and peek-a-boo.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 942, Cultural Factors

12. The nurse is performing a health assessment of a 3-month-old African-American boy. For what condition should this infant be monitored based on his race?

- A) Jaundice
- B) Iron deficiency
- C) Lactose intolerance
- D) Gastroesophageal reflux disease (GERD)

Ans: C

Feedback:

Many dietary practices are affected by culture, both in the types of food eaten and in the approach to progression of infant feeding. Some ethnic groups tend to be lactose intolerant (particularly blacks, Native Americans, and Asians); therefore, alternative sources of calcium must be offered. Jaundice, iron deficiency, and GERD are not seen at a significantly higher rate in African-American infants.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 948, Concept Mastery Alert

13. The nurse is promoting a healthy diet to guide a mother when feeding her 2-week-old girl. Which is the **most** effective anticipatory guidance?

- A) Substituting cow's milk if breast milk is not available
- B) Advocating iron supplements with bottle-feeding
- C) Advising fluid intake per feeding of 5 or 6 ounces
- D) Discouraging the addition of fruit juice to the diet

Ans: D

Feedback:

Discouraging the addition of fruit juice to the child's diet is the most effective anticipatory guidance. Fruit juice can displace important nutrients from breast milk or formula. Cow's milk is likely to result in an allergic reaction. If breast milk is not available, infant formula may be substituted. Advising fluid intake per feeding of 5 or 6 ounces is too much for this neonate, but is typical for an infant 4 to 6 months of age. Advocating iron supplements with bottle-feeding is unnecessary so long as the formula is fortified with iron.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 944, Breastfeeding Technique

14. The nurse is teaching a new mother the proper techniques for breastfeeding her newborn. Which is a recommended guideline that should be implemented?

- A) Wash the hands and breasts thoroughly prior to breastfeeding.
- B) Stroke the nipple against the baby's chin to stimulate wide opening of the baby's mouth.
- C) Bring the baby's wide-open mouth to the breast to form a seal around all of the nipple and areola.
- D) When finished, the mother can break the suction by firmly pulling the baby's mouth away from the nipple.

Ans: C

Feedback:

Before each breastfeeding session, mothers should wash their hands, but it is not necessary to wash the breast in most cases. The mother should then stroke the nipple against the baby's cheek to stimulate opening of the mouth and bring the baby's wide-open mouth to the breast to form a seal around all of the nipple and areola. When the infant is finished feeding, the mother can break the suction by inserting her finger into the baby's mouth.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 947, Box 25.2

15. The nurse is providing discharge teaching regarding formula preparation for a new mother. Which guideline would the nurse include in the teaching plan?

- A) Always wash bottles and nipples in hot soapy water and rinse well; do not wash them in the dishwasher.
- B) Store tightly covered ready-to-feed formula can after opening in refrigerator for up to 24 hours.
- C) Warm bottle of formula by placing bottle in a container of hot water, or microwaving formula.
- D) Do not add cereal to the formula in the bottle or sweeten the formula with honey.

Ans: D

Feedback:

Proper formula preparation includes the following: wash nipples and bottles in hot soapy water and rinse well or run nipples and bottles through the dishwasher; store tightly covered ready-to-feed formula can after opening in refrigerator for up to 48 hours; after mixing concentrate or powdered formula, store tightly covered in refrigerator for up to 48 hours; do not reheat and reuse partially used bottles; throw away the unused portion after each feeding; do not add cereal to the formula in the bottle; do not sweeten formula with honey; warm formula by placing bottle in a container of hot water; and do not microwave formula.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 948, Choosing Appropriate Solid Foods

16. The nurse is caring for a 4-week-old girl and her mother. Which is the **most** appropriate subject for anticipatory guidance?

- A) Promoting the digestibility of breast milk
- B) Telling how and when to introduce rice cereal
- C) Describing root reflex and latching on
- D) Advising how to choose a good formula

Ans: B

Feedback:

Telling the mother how to introduce rice cereal is the most appropriate subject for anticipatory guidance. Since this mother is already breast- or bottle-feeding her baby, educating her about these subjects would not inform her about what to expect in the next phase of development.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Communication and Documentation

Page and Header: 948, Choosing Appropriate Solid Foods

17. The nurse is providing anticipatory guidance to a mother of a 5-month-old boy about introducing solid foods. Which statement by the mother indicates that effective teaching has occurred?

- A) "I'll start with baby oatmeal cereal mixed with low-fat milk."
- B) "The cereal should be a fairly thin consistency at first."
- C) "I can puree the meat that we are eating to give to my baby."
- D) "Once he gets used to the cereal, then we'll try giving him a cup."

Ans: B

Feedback:

Iron-fortified rice cereal mixed with a small amount of formula or breast milk to a fairly thin consistency is typically the first solid food used. As the infant gets older, a thicker consistency is appropriate. Strained, pureed, or mashed meats may be introduced at 10 to 12 months of age. A cup is typically introduced at 6 to 8 months of age regardless of what or how much solid food is being consumed.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 941, Promoting Safety

18. The nurse is providing anticipatory guidance to the mother of a 9-month-old girl during a well-baby visit. Which topic would be **most** appropriate?

- A) Advising how to create a toddler-safe home
- B) Warning about small objects left on the floor
- C) Cautioning about putting the baby in a walker
- D) Telling about safety procedures during baths

Ans: A

Feedback:

The most appropriate topic for this mother would be advising her on how to create a toddler-safe home. The child will very soon be pulling herself up to standing and cruising the house. This will give her access to areas yet unexplored. Warning about small objects left on the floor, telling about safety procedures during baths, and cautioning about using baby walkers would no longer be anticipatory guidance as the child has passed these stages.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 924, Physical Growth

19. The nurse in a community clinic is caring for a 6-month-old boy and his mother.

Which intervention is **priority** to promote adequate growth?

- A) Monitoring the child's weight and height
- B) Encouraging a more frequent feeding schedule
- C) Assessing the child's current feeding pattern
- D) Recommending higher-calorie solid foods

Ans: A

Feedback:

Monitoring the child's weight and height is the priority intervention to promote adequate growth. Encouraging a more frequent feeding schedule, assessing the child's current feeding pattern, and recommending higher-calorie solid foods are interventions when the nursing diagnosis is that nutrition level does not meet body requirements.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 948, Choosing Appropriate Solid Foods

20. The nurse is caring for a 7-month-old girl during a well-child visit. Which intervention is **most** appropriate for this child?

- A) Discussing the type of sippy cup to use
- B) Advising about increased caloric needs
- C) Explaining how to prepare table meats
- D) Describing the tongue extrusion reflex

Ans: A

Feedback:

The cup may be introduced at 6 to 8 months of age. Old-fashioned sippy cups are preferred compared to the new style. The nurse would not advise about increased caloric needs as caloric needs drop at this age. Transition to table meat will not take place until age 10 to 12 months. Tongue extrusion reflex has disappeared at age 4 to 6 months.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 934, Communication and Language Development

21. The nurse is assessing a 12-month-old boy with an English-speaking father and a Spanish-speaking mother. The boy does not say mama or dada yet. What is the **priority intervention?**

- A) Performing a developmental evaluation of the child
- B) Encouraging the parents to speak English to the child
- C) Asking the mother if the child uses Spanish words
- D) Referring the child to a developmental specialist

Ans: C

Feedback:

Infants in bilingual families may use some words from each language. Therefore, the priority intervention in this situation would be to ask the mother if the child uses Spanish words. There is not enough evidence to warrant performing a developmental evaluation or referring the child to a developmental specialist. Encouraging the parents to speak English to the child is unnecessary if the child is progressing with Spanish first.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 942, Promoting Nutrition

22. A 6-month-old girl weighs 14.7 lb during a scheduled check-up. Her birth weight was 8 lb. What is the **priority** nursing intervention?

- A) Talking about solid food consumption
- B) Discouraging daily fruit juice intake
- C) Increasing the number of breastfeedings
- D) Discussing the child's feeding patterns

Ans: D

Feedback:

Assessing the current feeding pattern and daily intake is the priority intervention.

Talking about solid food consumption may not be appropriate for this child yet.

Discouraging daily fruit juice intake or increasing the number of breastfeedings may not be necessary until the situation is assessed.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 946, Feeding Patterns

23. The nurse is educating a first-time mother who has a 1-week-old boy. Which is the **most** accurate anticipatory guidance?

- A) Describing the effect of neonatal teeth on breastfeeding
- B) Explaining that the stomach holds less than 1 ounce
- C) Informing that fontanels will close by 6 months
- D) Telling that the step reflex persists until the child walks

Ans: B

Feedback:

Explaining that the child's stomach holds less than 1 ounce gives the mother a reason for frequent, small feedings and is the most helpful and accurate anticipatory guidance. Telling that the step reflex persists until the child walks and informing that fontanels will close by 6 months are inaccurate. The step reflex disappears at about 2 months and fontanels close between 12 and 18 months. Neonatal teeth are highly unusual and need no explanation unless they occur.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 951, Spitting Up

24. A mother is concerned about her infant's spitting up. Which suggestion would be **most** appropriate?

- A) "Put the infant in an infant seat after eating."
- B) "Limit burping to once during a feeding."
- C) "Feed the same amount but space out the feedings."
- D) "Keep the baby sitting up for about 30 minutes afterward."

Ans: D

Feedback:

Keeping the baby upright for 30 minutes after the feeding, burping the baby at least two or three times during feedings, and feeding smaller amounts on a more frequent basis may help to decrease spitting up. Positioning the infant in an infant seat compresses the stomach and is not recommended.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 949, Promoting Healthy Sleep and Rest

25. The nurse is providing anticipatory guidance to a mother to help promote healthy sleep for her 3-week-old baby. Which recommended guideline might be included in the teaching plan?

- A) Place the baby on a soft mattress with a firm, flat pillow for the head.
- B) Place the head of the bed near the window to provide fresh air, weather permitting.
- C) Place the baby on his or her back when sleeping.
- D) If the baby sleeps through the night, wake him or her up for the night feeding.

Ans: C

Feedback:

Sudden infant death syndrome (SIDS) has been associated with prone positioning of newborns and infants, so the infant should be placed to sleep on the back. The baby should sleep on a firm mattress without pillows or comforters. The baby's bed should be placed away from air conditioner vents, open windows, and open heaters. By 4 months of age, night waking may occur, but the infant should be capable of sleeping through the night and does not require a night feeding.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 950, Colic

26. The nurse is counseling the mother of a newborn who is concerned about her baby's constant crying. What teaching would be appropriate for this mother?

- A) Carrying the baby may increase the length of crying.
- B) Reducing stimulation may decrease the length of crying.
- C) Using vibration, white noise, or swaddling may increase crying.
- D) Using a swing or car ride may increase the incidence of crying episodes.

Ans: B

Feedback:

Prolonged crying leads to increased stress among caregivers. Reducing stimulation may decrease the length of crying, and carrying the infant more may be helpful. Some infants respond to the motion of an infant swing or a car ride. Vibration, white noise, or swaddling may also help to decrease fussing in some infants. Parents should try one intervention at a time, taking care not to stimulate the infant excessively in the process of searching for solutions.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 951, Thumb Sucking, Pacifiers, and Security Items

27. The parent of a 6-month-old infant asks the nurse for advice about his son's thumb sucking. What would be the nurse's **best** response to this parent?

- A) "Thumb sucking is a healthy self-comforting activity."
- B) "Thumb sucking leads to the need for orthodontic braces."
- C) "Caregivers should pay special attention to the thumb sucking to stop it."
- D) "Thumb sucking should be replaced with the use of a pacifier."

Ans: A

Feedback:

Thumb sucking is a healthy self-comforting activity. Infants who suck their thumbs or pacifiers often are better able to soothe themselves than those who do not. Studies have not shown that sucking either thumbs or pacifiers leads to the need for orthodontic braces unless the sucking continues well beyond the early school-age period. The infant who has become attached to thumb sucking should not have additional attention drawn to the issue, as that may prolong thumb sucking. Pacifiers should not be used to replace thumb sucking as this habit will also need to be discouraged as the child grows.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 931, 932, Cognitive Development

28. At which age would the nurse expect to find the beginning of object permanence?

- A) 1 month
- B) 6 months
- C) 9 months
- D) 12 months

Ans: B

Feedback:

Object permanence begins to develop between 4 and 7 months of age and is solidified by approximately age 8 months. By age 12 months, the infant knows he or she is separate from the parent or caregiver.

Format: Multiple Select

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 925, States of Consciousness

29. The nurse is assessing the infants in the nursery for the six stages of consciousness. The nurse becomes concerned when assessing which infants? Select all that apply.

- A) An infant rapidly moves from deep sleep to crying.
- B) An infant moves from active alert state to drowsiness.
- C) An infant progresses slowly from deep sleep to light sleep.
- D) An infant frequently skips the quiet alert state during the six stages of consciousness.
- E) An infant ends the stages of consciousness with crying.

Ans: A, B, D

Feedback:

The nurse becomes concerned if the infant does not move slowly through six states of consciousness, which begin with deep sleep. The infant should then progress as follows: light sleep, drowsiness, quiet alert state, active alert state, and finally crying. States are not normally skipped.

Format: Multiple Select

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 944, Breastfeeding Technique

30. A new mother tells the nurse that she is having difficulty breastfeeding her baby. When observing the mother, which actions prompt the nurse to provide teaching about proper breastfeeding techniques? Select all that apply.

- A) The mother carefully washes her breasts prior to feeding the infant.
- B) The mother feeds the infant every hour.
- C) The mother supplements feedings with water.
- D) The mother holds her breast in the "C" position.
- E) The mother strokes the nipple against the infant's face.

Ans: A, B, C

Feedback:

The mother should wash her hands prior to breastfeeding the infant. There is no need to wash the breasts in most circumstances. The best time to feed the infant is on demand rather than hourly, and there is no need to supplement breastfeeding with water. The "C" position and stroking the nipple against the infant's face promote effective breastfeeding.

Format: Short Answer

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 924, Growth and Development Overview

31. The nurse is assessing the developmental milestones of an infant. The infant was born 8 weeks ago and was 4 weeks premature. The nurse anticipates that the infant will be meeting milestones for what age of child? Record your answer in weeks.

Ans: 4

Feedback:

To determine adjusted age, subtract the number of weeks that the infant was premature (4 weeks) from the infant's chronologic age (8 weeks).

Chapter 26

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 956, Physical Growth

1. The nurse is performing a physical assessment of a 3-year-old girl. What finding would be a concern for the nurse?

- A) The toddler gained 4 lb in weight since last year.
- B) The toddler gained 3 in in height since last year.
- C) The toddler's anterior fontanel is not fully closed.
- D) The circumference of the child's head increased 1 in since last year.

Ans: C

Feedback:

The anterior fontanel should be closed by the time the child is 18 months old. The average toddler weight gain is 3 to 5 lb per year. Length/height increases by an average of 3 in per year. Head circumference increases about 1 in from when the child is between 1 and 2 years of age, then increases an average of a half inch per year until age 5.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Communication and Documentation

Page and Header: 956, Neurologic System

2. The nurse is describing the maturation of various organ systems during toddlerhood to the parents. What would the nurse correctly include in this description?

- A) Myelination of the brain and spinal cord is complete at about 24 months.
- B) Alveoli reach adult numbers by 3 years of age.

- C) Urine output in a toddler typically averages approximately 30 mL/hour.
- D) Toddlers typically have strong abdominal muscles by the age of 2.

Ans: A

Feedback:

Myelination of the brain and spinal cord continues to progress and is complete around 24 months of age. Alveoli reach adult numbers usually around the age of 7. Urine output in a toddler typically averages 1 mL/kg/hour. Abdominal musculature in a toddler is weak, resulting in a pot-bellied appearance.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 957, Psychosocial Development

3. The nurse is teaching the parents of a 2-year-old toddler methods of dealing with their child's "negativism." Based on Erikson's theory of development, what would be an appropriate intervention for this child?

- A) Discourage solitary play; encourage playing with other children.
- B) Encourage the child to pick out his own clothes.
- C) Use "time-outs" whenever the child says "no" inappropriately.
- D) Encourage the child to take turns when playing games.

Ans: B

Feedback:

Erikson defines the toddler period as a time of autonomy versus shame and doubt. It is a time of exerting independence. Allowing the child to choose his own clothes helps him to assert his independence. Negativism and always saying "no" is a normal part of healthy development and is occurring as a result of the toddler's attempt to assert his or her independence. It should not be punished with "time-outs." The toddler should be encouraged to play alone and with other children. Toddlers cannot take turns in games until age 3.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 957, Cognitive Development

4. The nurse is caring for a toddler who is in Piaget's sensorimotor stage of cognitive development. Which task would the nurse expect the toddler to be able to perform?

- A) Completing puzzles with four pieces
- B) Winding up a mechanical toy
- C) Playing make-believe with dolls
- D) Knowing which are his or her toys

Ans: D

Feedback:

The toddler in Piaget's sensorimotor stage of cognitive development (18 to 24 months) understands requests, is capable of following simple directions, and has a sense of ownership (knowing which toys are his). The other tasks are accomplished by the child in the preoperational stage (2 to 7 years).

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 960, Table 26.2

5. The nurse is observing a 24-month-old boy in a day care center. Which finding suggests delayed motor development?

- A) The child has trouble undressing himself.
- B) The child is unable to push a toy lawnmower.
- C) The child is unable to unscrew a jar lid.
- D) The child falls when he bends over.

Ans: B

Feedback:

Children with normal motor development are able to push toys with wheels at 24 months of age. He won't be ready to undress himself, unscrew a jar lid, or bend over without falling until about 36 months of age.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 960, Table 26.2

6. What activity would the nurse expect to find in an 18-month-old?

- A) Standing on tiptoes
- B) Pedaling a tricycle
- C) Climbing stairs with assistance
- D) Carrying a large toy while walking

Ans: C

Feedback:

Toddlers continue to progress with motor skills. An 18-month-old should be able to climb stairs with assistance. A 24-month-old should be able to stand on his or her tiptoes and carry a large toy while walking. A 36-month-old would be able to pedal a tricycle.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 960, Table 26.2

7. The pediatric nurse is planning quiet activities for a hospitalized 18-month-old.

What would be an appropriate activity for a child of this age group?

- A) Painting by number
- B) Putting shapes into appropriate holes
- C) Stacking blocks
- D) Using crayons to color in a coloring book

Ans: C

Feedback:

At 18 months, the child can stack four blocks. The 24-month-old can paint (but not by number), scribble, and color, and put round pegs into holes.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 957, Cognitive Development

8. The nurse is performing a cognitive assessment of a 2-year-old. Which behavior would alert the nurse to a developmental delay in this area?

- A) The child cannot say name, age, and gender.
- B) The child cannot follow a series of two independent commands.
- C) The child has a vocabulary of 40 to 50 words.
- D) The child does not point to named body parts.

Ans: D

Feedback:

The 2-year-old can point to named body parts and has a vocabulary of 40 to 50 words. At 30 months old, a child can follow a series of two independent commands and at 3 years old, a child can say name, age, and gender.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 960, Communication and Language Development

9. The nurse is interviewing a 3-year-old girl who tells the nurse: "Want go potty." The parents tell the nurse that their daughter often speaks in this type of broken speech. What would be the nurse's appropriate response to this concern?

- A) "This is a normal, common speech pattern in the 3-year-old and is called telegraphic speech."

- B) "This is considered a developmental delay in the 3-year-old and we should consult a speech therapist."
- C) "This is a condition known as echolalia and can be corrected if you work with your daughter on language skills."
- D) "This is a condition known as stuttering and it is a normal pattern of speech development in the toddler."

Ans: A

Feedback:

Telegraphic speech is common in the 3-year-old. Telegraphic speech refers to speech that contains only the essential words to get the point across, much like a telegram. In telegraphic speech, the nouns and verbs are present and are verbalized in the appropriate order (Feigelman, 2016b). Echolalia (repetition of words and phrases without understanding) normally occurs in toddlers younger than 30 months of age. "Why" and "what" questions dominate the older toddler's language. Stuttering usually has its onset at between 2 and 4 years of age. It occurs more often in boys than in girls. About 75% of all cases of stuttering resolve within 1 to 2 years after they start.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 960, Communication and Language Development

10. After teaching a group of parents about language development in toddlers, what if stated by a member of the group indicates successful teaching?

- A) "When my 3-year-old asks 'why?' all the time, this is completely normal."
- B) "A 15-month-old should be able to point to his eyes when asked to do so."
- C) "At age 2 years, my son should be able to understand things like *under* or *on*."
- D) "An 18-month-old would most likely use words and gestures to communicate."

Ans: A

Feedback:

Language development occurs rapidly in a toddler. By age 3 years, "why" and "what" questions dominate in the child's language. Pointing to named body parts is characteristic of a 2-year-old. Understanding concepts such as *on*, *under*, or *in* is typical of a 3-year-old. A 1-year-old would communicate with words and gestures.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 959, 960, Sensory Development

11. The nurse is testing the sensory development of a toddler brought to the clinic for a well visit. What might alert the nurse to a potential problem with the child's sensory development?

- A) The toddler places the nurse's stethoscope in his mouth.
- B) The toddler's vision tests at 20/50 in both eyes.
- C) The toddler does not respond to commands whispered in his ear.
- D) The toddler's taste discrimination is not at adult levels yet.

Ans: C

Feedback:

Hearing should be at the adult level, as infants are ordinarily born with hearing intact. Therefore, the toddler should hear commands whispered in his ear. Toddlers examine new items by feeling them, looking at them, shaking them to hear what sound they make, smelling them, and placing them in their mouths. Toddler vision continues to progress and should be 20/50 to 20/40 in both eyes. Though taste discrimination is not completely developed, toddlers may exhibit preferences for certain flavors of foods.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 961, Emotional and Social Development

12. The nurse observing toddlers in a day care center notes that they may be happy and pleasant one moment and overreact to limit setting the next minute by throwing a tantrum. What is the focus of the toddler's developmental task that is driving this behavior?

- A) The need for separation and control
- B) The need for love and belonging
- C) The need for safety and security
- D) The need for peer approval

Ans: A

Feedback:

Emotional development in the toddler years is focused on separation and individuation. The focus in infancy is on love and belonging, and the need for peer approval occurs in the adolescent. Safety and security are concerns in all levels of development, but not the primary focus.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 962, Emotional and Social Development

13. The nurse is teaching parents interventions appropriate to the emotional development of their toddlers. What is a recommended intervention for this age group?

- A) Remove children's security blankets at this stage to help them assert their autonomy.
- B) Distract toddlers from exploring their own body parts, particularly their genitals.
- C) Do not blame toddlers for aggressive behavior; instead, point out the results of their behavior.
- D) Offer toddlers many choices to foster control over their environment.

Ans: C

Feedback:

Toddlers should not be blamed for their aggressive behavior; adults can assist the toddler in building empathy by pointing out when someone is hurt and explaining what happened. Adults should allow toddlers to rely on a security item to self-soothe as this is a function of autonomy and is viewed as a sign of a nurturing environment, rather than one of neglect. Toddlers may question parents about the difference between male and female body parts and may begin to explore their own genitals. This is normal behavior in this age group. Offering limited choices is one way of allowing toddlers some control over their environment and helping them to establish a sense of mastery.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 962, Emotional and Social Development

14. The nurse is assessing a 3-year-old boy's development during a well-child visit.

Which response by the child indicates the need for further assessment?

- A) He says a swear word when he hurts himself playing.
- B) He says "pew" when his sister has soiled her diaper.
- C) He laughs when his brother cries getting vaccinated.
- D) He constantly asks "why?" whenever he is told a fact.

Ans: C

Feedback:

Laughing when his brother cries when being vaccinated indicates that the child hasn't yet developed a sense of empathy or that there may be psychosocial issues, such as sibling rivalry, that should be assessed. The child may repeat a word even if it is out of context. This is called echolalia. Older toddlers have a well-developed sense of smell and will comment if they don't like a smell. The incessant "why" is very common to toddlers' speech.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 963, 964, The Nurse's Role in Toddler Growth and Development

15. The nurse is designing a nursing care plan for a toddler with lymphoma, who is hospitalized for treatment. What is a **priority** intervention that the nurse should include in this child's nursing plan?

- A) Limiting visitors to scheduled visiting hours
- B) Planning physical therapy for the child
- C) Introducing the toddler to other toddlers in the unit
- D) Monitoring the toddler for developmental delays

Ans: D

Feedback:

When the toddler is hospitalized, growth and development may be altered. The toddler's primary task is establishing autonomy, and the toddler's focus is mobility and language development. The nurse caring for the hospitalized toddler must use knowledge of normal growth and development to be successful in interactions with the toddler, promote continued development, and recognize delays. Parents should be encouraged to stay with the toddler to avoid separation anxiety. Planning activities and socialization of the toddler is important, but the priority intervention is monitoring for, and addressing, developmental delays that may occur in the hospital.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 966, Promoting Growth and Development Through Play

16. The nurse is watching toddlers at play. Which normal behavior would the nurse observe?

- A) Toddlers engage in parallel play.
- B) Toddlers engage in solitary play.

- C) Toddlers engage in cooperative play.
- D) Toddlers do not engage in play outside the home.

Ans: A

Feedback:

Toddlers typically play alongside another child (parallel play) rather than cooperatively. Infants engage in solitary play.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 968, Safety in the Car

17. The nurse is developing a teaching plan for toddler safety to present at a parenting seminar. Which safety intervention should the nurse address?

- A) Encourage parents to enroll toddlers in swimming classes to avoid the need for constant supervision around water.
- B) Advise parents to keep pot handles on stoves turned outward to avoid accidental burns.
- C) Encourage parents to smoke only in designated rooms in the house or outside the house.
- D) Advise parents to use a forward-facing car seat with harness straps and a clip, placed in the back seat of the car.

Ans: D

Feedback:

Safety is of prime concern throughout the toddler period. The safest place for the toddler to ride is in the back seat of the car. Parents should use the appropriate size and style of car seat for the child's weight and age as required by the state. At a minimum, all children over 20 lb and up to 40 lb should be in a forward-facing car seat with harness straps and a clip. Parents who want to enroll a toddler in a swimming class should be aware that a water safety skills class would be most appropriate. However, even toddlers who have completed a swimming program still need *constant* supervision in the water. Pot handles on stoves should be turned inward to avoid accidental burn. Nurses should counsel parents to stop smoking (optimal), but if they continue smoking never to smoke inside the home or car with children present.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 974, Promoting Healthy Sleep and Rest

18. During a health history, the nurse explores the sleeping habits of a 3-year-old boy by interviewing his parents. Which statement from the parents reflects a recommended guideline for promoting healthy sleep in this age group?

- A) "Our son sleeps through the night, and we insist that he takes two naps a day."
- B) "We keep a strict bedtime ritual for our son, which includes a bath and bedtime story."
- C) "Our son still sleeps in a crib because we feel it is the safest place for him at night."
- D) "Our son occasionally experiences night walking so we allow him to stay up later when this happens."

Ans: B

Feedback:

Consistent bedtime rituals help the toddler prepare for sleep; the parent should be advised to choose a bedtime and stick to it as much as possible. The nightly routine might include a bath followed by reading a story. A typical toddler should sleep through the night and take one daytime nap. Most children discontinue daytime napping at around 3 years of age. When the crib becomes unsafe (that is, when the toddler becomes physically capable of climbing over the rails), then he or she must make the transition to a bed. Attention during night waking should be minimized so that the toddler receives no reward for being awake at night.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 974, Promoting Healthy Sleep and Rest

19. The nurse is teaching good sleep habits for toddlers to the mother of a 3-year-old boy. Which response indicates the mother understands sleep requirements for her son?

- A) "I'll put him to bed at 7 PM, except Friday and Saturday."
- B) "He needs 12 hours of sleep per day including his nap."
- C) "I need to put the side down on the crib so he can get out."
- D) "His father can give him a horseback ride into his bed."

Ans: B

Feedback:

The mother understands her child needs 12 hours of sleep and one nap per day. Routines, such as the same bedtime every night, promote good sleep. However, a horseback ride to bed may cause problems because it may not provide a calming transition from play to sleep. A bath and reading a book would be better. If the child can climb out of a crib, he needs to be in a youth bed or regular bed to avoid injury.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 975, Promoting Healthy Teeth and Gums

20. The parents of a 1-year-old girl, both of whom have perfect teeth, are concerned about their child getting dental caries. Which is the **best** advice the nurse can provide?

- A) Tell the parents to limit the child's eating to meal and snack times.
- B) Urge the parents to take the child to a dentist for a check-up.
- C) Advise the parents to reduce carbohydrates in the child's diet.
- D) Advise the parents to use fluoride toothpaste.

Ans: A

Feedback:

Telling the parents to limit eating to meal and snack times is the best advice for preventing dental caries. This reduces the amount of exposure the child's teeth have to food. Urging them to take the child to see a dentist is sound advice but doesn't suggest actions they can take now to prevent caries. Carbohydrates react with oral bacteria to cause caries, but they should not be reduced from the diet. Avoiding fluoridated toothpaste may help prevent fluorosis.

Format: Multiple Select

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 971, Weaning, Teaching About Nutritional Needs

21. The nurse is helping parents prepare a healthy meal plan for their toddler. Which guidelines for promoting nutrition should be followed when planning meals? Select all that apply.

- A) The child younger than 2 years of age should have his or her fat intake restricted.
- B) Extending breastfeeding into toddlerhood is believed to be beneficial to the child.
- C) Weaning from the bottle should occur by 6 to 12 months of age.

D) Adequate calcium intake and appropriate exercise lay the foundation for proper bone mineralization.

E) The toddler requires an average intake of 700 mg calcium per day.

F) Toddlers tend to have the highest daily iron intake of any age group.

Ans: B, D, E

Feedback:

Extending breastfeeding into toddlerhood is believed to be beneficial to the child as it is known to help prevent obesity. Adequate calcium intake and appropriate exercise lay the foundation for proper bone mineralization. The toddler requires an average intake of 500 mg calcium per day. The child younger than 2 years of age should not have his or her fat intake restricted, but this does not mean that unhealthy foods such as sweets should be eaten liberally. Weaning from the bottle should occur by 12 to 15 months of age. Prolonged bottle-feeding is associated with the development of dental caries. It is important for toddlers to consume adequate amounts of iron since they tend to have the lowest daily iron intake of any age group.

Format: Multiple Select

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 972, Box 26.4

22. The nurse is choosing foods for a toddler's diet that are high in vitamin A. What foods could be added to the menu? Select all that apply.

A) Applesauce

B) Avocados

C) Broccoli

D) Sweet potatoes

E) Spinach

F) Carrots

Ans: D, E, F

Feedback:

Foods that are high in vitamin A include apricots, cantaloupe, carrots, mangos, spinach and dark greens, and sweet potatoes. Applesauce is high in fiber, and avocados and broccoli are high in folate.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 971, Teaching About Nutritional Needs

23. When instructing the parents of a toddler about appropriate nutrition, what would the nurse recommend?

- A) About 12 to 16 ounces of fruit juice per day
- B) Approximately 16 to 24 ounces of milk per day
- C) Fat intake of 30% to 40% of total calories
- D) An average of 10 to 12 grams of fiber per day

Ans: B

Feedback:

Milk intake should be limited to 16 to 24 ounces per day, with fruit juice limited to 4 to 6 ounces per day. A toddler's total fat intake should be 20% to 30% of total calories. The daily recommended fiber intake is 19 grams.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 973, Preventing Overweight and Obesity

24. The nurse is teaching the parents of an overweight 18-month-old girl about diet.

Which intervention will be **most** effective for promoting proportionate growth?

- A) Remove high-calorie, low-nutrient foods from the diet.
- B) Ensure 30 minutes of unstructured activity per day.
- C) Avoid sharing your snacks and candy with the child.
- D) Reduce the amount of high-fat food the child eats.

Ans: A

Feedback:

The most effective intervention will be to remove high-calorie, low-nutrient foods from the diet in order to reduce the number of calories and increase the nutritional value. Exercise is also important, but a child this age should have 30 minutes of structured physical activity plus several hours of unstructured physical activity per day. The parents should set an example for good eating habits. Dietary fat should not be restricted for an 18-month-old child because it is necessary for nervous system development.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 977, Toilet Teaching

25. The nurse is providing anticipatory guidance to the parents of an 18-month-old girl. Which guidance will be **most** helpful for toilet teaching?

- A) Telling them either one may demonstrate toilet use
- B) Assuring them that bladder control occurs first
- C) Telling them that curiosity is a sure sign of readiness
- D) Advising them to use praise, not scolding

Ans: D

Feedback:

The most helpful guidance for toilet teaching is to urge the parents to use only praise, but never to scold, throughout the process. It is best for the same-sex parent to demonstrate toilet use. Bowel control will occur first. It may take additional months for nighttime bladder control to be achieved. Curiosity is a sign of readiness for toilet teaching, but by no means a sure sign.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Caring

Page and Header: 966, Promoting Healthy Growth and Development

26. The parents of a 2-year-old girl are frustrated by the frequent confrontations they have with their child. Which is the **best** anticipatory guidance the nurse can offer to prevent confrontations?

- A) "Respond in a calm but firm manner."
- B) "You need to adhere to various routines."
- C) "Put her in time-out when she misbehaves."
- D) "It's important to toddler-proof your home."

Ans: B

Feedback:

Making expectations known through everyday routines helps to avoid confrontations. This helps the child know what to expect and how to behave. It is the best guidance to give these parents. Calm response and time-out are effective ways to discipline, but do not help to prevent confrontations. Toddler-proofing the house doesn't eliminate all the opportunities for confrontation.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Caring

Page and Header: 978, Negativism

27. The nurse is providing guidance after observing a mother interact with her negative 2-year-old boy. For which interaction will the nurse advise the mother that she is handling the negativism properly?

- A) Telling the child to stop tearing pages from magazines
- B) Asking the child if he would please quit throwing toys
- C) Telling the child firmly that we don't scream in the office
- D) Saying, "Please come over here and sit in this chair. OK?"

Ans: C

Feedback:

Telling the child firmly that we don't scream in the office gets the point across to the child that his behavior is unacceptable while role modeling appropriate communication. Telling the child to stop tearing up magazines does not give him direction for appropriate behavior. Asking the child if he would quit throwing toys gives him an opportunity to say "no," and is the same as asking "OK?" at the end of a direction.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 977, Toilet Teaching

28. The nurse is teaching the parents of a 2-year-old girl how to deal with common toddler situations. Which is the **best** advice?

- A) Discipline the child for regressive behavior.
- B) Scold the child for public thumb sucking.
- C) Tell the older sibling to not act like a baby.
- D) Have the child help clean up a bowel accident.

Ans: D

Feedback:

Having the child help clean up a bowel accident is the best advice. Toddlers should never be punished for bowel or bladder "accidents," but gently reminded about toileting. Regressive behavior is best ignored, while appropriate behavior should be praised. Telling the older sibling to not act like a baby is a negative approach. It would be better to have the child be mother's helper. Calmly telling the child that thumb sucking is something that is done at home is better than scolding the child.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 963, Cultural Influences on Growth and Development

29. The nurse is assessing a 2-year-old boy who has missed some developmental milestones. Which finding will point to the cause of motor skill delays?

- A) The mother is suffering from depression.
- B) The child is homeless and has no toys.
- C) The mother describes an inadequate diet.
- D) The child is unperturbed by a loud noise.

Ans: B

Feedback:

Children develop through play, so a child without any toys may have trouble developing the motor skills appropriate to his age. Maternal depression is a risk factor for poor cognitive development. Inadequate diet will cause growth deficiencies. A child who does not respond to a loud noise probably has hearing loss, which will lead to a language deficit.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Understand

Integrated Process: Caring

Page and Header: 976, Promoting Appropriate Discipline

30. The nurse emphasizes that a toddler younger than the age of 18 months should never be spanked primarily for which reason?

- A) Spanking in a child this age predisposes the child to a pro-violence attitude.
- B) The child will become resentful and angry, leading to more outbursts.
- C) Spanking demonstrates a poor model for problem-solving skills.
- D) There is an increased risk for physical injury in this age group.

Ans: D

Feedback:

Spanking should never be used with toddlers younger than 18 months of age because there is an increased possibility of physical injury. Although spanking or other forms of corporal punishment lead to a pro-violence attitude, create resentment and anger in the child, and are a poor model for learning effective problem-solving skills, the risk of physical injury in this age group is paramount.

Chapter 27

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 984, Physical Growth

1. The nurse is conducting a well-child examination of a 5-year-old girl, who was 40 in tall at her last examination at age 4. Which height measurement would be within the normal range of growth expected for a preschooler?

- A) 41 in
- B) 43 in
- C) 45 in
- D) 47 in

Ans: B

Feedback:

The average preschool-age child will grow 2.5 to 3 in (6.5 to 7.8 cm) per year. The average 3-year-old is 37 in tall (96.2 cm), the average 4-year-old is 40.5 in tall (103.7 cm), and the average 5-year-old is 43 in tall (118.5 cm).

Format: Multiple Select

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 984, Physiologic Changes

2. The nurse is teaching the parents of a 4-year-old boy about the normal maturation of the child's organs during the preschool years and their effect on body functions. Which statements accurately describe these changes? Select all that apply.

- A) Myelination of the spinal cord allows for bowel and bladder control to be complete in most children by age 3 years.

- B) The respiratory structures are continuing to grow in size, and the number of alveoli continues to increase, reaching the adult number at about 7 years of age.
- C) Heart rate increases and blood pressure decreases slightly during the preschool years; an innocent heart murmur may be heard upon auscultation.
- D) The bones continue to increase in length and the muscles continue to strengthen and mature; however, the musculoskeletal system is still not fully mature.
- E) The small intestine is continuing to grow in length, and stool passage usually occurs once or twice per day in the average preschool-age child.
- F) The urethra remains long in both boys and girls, making them more susceptible to urinary tract infections than adults.

Ans: A, B, D, E

Feedback:

Most of the body systems have matured by the preschool years. Myelination of the spinal cord allows for bowel and bladder control to be complete in most children by age 3 years. The respiratory structures are continuing to grow in size, and the number of alveoli continues to increase, reaching the adult number at about 7 years of age. The bones continue to increase in length and the muscles continue to strengthen and mature. However, the musculoskeletal system is still not fully mature. The small intestine is continuing to grow in length, and stool passage usually occurs once or twice per day in the average preschooler. The 4-year-old generally has adequate bowel control. Heart rate decreases and blood pressure increases slightly during the preschool years. An innocent heart murmur may be heard upon auscultation. The urethra remains short in both boys and girls, making them more susceptible to urinary tract infections than adults.

Format: Multiple Select

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 986, Table 27.1

3. The nurse is assessing the psychosocial development of a preschooler. What are normal activities characteristic of the preschooler? Select all that apply.

- A) Plans activities and makes up games.
- B) Initiates activities with others.
- C) Acts out roles of other people.
- D) Engages in parallel play with peers.
- E) Classifies or groups objects by their common elements.
- F) Understands relationships among objects.

Ans: A, B, C

Feedback:

The many activities of the preschooler include beginning to plan activities, making up games, initiating activities with others, and acting out the roles of other people (real and imaginary). Toddlers engage in parallel play; preschoolers engage in cooperative play. School-age children classify or group objects by common elements and understand relationships among objects.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 985, Cognitive Development

4. The nurse is caring for a 5-year-old girl posttonsillectomy. The girl looks out the window and tells the nurse that it is raining and says, "The sky is crying because it is sad that my throat hurts." The nurse understands that the girl is demonstrating which mental process?

- A) Magical thinking

- B) Centration
- C) Transduction
- D) Animism

Ans: A

Feedback:

The nurse understands that the girl is demonstrating magical thinking. Magical thinking is a normal part of preschool development. The preschool-age child believes her thoughts to be all-powerful. Transduction is reasoning by viewing one situation as the basis for another situation whether or not they are truly causally linked. Animism is attributing life-like qualities to inanimate objects. Centration is focusing on one aspect of a situation while neglecting others.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Understand

Integrated Process: Communication and Documentation

Page and Header: 985, Moral and Spiritual Development

5. The parents of a 4-year-old ask the nurse when their child will be able to differentiate right from wrong and develop morals. What would be the **best** response of the nurse?

- A) "The preschooler has no sense of right and wrong."
- B) "The preschooler is developing a conscience."
- C) "The preschooler sees morality as internal to self."
- D) "The preschooler's morals are his or her own, right or wrong."

Ans: B

Feedback:

The preschool child can understand the concepts of right and wrong and is developing a conscience. Preschool children see morality as external to themselves; they defer to power (that of the adult). The child's moral standards are those of their parents or other adults who influence them, not necessarily their own.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 986, Table 27.1

6. Which activity would the nurse least likely include as exemplifying the preconceptual phase of Piaget's preoperational stage?

- A) Displays of animism
- B) Use of active imaginations
- C) Understanding of opposites
- D) Beginning questioning of parents' values

Ans: D

Feedback:

In the intuitive phase of Piaget's preoperational stage, the child begins to question parents' values. Animism, active imaginations, and an understanding of opposites would characterize the preconceptual phase of Piaget's preoperational stage.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 993, Promoting Healthy Growth and Development, Table 27.4

7. The nurse is assessing the motor skills of a 5-year-old girl. Which finding would cause the nurse to be concerned?

- A) Can copy a square on another piece of paper
- B) Can dress and undress herself without help
- C) Draws a person with three body parts
- D) Is beginning to tie her own shoelaces

Ans: C

Feedback:

By the age of 5 years, the child should be able to draw a person with a body and at least six body parts. She should also be able to copy triangles and other geometric patterns and dress and undress herself and should be learning to tie her shoelaces.

Format: Multiple Select

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 995, Promoting Language Development

8. The school nurse is helping parents choose books for their preschoolers. What literacy skills present in the preschooler would the nurse consider when making choices? Select all that apply.

- A) Preschoolers enjoy books with pictures that tell stories.
- B) Preschoolers like stories with repeated phrases as they help keep their attention.
- C) Preschoolers like stories that describe experiences different from their own.
- D) Preschoolers demonstrate early literacy skills by reciting stories or portions of books.
- E) Preschoolers may retell the story from the book, pretend to read books, and ask questions about the story.
- F) Preschoolers do not have enough focus and expanded attention to notice when a page is skipped during reading.

Ans: A, B, D, E

Feedback:

Preschoolers enjoy books with pictures that tell stories. Stories with repeated phrases help to keep the child's attention. Also, children like stories that describe experiences similar to their own. The preschool child demonstrates early literacy skills by reciting stories or portions of books. He or she also may retell the story from the book, pretend to read books, and ask questions about the story. The preschool child has enough focus and expanded attention to notice when a page is skipped during reading and will call it to the parent's attention.

Format: Multiple Select

Client Needs: Psychosocial Integrity

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 996, Choosing a Preschool/Starting Kindergarten

9. The parents of a preschooler ask the nurse to help them choose a preschool for their child. What are recommended guidelines and goals for choosing a preschool?

Select all that apply.

- A) The main goal of preschool is to improve reading and writing skills and readiness for entering into grade school.
- B) When selecting a preschool, the parent may want to consider the accreditation of the school and the teachers' qualifications.
- C) The teachers should decide how focused on curriculum the school should be for each individual student.
- D) The parent should observe the classroom, evaluating the environment, noise level, and sanitary practices.
- E) The type of discipline used in the school is also an important factor. Parents should choose a preschool that uses corporal punishment.
- F) The parent should observe the classroom to determine how the children interact with each other and how the teachers interact with the children.

Ans: B, D, F

Feedback:

When selecting a preschool, the parent may want to consider the accreditation of the school, the teachers' qualifications, and recommendations of other parents. The parent should observe the classroom, evaluating the environment, noise level, and sanitary practices, as well as how the children interact with each other and how the teachers interact with the children. The main goal of preschool is to foster the child's social skills and accustom him or her to the group environment. The parents must decide how focused on curriculum they want the school to be. The type of discipline used in the school is also an important factor. Parents should not choose a preschool that uses corporal punishment.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 984, Physiologic Changes

10. The mother of a 4-year-old boy tells the nurse that her son occasionally wets his pants during the day. How should the nurse respond?

- A) "Is there a family history of diabetes?"
- B) "Suddenly having accidents can be a sign of diabetes."
- C) "That's normal; don't worry about it."
- D) "Tell me about the circumstances when this occurs."

Ans: D

Feedback:

Bladder control is present in the 4- and 5-year-old child, but an occasional accident may occur, particularly in stressful situations or when the child is absorbed in an interesting activity. The nurse needs to ask an open-ended question to determine the circumstances when the child has had accidents. Simply telling the mother that it is normal does not address the mother's concerns. The nurse does need to gather more information, because accidents in a previously potty-trained child can be a sign of diabetes.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 985, 986, Psychosocial Development, Table 27.1

11. The nurse is explaining to parents that the preschooler's developmental task is focused on the development of initiative rather than guilt. What is a **priority** intervention the nurse might recommend for parents of preschoolers to stimulate initiative?

- A) Reward the child for initiative in order to build self-esteem.
- B) Change the routine of the preschooler often to stimulate initiative.
- C) Do not set limits on the preschooler's behavior as this results in low self-esteem.
- D) As a parent, decide how and with whom the child will play.

Ans: A

Feedback:

The building of self-esteem continues throughout the preschool period. It is of particular importance during these years, as the preschooler's developmental task is focused on the development of initiative rather than guilt. A sense of guilt will contribute to low self-esteem, whereas a child who is rewarded for his or her initiative will have increased self-confidence. Routine and ritual continue to be important throughout the preschool years, as they help the child to develop a sense of time as well as provide the structure for the child to feel safe and secure. Also, consistent limits provide the preschooler with expectation and guidance. Giving children opportunities to decide how and with whom they want to play also helps them develop initiative.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1000, 1001, Promoting Healthy Sleep and Rest, Comparison Chart 27.1

12. The parents of a 5-year-old boy tell the nurse that their son is having frequent episodes of night terrors. Which statement would indicate that the boy is having nightmares instead of night terrors?

- A) "It usually happens about an hour after he falls asleep."
- B) "He will tell us about what happened in his dream."
- C) "He is completely unaware that we are there."
- D) "When we try to comfort him, he screams even more."

Ans: B

Feedback:

During a nightmare, a child will have a memory of the occurrence and may remember the dream and talk about it later. With night terrors, the child has no memory of the event. The other statements are indicative of night terrors.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 985, Cognitive Development

13. The mother of a 5-year-old boy calls the nurse and seeks advice on how to assist the child with the recent death of his paternal grandfather. The boy keeps asking when his grandpa is coming back. How should the nurse respond?

- A) "It is best to just ignore this and to not respond to his questions."
- B) "This is normal; children his age do not understand the permanence of death."
- C) "You have to keep repeating that his grandfather is never coming back."
- D) "He will eventually figure this out on his own."

Ans: B

Feedback:

The nurse needs to remind the mother that preschoolers do not completely understand the concept of death or its permanence. Telling the mother that it is best to ignore the boy's questions or that the boy will eventually figure this out on his own does not teach. Repeating that the grandfather is not coming back does not consider the developmental stage of the child and is inappropriate.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 991, The Nurse's Role in Preschool Growth and Development

14. The nurse is developing a nursing care plan for a hospitalized 6-year-old. Which behavior would warrant nursing intervention?

- A) The child pretends he is talking to an imaginary friend when the nurse addresses the child.
- B) The child states that her fairy godmother is going to come and take her home.

C) The child starts talking about his grandmother and then quickly changes the subject to a new toy he received.

D) The child does not want to play games with other children on the hospital ward.

Ans: D

Feedback:

The preschooler begins to plan activities, make up games, and initiate activities with others. Not wanting to play games with other children is a sign of a developmental delay and nursing intervention is recommended. The preschooler often has an imaginary friend who serves as a creative way for the preschooler to sample different activities and behaviors and practice conversational skills. Through make-believe and magical thinking, preschool children satisfy their curiosity about differences in the world around them. The preschooler uses transduction when reasoning: he or she extrapolates from a particular situation to another, even though the events may be unrelated.

Format: Multiple Select

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 985, Cognitive Development

15. The nurse is caring for preschoolers in a day care center. For this age group, of what developmental milestones should the nurse be aware? Select all that apply.

- A) Counting 10 or more objects
- B) Correctly naming at least four colors
- C) Understanding the concept of time
- D) Knowing everyday objects
- E) Understanding the differences of others
- F) Forming concepts as logical as an adult's

Ans: A, B, C, D

Feedback:

The child in the intuitive phase can count 10 or more objects, correctly name at least four colors, and better understand the concept of time, and he or she knows about things that are used in everyday life, such as appliances, money, and food. The preschooler forms concepts that are not as complete or as logical as the adult's, and tolerates others' differences but doesn't understand them.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 993, Promoting Growth and Development Through Play

16. When observing a group of preschoolers at play in the clinic waiting room, which type of play would the nurse be least likely to note?

- A) Parallel play
- B) Cooperative play
- C) Dramatic play
- D) Fantasy play

Ans: A

Feedback:

Parallel play is associated with toddlers. Cooperative, dramatic, and fantasy play are commonly used by preschoolers.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 993, Promoting Healthy Growth and Development, Table 27.4

17. The nurse is supervising lunch time for children on a pediatric ward. Which observation, if noted by the nurse, would require further assessment?

- A) A child has a full set of primary teeth.
- B) A child has no difficulty chewing and swallowing meat.
- C) A child uses his fingers and refuses to use a fork.

D) A child is a picky eater.

Ans: C

Feedback:

The preschool child has learned to use utensils fairly effectively to feed himself or herself, has a full set of primary teeth, and is able to chew and swallow competently. Preschool children may be picky eaters. They may eat only a limited variety of foods or foods prepared in certain ways and may not be very willing to try new things.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 998, Nutritional Needs

18. The nurse of a preschool child is helping parents develop a healthy meal plan for their child. What nutritional requirements for this age group should the nurse consider?

- A) The 3- to 5-year-old requires 300 to 500 mg calcium and 10 mg iron daily.
- B) The 3-year-old should consume 10 mg dietary fiber daily.
- C) The 4- to 8-year-old requires 15 mg dietary fiber per day.
- D) The typical preschooler requires about 85 kcal/kg of body weight.

Ans: D

Feedback:

The typical preschooler requires about 85 kcal/kg of body weight. The 3- to 5-year-old requires 700 to 1,000 mg calcium and 10 mg iron daily. The 3-year-old should consume 19 mg dietary fiber daily, while the 4- to 8-year-old requires 25 mg dietary fiber per day.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 998, Nutritional Needs, Box 27.2

19. The parents of a 4-year-old who is a picky eater ask the nurse what foods to include in their child's diet to provide adequate iron consumption. Which food would the nurse recommend?

- A) Cooked lentils
- B) Whole milk
- C) Oranges
- D) Sweet potatoes

Ans: A

Feedback:

Lentils are a good source of iron. Whole milk, oranges, and sweet potatoes are good sources of calcium.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 999, Promoting Healthy Eating Habits

20. The nurse is counseling parents of a picky eater on how to promote healthy eating habits in their child. Which intervention would be appropriate advice?

- A) Allow the child to pick out his or her own foods for meals.
- B) Present the food matter-of-factly and allow the child to choose what to eat.
- C) Offer high-fat snacks if the child does not eat, to get them to eat something.
- D) Offer the child a special treat if he or she eats all the food on the plate.

Ans: B

Feedback:

The parents should maintain a matter-of-fact approach, offer the meal or snack, and then allow the child to decide how much of the food, if any, he or she is going to eat. High-fat, nutrient-poor snacks should not be substituted for healthy foods just to coax the child to "eat something." If the preschooler is growing well, then the pickiness is not a cause for concern. A larger concern may be the negative relationship that can develop between the parent and child relating to mealtime. The more the parent coaxes, cajoles, bribes, and threatens, the less likely the child is to try new foods or even eat the ones he or she likes that are served. The child should be offered a healthy diet, with foods from all groups over the course of the day as recommended by the U.S. Department of Agriculture.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 998, Nutritional Needs, Box 27.2

21. Which food suggestion would be **most** appropriate for the mother of a preschooler to ensure an adequate intake of calcium?

- A) Spinach
- B) White beans
- C) Enriched bread
- D) Fortified cereal

Ans: B

Feedback:

To ensure an adequate intake of calcium, the nurse should suggest white beans, because 1 ounce of dried white beans when cooked provides 160 mg of calcium. Spinach, enriched bread, and fortified cereal are good sources of iron.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 987, Sensory Development

22. The nurse is providing teaching about accidental poisoning to the family of a 3-year-old. The nurse understands that a child of this age is at increased risk of accidental ingestion due to which sensory alteration?

- A) A less discriminating sense of taste
- B) A lack of fully developed hearing
- C) Visual acuity that has not fully developed
- D) A less discriminating sense of touch

Ans: A

Feedback:

The young preschooler may have a less discriminating sense of taste than the older child, making him or her at increased risk for accidental ingestion. A less discriminating sense of touch and developing visual acuity would not increase the risk. Hearing is intact at birth and it does not increase the child's risk for accidental ingestion.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 996, Take Note!

23. The nurse is conducting a well-child assessment for a 5-year-old boy in preparation for kindergarten. The boy's grandmother is his primary caregiver because the boy's mother has suffered from depression and substance abuse issues. The nurse understands that the child is at increased risk for which developmental problem?

- A) Lack of social and emotional readiness for school
- B) Stuttering
- C) Speech and language delays
- D) Fine motor skills delay

Ans: A

Feedback:

Risk factors for lack of social and emotional readiness for school include insecure attachment in the early years, maternal depression, parental substance abuse, and low socioeconomic status.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 990, Fears

24. A nurse is caring for a 4-year-old girl. The mother says that the girl is afraid of cats and dogs and does not like to go to the playground anymore because she wants to avoid the dogs that are often being walked at the park. What should the nurse tell the mother?

- A) "It is best to avoid the playground until she outgrows the fear."
- B) "She needs to face her fears head-on; take her to the park as much as possible."
- C) "Acknowledge her fear and help her develop a strategy for dealing with it."
- D) "Try to minimize her fears and insist that she go to the park."

Ans: C

Feedback:

Preschoolers have vivid imaginations and experience a variety of fears. It is best to acknowledge the fear, rather than minimize it, and then collaborate with the child on strategies for dealing with the fear. Avoiding the playground will not address the child's fears. Forcing the child to face her fear without enlisting her input to help deal with the fear does not teach. It is also important for the mother to find out if an incident involving cats and dogs occurred without her knowledge.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Cognitive Level: Knowledge

Integrated Process: Teaching/Learning

Page and Header: 996, Safety in the Car

25. The nurse is providing teaching about car safety to the parents of a 5-year-old girl who weighs 45 lb. What should the nurse instruct the parents to do?

- A) "Place her in a booster seat with lap and shoulder belts in the front seat."
- B) "Place her in the back seat with the lap and shoulder belts in place."
- C) "Place her in a forward-facing car seat with a harness and top tether."
- D) "Place her in a booster seat with lap and shoulder belts in the back seat."

Ans: D

Feedback:

A child who weighs between 40 and 80 lb should ride in a booster seat that utilizes both the lap and shoulder belts in the back seat. When a child is large enough to sit up straight with the knees bent at the front edge of the seat, then he or she may sit directly on the seat of the car with lap/shoulder belt securely and appropriately attached. The back seat of the car is the safest place for a child to ride. A forward-facing car seat with harness and top tether is for a preschooler who weighs less than 40 lb.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 985, Moral and Spiritual Development

26. The nurse is caring for a premature baby in the NICU. The mother reports that the infant's normally happy and outgoing 5-year-old sister is acting sad and withdrawn. The nurse understands that due to her developmental stage, the girl is at risk of what happening?

- A) Viewing her baby sister's illness as her fault
- B) Harming the baby
- C) Experiencing clinical depression
- D) Creating an imaginary friend to cope with the situation

Ans: A

Feedback:

Since the preschool child is facing the psychosocial task of initiative versus guilt, it is natural for the child to experience guilt when something goes wrong. The child may have a strong belief that if someone is ill or dying, he or she may be at fault and the illness or death is punishment. It is less likely that the girl would be at risk of harming the baby or experiencing clinical depression as a result of the baby's illness. The child may create an imaginary friend to cope with the illness, but would not withdraw or express sadness as a result of the imaginary friend.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1002, Lying

27. When providing anticipatory guidance to parents about their preschool son who was caught in a lie, what would the nurse emphasize?

- A) "You need to determine the reason for lying before punishing the child."
- B) "Lying should never be tolerated and the child should be punished."
- C) "The misbehavior is usually more serious than the lying itself."
- D) "It is okay to become angry when dealing with the child's lying."

Ans: A

Feedback:

Lying is common in preschool children and occurs for a variety of reasons, such as fearing punishment, getting carried away by imagination, or imitating what another person has done. Regardless, the parent should ascertain the reason for the lying before punishing the child. The child also needs to learn that the lying is usually far worse than the misbehavior. Parents need to remain calm and serve as a role model of an even temper.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1002, Sex Education

28. The nurse is providing anticipatory guidance for parents of a preschooler regarding sex education. What is a recommended guideline when dealing with this issue?

- A) Be prepared to thoroughly cover a topic before the child asks about it.
- B) Before answering questions, find out what the child thinks about the subject.
- C) Expand upon the topic when answering questions to prevent further confusion.
- D) Provide a less than honest response to shelter the child from knowledge that is too advanced.

Ans: B

Feedback:

Preschoolers are very inquisitive and want to learn about everything around them; therefore, they are very likely to ask questions about sex and where babies come from. Before attempting to answer questions, parents should try to find out first what the child is really asking and what the child already thinks about that subject. Then they should provide a simple, direct, and honest answer. The child needs only the information that he or she is requesting.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1002, Masturbation

29. The parents of a preschooler express concern to the nurse about their son's new habit of masturbating. What is an appropriate response to this concern?

- A) Tell the child in a firm manner that this behavior is not acceptable.
- B) When the child displays this behavior, place him in a "time-out."
- C) Treat the action in a matter-of-fact manner emphasizing safety.
- D) Consult a psychotherapist to determine the reason for this behavior.

Ans: C

Feedback:

Masturbation is a healthy and natural part of normal preschool development if it occurs in moderation. If the parent overreacts to this behavior, then it may occur more frequently. Masturbation should be treated in a matter-of-fact way by the parent. The child needs to learn certain rules about this activity: nudity and masturbation are not acceptable in public. The child should also be taught safety: no other person can touch the private parts unless it is the parent, healthcare provider, or nurse checking to see when something is wrong.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 984, Physical Growth

30. The parents of a 5-year-old are concerned that their son is too short for his age. The nurse measures the child's height at 40 in (101.6 cm). How should the nurse respond?

- A) "Some children are short for their age during the preschool years but usually catch up during early childhood."
- B) "Are most of the adults in your family short? It may be hereditary that your child will be shorter than average."
- C) "The average height for a 5-year-old is 43 in tall (118.5 cm), so your son is within the normal range for height."
- D) "I am sure his height is a concern, but if you start choosing nutrient-dense foods, he will likely catch up to normal in height."

Ans: C

Feedback:

The average preschool-age child will grow 2.5 to 3 in (6.5 to 7.8 cm) per year. The average 3-year-old is 37 in tall (96.2 cm), the average 4-year-old is 40.5 in tall (103.7 cm), and the average 5-year-old is 43 in tall (118.5 cm).

Chapter 28

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1008, Physical Growth

1. The nurse is performing a physical assessment of a 10-year-old boy. The nurse notes that during last year's check-up, the child weighed 80 lb. According to average growth for this age group, what would be his expected current weight?

- A) 81 lb
- B) 85 lb
- C) 87 lb
- D) 89 lb

Ans: C

Feedback:

From 6 to 12 years of age, an increase of 7 lb (3 to 3.5 kg) per year in weight is expected.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1009, Respiratory System

2. The nurse is performing an annual check-up for an 8-year-old child. Compared to the previous assessment of this child, which characteristic would **most** likely be observed?

- A) Breathing is diaphragmatic.
- B) Pulse rate is increased.
- C) Secondary sex characteristics are present.
- D) Blood pressure has reached adult level.

Ans: A

Feedback:

The child's respiratory system is maturing, so abdominal breathing has been replaced by diaphragmatic breathing. Pulse rate will decrease, rather than increase, during this time. Secondary sex characteristics will not appear until the late school-age years. Blood pressure will not reach the adult level until adolescence.

Format: Multiple Select

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1008, 1009, Physiologic Changes

3. The pediatric nurse is aware of the maturation of organ systems in the school-age child. What accurately describes these changes? Select all that apply.

- A) The brain grows very slowly during the school-age years and growth is complete by the time the child is 12 years of age.
- B) Respiratory rates decrease, abdominal breathing disappears, and respirations become diaphragmatic in nature.
- C) The school-age child's blood pressure increases and the pulse rate decreases, and the heart grows more slowly during the middle years.
- D) The school-age child experiences more gastrointestinal upsets compared with earlier years since the stomach capacity increases.
- E) Bladder capacity increases, but varies among individual children, and girls generally have a greater bladder capacity than boys.
- F) Pubescence typically occurs in the 2 years before the beginning of puberty and is characterized by the development of secondary sexual characteristics.

Ans: B, C, E, F

Feedback:

Respiratory rates decrease, abdominal breathing disappears, and respirations become diaphragmatic in nature. The school-age child's blood pressure increases and the pulse rate decreases. The heart grows more slowly during the middle years and is smaller in size in relation to the rest of the body than at any other development stage. Bladder capacity increases, but varies among individual children. Girls generally have a greater bladder capacity than boys. Pubescence typically occurs in the 2 years before the beginning of puberty and is characterized by the development of secondary sexual characteristics. The brain and skull grow very slowly during the school-age years. Brain growth is complete by the time the child is 10 years of age. The school-age child experiences fewer gastrointestinal upsets compared with earlier years. Stomach capacity increases, which permits retention of food for longer periods of time.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Analyze

Integrated Process: Communication and Documentation

Page and Header: 1009, Genitourinary System

4. The nurse is using the formula for bladder capacity to measure the bladder capacity of a 9-year-old girl. What number would the nurse document for this measurement?

- A) 9 ounces
- B) 10 ounces
- C) 11 ounces
- D) 12 ounces

Ans: C

Feedback:

The formula for bladder capacity is age in years plus 2 ounces. Therefore, the bladder capacity of the 9-year-old would be 11 ounces.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1009, Psychosocial Development

5. The nurse knows that the school-age child is in Erikson's stage of industry versus inferiority. Which **best** exemplifies a school-ager working toward accomplishing this developmental task?

- A) The child signs up for after-school activities.
- B) The child performs his bedtime preparations autonomously.
- C) The child becomes aware of the opposite sex.
- D) The child is developing a conscience.

Ans: A

Feedback:

Erikson (1963) describes the task of the school-age years to be a sense of industry versus inferiority. During this time, the child is developing his or her sense of self-worth by becoming involved in multiple activities at home, at school, and in the community, which develop his or her cognitive and social skills. Achieving independence is a task of the preschooler who also is developing a conscience at that age. Awareness of the opposite sex occurs in, but is not the focus of, the school-age child.

Format: Multiple Select

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1010, Cognitive Development

6. The school nurse providing school health screenings knows that the 7- to 11-year-old is in Piaget's stage of concrete operational thoughts. What should this age group accomplish when developing operations? Select all that apply.

- A) Ability to assimilate and coordinate information about the world from different dimensions
- B) Ability to see things from another person's point of view and think through an action
- C) Ability to use stored memories of past experiences to evaluate and interpret present situations
- D) Ability to think about a problem from all points of view, ranking the possible solutions while solving the problem
- E) Ability to think outside of the present and incorporate into thinking concepts that do exist as well as concepts that might exist
- F) Ability to understand the principle of conservation—that matter does not change when its form changes

Ans: A, B, C, F

Feedback:

Piaget's stage of cognitive development for the 7- to 11-year-old is the period of concrete operational thoughts. In developing concrete operations, the child is able to assimilate and coordinate information about the world from different dimensions. He or she is able to see things from another person's point of view and think through an action, anticipating its consequences and the possibility of having to rethink the action. The school-age child is able to use stored memories of past experiences to evaluate and interpret present situations. Also, during concrete operational thinking, the school-age child develops an understanding of the principle of conservation—that matter does not change when its form changes. According to Piaget, the *adolescent* progresses from a concrete framework of thinking to an abstract one in the formal operational period. During this period, the adolescent is able to think about a problem from all points of view, ranking the possible solutions while solving the problem. The adolescent also develops the ability to think outside of the present; that is, he or she can incorporate into thinking concepts that do exist as well as concepts that might exist. His or her thinking becomes logical, organized, and consistent.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Create

Integrated Process: Teaching/Learning

Page and Header: 1011, Moral and Spiritual Development

7. The nurse explains to parents of school-age children that according to Kohlberg's theory of moral development, their child is at the conventional stage of moral development. Which is the nurse's **best** explanation for the motivation for school-age children to follow rules?

- A) They follow rules out of a sense of being a "good person."
- B) They follow rules out of fear of being punished.
- C) They follow rules in order to receive praise from caretakers.
- D) They follow rules because it is in their nature to do so.

Ans: A

Feedback:

During the school-age years, the child's sense of morality is constantly being developed. According to Kohlberg, the school-age child is at the conventional stage of moral development. The 7- to 10-year-old usually follows rules out of a sense of being a "good person." He or she wants to be a good person to his or her parents, friends, and teachers and to himself or herself.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1011, Moral and Spiritual Development

8. The nurse is talking with a chatty 7-year-old girl during her regular check-up.

Which behaviors would the child also be expected to exhibit?

- A) Showing no interest in what the nurse sees in her ears
- B) Explaining what is right and what is wrong
- C) Demonstrating independence from her mother
- D) Showing no concern when the nurse hurts her own finger

Ans: B

Feedback:

At this age, behavior is seen by the child as either completely right or wrong. The child will almost surely want to know why the nurse looks in her ears. The child depends heavily on parents for support and encouragement at this age. This is a time when children gain empathy, so the child would show concern for the nurse's injury.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 1011, Motor Skill Development

9. The nurse is assessing the gross motor skills of an 8-year-old boy. Which interview question would facilitate this assessment?

- A) "Do you like to do puzzles?"
- B) "Do you play any instruments?"
- C) "Do you participate in any sports?"
- D) "Do you like to construct models?"

Ans: C

Feedback:

To assess the gross motor skills of school-age children, the nurse should ask questions about participation in sports and after-school activities. For fine motor skills, the nurse could ask questions about band membership, constructing models, and writing skills.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1012, Sensory Development

10. The school nurse is conducting vision screening for a 7-year-old girl and documents the condition "amblyopia." What would the nurse tell the parents about this condition?

- A) "Amblyopia is an uncorrected refractive error of the eye."
- B) "Amblyopia is reduced vision in an eye that has not been adequately used during early development."
- C) "Amblyopia is a malalignment of the eye, which occurs at birth."
- D) "Amblyopia is a clouding of the lens of the eye caused by trauma to the eye."

Ans: B

Feedback:

Some problems frequently identified in school-age children include amblyopia (lazy eye), uncorrected refractive errors or other eye defects, and malalignment of the eyes (called *strabismus*). Amblyopia is reduced vision in an eye that has not been adequately used during early development. Inadequate use can result from conditions such as strabismus, being cross-eyed, or one eye being more nearsighted, farsighted, or astigmatic than the other eye. Amblyopia is the leading cause of visual impairment in children (National Eye Institute, 2008) and if untreated can result in vision loss.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1012, Communication and Language Development

11. The school nurse knows that school-age children are developing metalinguistic awareness. Which is an example of this skill?

- A) The child enjoys reading books.
- B) The child enjoys conversations with peers.
- C) The child enjoys speaking on the phone.
- D) The child enjoys telling jokes.

Ans: D

Feedback:

Language skills continue to accelerate during the school-age years. School-age children develop metalinguistic awareness—an ability to think about language and comment on its properties. This enables them to enjoy jokes and riddles due to their understanding of double meanings and play on words and sounds.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1013, Temperament

12. A mother brings her 6-year-old son in for a check-up because the child is reporting stomachaches. It is the beginning of the school year. What might the mother also mention?

- A) The child cries before going to school.
- B) The child made friends the first day of school.
- C) The child fights with siblings more often.
- D) The child loves the crowds in the lunchroom.

Ans: A

Feedback:

This child has a slow-to-warm-up temperament. The child may also be crying before going to school. Making friends the first day of school and enjoying the crowds in the lunchroom are typical of a child with an easy temperament. Irritability is typical of a child with a difficult temperament.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1013, Peer Relationships

13. The nurse is teaching the parents of a 9-year-old girl about the socialization that is occurring in their child through school contacts. Which information would the nurse include in her teaching plan?

- A) Teachers are the most influential people in the development of the school-age child's social network.
- B) Continuous peer relationships provide the most important social interaction for school-age children.
- C) Parents should establish norms and standards that signify acceptance or rejection.
- D) A characteristic of school-age children is their formation of groups with no rules and values involved.

Ans: B

Feedback:

Continuous peer relationships provide the most important social interaction for school-age children. Peer and peer-group identification are most essential to the socialization of the school-age child. Peer groups establish norms and standards that signify acceptance or rejection. Valuable lessons are learned from interactions with children their own age. A characteristic of school-age children is their formation of groups with rules and values.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1014, Peer Relationships

14. During a well-child check-up, the parents of a 9-year-old boy tell the nurse that their son's friends told him that soccer is a stupid game, and now he wants to play baseball. Which comment by the nurse **best** explains the effects of peer groups?

- A) "The child's best friends will continue playing soccer."
- B) "The children will cheer for each other regardless of the sport being played."

- C) "Your child will rarely talk to you about his friends."
- D) "Acceptance by friends, especially of the same sex, is very important at this age."

Ans: D

Feedback:

Peer relationships, especially of the same sex, are very important and can influence the child's relationship with his parents. They can provide enough support that he can risk parental conflict and stand his ground about playing soccer. At this age, peer groups are made up of the child's best friends, and they happen to be playing baseball. Peer groups have rules and take up sides against the soccer player. Peers are an authority, so the child will let his parents know their opinions.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1008, Physical Growth

15. The nurse is performing a physical examination of an 11-year-old girl. What observations would be expected?

- A) The child has not gained weight since last year.
- B) The child has grown 2.5 in since last year.
- C) The child breathes abdominally.
- D) The child's third molars are about to erupt.

Ans: B

Feedback:

From 6 to 12 years of age, children grow an average of 2.5 in (6 to 7 cm) per year, increasing their height by at least 1 foot. An increase of 7 lb (3 to 3.5 kg) per year in weight is expected. Abdominal breathing is typical of a preschooler and would have disappeared several years earlier. The third molars do not erupt until late adolescence.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1010, Cognitive Development, Table 28.1

16. What finding would the nurse **most** likely discover in a 10-year-old child in the period of concrete operational thought?

- A) Participation in abstract thinking
- B) Ability to classify similar objects
- C) Problem solving via the scientific method
- D) Ability to make independent decisions

Ans: B

Feedback:

During the period of concrete operational thought, children are able to classify or group objects based on their common elements. Abstract thinking, problem solving via the scientific method, and independent decision making are higher-level functions, typically seen in adolescents.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1018, Car Safety

17. After teaching the parents of a 9-year-old girl about safety, which statement indicates the need for additional teaching?

- A) "She can ride in the front seat of the car once she is 10 years old."
- B) "We need to buy her a helmet so she can ride her scooter."
- C) "She should ride her bike with the traffic on the side of the road."
- D) "We signed her up for swim lessons at the local community center."

Ans: A

Feedback:

Children younger than 12 years of age must sit in the back seat of the car. Laws in most states require helmets for riding bicycles and scooters. When riding a bike, the child should ride on the side of the road traveling with the traffic. Children should know how to swim. If swimming skills are limited, the child must wear a life preserver at all times.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1022, Nutritional Needs

18. The nurse is teaching parents to plan nutritional meals for their 7-year-old son who is overweight. Which guideline might the nurse include in the teaching plan?

- A) School-age children with an average body weight of 20 to 35 kg need approximately 90 calories per kilogram daily.
- B) The average water requirement for a school-age child per 24 hours ranges from 2,000 to 2,500 mL per day.
- C) The school-age child needs 28 g of protein and 800 mg of calcium for maintenance of growth and good nutrition.
- D) In the school-age child, calories needed to sustain weight increase, while the appetite decreases.

Ans: C

Feedback:

The 4- to 8-year-old child needs 1,000 mg of calcium for maintenance of growth and good nutrition and 10% to 30% of calories should come from protein. School-age children with an average body weight of 20 to 35 kg need approximately 70 calories per kilogram daily (1,400 to 2,100 calories per day). The average water requirement per 24 hours ranges from 1,800 to 2,200 mL per day. Growth, body composition, and body shape remain constant during the late school-age years. Needed calories decrease while the appetite increases.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1022, 1023, Preventing the Development of Overweight and Obesity

19. The nurse has determined that an 8-year-old girl is at risk for being overweight. Which intervention would be a **priority** prior to developing the care plan?

- A) Determining the need for additional caloric intake
- B) Asking the parents who they want to work with the child
- C) Interviewing the parents about their eating habits
- D) Discussing the influence of peers on the child's diet

Ans: C

Feedback:

The nurse would need to find out what the parents' eating habits are like. It would not be necessary to determine the need for additional caloric intake. Developing a multidisciplinary plan is an intervention for a child with growth and development problems. Discussing the influence of peers is an intervention used for preventing injury.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1025, Television, Video Games, and the Internet, Healthy People 2030

20. The school nurse is preparing a talk on the influence of the media on school-age children to present at the next PTO meeting. Which fact might the nurse include in the introduction?

- A) Children in the United States spend about 6 hours a day either watching TV or playing video games.
- B) A child will see 2,000 murders by the end of grade school and 20,000 commercials a year.
- C) A school-age child cannot determine what is real from what is fantasy; therefore, TV and video games can lead to aggressive behavior.
- D) Parents should limit television watching and videogame playing to 2 hours per day.

Ans: D

Feedback:

Parents should limit television watching and videogame playing to 2 hours per day. Children in the United States spend about 4 hours a day either watching TV or playing video games. A child will see 8,000 murders by the end of grade school and 40,000 commercials a year. Although school-age children can determine what is real from what is fantasy, research has shown that this amount of time in front of the TV—watching it or playing video games—can lead to aggressive behavior, less physical activity, and altered body image.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1027, School Refusal

21. The mother of a 7-year-old girl tells the school nurse that her child is deathly afraid of going to school. What would be the **best** intervention the nurse could suggest in this situation?

- A) Return the child to school and investigate the cause of the fear.
- B) Have the child stay home from school until any issues causing this fear are resolved.

C) Investigate a new school for the child to attend that the child will not be afraid of.

D) Tell the child that privileges will be taken away if she does not return to school.

Ans: A

Feedback:

It is important to investigate specific causes of school refusal/school phobia and take appropriate action. The parents should return the child to school, investigate the cause of the fear, support the child, collaborate with teachers, and praise success in school attendance. This is not a situation for punishment, and changing schools would not solve the child's school phobia.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1027, 1028, Latchkey Children

22. Two working parents are discussing with the school nurse the possibility of their 12-year-old girl going home alone after school. What suggestion should the nurse make?

A) Provide entertainment until the parents come home.

B) Allow the child to go to a friend's house.

C) Teach her how to take a message if someone calls.

D) Purchase caller ID for the phone.

Ans: D

Feedback:

Having caller ID allows the child to answer the phone if Mom or Dad calls while ignoring all other calls. Rather than entertaining the child, this would be a better time for homework, age-appropriate chores, and limited entertainment. If the child goes to a friend's house, it should be prearranged between the parents, not spur of the moment. It is safer if the child does not answer the phone instead of taking a message.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1018, Reading, Box 28.1

23. The parents of an 8-year-old boy are interested in promoting learning through reading to their son. Which suggestion by the nurse would **best** promote this goal?

- A) Have the parents choose what he should read initially.
- B) Tell the child to read instead of watch TV with his parents.
- C) Tell the parents that reading is for the child to do by himself.
- D) Take the child to the library to check out some books.

Ans: D

Feedback:

Taking the child to the library can be a positive start to the reading experience. It is best to let the librarian recommend books that will be appropriate for the child, but let the child choose from recommended materials. Set an example by reading instead of watching TV while the child is not in bed. Reading to the child is a valuable parent-child activity that can expose the child to classic works that are beyond the child's present reading ability.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Understand

Integrated Process: Caring

24. The nurse is caring for a 7-year-old girl who is scheduled for a hernia repair and is very scared. Which fear would she also **most** likely have at this age?

- A) Fear of being kidnapped
- B) Fear of cutting her finger
- C) Fear of sudden loud noises
- D) Fear of the neighbor's dog

Ans: A

Feedback:

At this age, the child will be fearful of being kidnapped. She should have outgrown her fears of harm to her body, noises, and dogs, all of which are typical preschooler fears.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Caring

Page and Header: 1028, Stealing, Lying, and Cheating

25. The nurse is counseling the parents of a 10-year-old child who was caught stealing at school. Which topic should the nurse cover?

- A) Having the child return the property in front of his or her class
- B) Discussing ways for the child to save face
- C) Finding out what is currently going on at home
- D) Reminding the child daily that stealing is wrong

Ans: C

Feedback:

The parents need to understand the child's behavior. The reason for stealing at age 10 may be that the child wants the item or is trying to impress peers, or it may be a sign of anxiety. More information is needed before the nurse can effectively work with the family. The parents should work together with the child to decide how the item will be returned. The child will lose face but gain integrity by returning the stolen item. Reminding the child about stealing on a daily basis may ruin the child's self-esteem.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1014, Peer Relationships

26. When providing anticipatory guidance to a group of parents with school-age children, what would the nurse describe as the **most** important aspect of social interaction?

- A) School
- B) Peer relationships
- C) Family
- D) Temperament

Ans: B

Feedback:

Although school, family, and temperament are important influences on social interaction, peer relationships at this time provide the most important social interaction for school-age children.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1028, Bullying

27. The school nurse is teaching parents about the effects of bullying on school children. What accurately describes this developmental concern?

- A) Children who bully are those who report themselves as being lonely and having difficulty in forming friendships.
- B) Children with health issues, such as, disabilities, obesity, and food allergies, are at a decreased risk of being bullied.

C) In general, about 20% of all children attending school are frightened and afraid most of the day.

D) Both boys and girls are bullied; boys usually bully boys and use force more often.

Ans: D

Feedback:

Both boys and girls are bullied and can bully others. Boys usually bully boys and use force more often, and boys are twice as likely to be victims of bullying. Bullied children are those who report themselves as being lonely and having difficulty in forming friendships. Children with health issues, such as disabilities, obesity, and food allergies, are at an increased risk of being bullied. In general, about 10% of all children attending school are bullied on a regular basis with approximately 50% of children reporting having been bullied at some point in their school-age years.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1029, Tobacco and Alcohol Education

28. The nurse is providing anticipatory guidance for parents of a school-age child on teaching the dangers of drugs and alcohol. What advice might be helpful for these parents?

A) School-age children are not ready to absorb information that deals with drugs and alcohol.

B) School-age children can think critically to interpret messages seen in advertising, media, and sports.

C) Parents must prevent their child from being exposed to messages that are in conflict with their values.

D) Discussions with children need to be based on facts and focused on the past and future.

Ans: B

Feedback:

School-age children can be taught how to think critically to interpret messages seen in advertising, media, sports, and entertainment personalities. School-age children are ready to absorb information that deals with drugs and alcohol and may be exposed to messages that are in conflict with their parents' values regarding smoking and alcohol. This may occur at school and cannot be prevented. Discussions with children need to be based on facts and focused on the present.

Format: Multiple Select

Client Needs: Psychosocial Integrity

Cognitive Level: Analyze

Integrated Process: Caring

Page and Header: 1009, Prepubescence

29. A 12-year-old girl is experiencing prepubescence and tells the school nurse that she feels "very out of place" in her school. What would be acceptable responses by the nurse? Select all that apply.

- A) "It must be difficult for you. Why don't you sit down, and we can talk about it?"
- B) "I would suggest that you talk to your parents about your feelings. This isn't something that I can talk to you about."
- C) "All of the girls and boys will be going through the same thing as you so that should make you feel a little better."
- D) "Tell me how this makes you feel. Talking about your feelings may help you feel better about school."
- E) "I went through the same thing when I was in school. I know it doesn't feel like it now, but I promise it will get easier."

Ans: A, D

Feedback:

Prepubescence typically occurs in the 2 years before the beginning of puberty and is characterized by the development of secondary sexual characteristics, a period of rapid growth for girls, and a period of continued growth for boys. Acknowledging the student's feelings and encouraging her to talk about her feelings will likely help her to feel better about herself. She may not be comfortable with talking about her feelings with her parents at this point, and the nurse discussing this topic with the student is acceptable. Telling her that everyone goes through it and that it will "get easier" does not address the student's feelings and is nontherapeutic communication.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Analyze

Integrated Process: Communication and Documentation

Page and Header: 1012, Fine Motor Skills

30. The mother of a 12-year-old boy is talking with the school nurse about her son's clumsiness. She reports that he seems to fall a lot, his writing is horrible, and as much as he practices, he can't play his guitar very well. How should the nurse respond to the mother?

- A) "Boys tend to take a bit longer than girls to mature."
- B) "Have you spoken with your pediatrician about your observations?"
- C) "Boys tend to refine their fine motor skills by this age."
- D) "I will make a note of your observations and talk to his teachers."

Ans: B

Feedback:

Myelinization of the central nervous system is reflected by refinement of fine motor skills. The child between 10 and 12 years of age begins to exhibit manipulative skills comparable to adults. In order to determine if the child is delayed in fine motor skill development, the pediatrician should be made aware because further examination or testing may be warranted. Just stating the fact that his motor skills should be developed by this age, although true, does not address the mother's concerns. The teachers can be notified of the mother's observations, but the child should still be assessed by the pediatrician.

Chapter 29

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1034, Introduction

1. The nurse teaches parents of adolescents that adolescents need the support of parents and nurses to facilitate healthy lifestyles. What should be a **priority** focus of this guidance?

- A) Reducing risk-taking behavior
- B) Promoting adequate physical growth
- C) Maximizing learning potential
- D) Teaching personal hygiene routines

Ans: A

Feedback:

The adolescent experiences drastic changes in the physical, cognitive, psychosocial, and psychosexual areas. With this rapid growth during adolescence, the development of secondary sexual characteristics, and interest in the opposite sex, the adolescent needs the support and guidance of parents and nurses to facilitate healthy lifestyles and to reduce risk-taking behaviors. Promoting physical growth, maximizing learning potential, and teaching hygiene are secondary to reducing risky behavior.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1036, Musculoskeletal System

2. The nurse has seen a 15-year-old girl and a 16-year-old boy during health surveillance visits. Which physical characteristics would be seen in both teenagers?

- A) Decreased respiratory rates of 15 to 20 breaths per minute
- B) Eruption of the last four molars
- C) Increased shoulder, chest, and hip widths
- D) Fully functioning sweat and sebaceous glands

Ans: C

Feedback:

Both teenagers are in the middle state of adolescence, which is marked by an increase in shoulder, chest, and hip widths. Decreased respiratory rate occurs in early adolescence, as do fully functioning sweat and sebaceous glands. Eruption of the last four molars occurs in late adolescence.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1034, 1035, Physiologic Changes Associated with Puberty

3. The nurse is performing an assessment of the reproductive system of a 17-year-old girl. What would alert the nurse to a developmental delay in this girl?

- A) Areola and papilla separate from the contour of the breast
- B) Mature distribution and coarseness of pubic hair
- C) Developed breast tissue
- D) Absence of first menstrual period

Ans: D

Feedback:

The first menstrual period usually begins between the ages of 9 and 15 years (average 12.8 years). Breast budding (thelarche) occurs at approximately ages 9 to 11 years and is followed by the growth of pubic hair.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1035, Physical Growth

4. The school nurse is performing health assessments on students in middle school. Of what developmental milestone should the nurse be aware?

- A) Height in girls increases rapidly after menarche and usually ceases immediately after menarche.
- B) Boys' growth spurts usually begin between the ages of 8 and 14 years and end between the ages of $13\frac{1}{2}$ and $17\frac{1}{2}$ years.
- C) Peak height velocity (PHV) occurs at approximately 12 years of age in girls or about 6 to 12 months after menarche.
- D) Boys reach PHV and peak weight velocity (PWV) at about 16 years of age.

Ans: C

Feedback:

PHV occurs at approximately 12 years of age in girls or about 6 to 12 months after menarche. Height in girls increases rapidly after menarche and usually ceases 2 to $2\frac{1}{2}$ years after menarche. Boys' growth spurt occurs later than girls' and usually begins between the ages of $10\frac{1}{2}$ and 16 years and ends sometime between the ages of $13\frac{1}{2}$ and $17\frac{1}{2}$ years. Boys reach PHV at about 14 years of age. PWV occurs about 6 months after menarche in girls and at about 14 years of age in boys.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Communication and Documentation

Page and Header: 1034, Physiologic Changes Associated with Puberty

5. After assessing a 10-year-old girl, the nurse documents the appearance of breast buds, identifying this as what body change?

- A) Menarche
- B) Thelarche
- C) Puberty
- D) Tanner stage 5

Ans: B

Feedback:

"Thelarche" is the term used to describe breast budding. Menarche refers to the first menstrual period. Puberty refers to the biologic changes that occur during adolescence. Tanner stage 5 involves maturation of the breast tissue to adult configuration.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1036, Cardiovascular System

6. When describing the various changes that occur in organ systems during adolescence, what would the nurse include?

- A) Significant increase in brain size
- B) Ossification completed later in girls
- C) Decrease in heart rate
- D) Decrease in activity of sebaceous glands

Ans: C

Feedback:

During adolescence, the heart rate decreases while the systolic blood pressure increases. Brain growth continues, but the size of the brain does not increase significantly. Ossification is more advanced in girls and occurs at an earlier age. Sebaceous gland activity increases during adolescence.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1038, Gross Motor Skills

7. The school nurse is performing a physical examination on a 13-year-old boy who is on the soccer team. What is a physical quality that develops during these early adolescent years?

- A) Coordination
- B) Endurance
- C) Speed
- D) Accuracy

Ans: B

Feedback:

It is usually during early adolescence that teenagers begin to develop endurance.

Their concentration has increased so they can follow complicated instructions.

Coordination can be a problem because of the uneven growth spurts. During middle adolescence, speed and accuracy increase while coordination also improves.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1036, Psychosocial Development

8. Based on Erikson's developmental theory, what is the major developmental task of the adolescent?

- A) Gaining independence
- B) Finding an identity
- C) Coordinating information
- D) Mastering motor skills

Ans: B

Feedback:

According to Erikson, it is during adolescence that teenagers achieve a sense of identity. The toddler developed a sense of trust in infancy and is ready to give up dependence and to assert his or her sense of control and autonomy. The psychosocial task of the preschool years is establishing a sense of initiative versus guilt by mastering skills. In the school-age years, the child develops concrete operations and is able to assimilate and coordinate information about the world from different dimensions.

Format: Multiple Select

Client Needs: Psychosocial Integrity

Cognitive Level: Analyze

Integrated Process: Culture and Spirituality

Page and Header: 1038, Moral and Spiritual Development

9. The nurse assesses the spirituality of an adolescent. What are normal moral and spiritual milestones in this age group? Select all that apply.

- A) Adolescents will base their actions on the avoidance of punishment and the attainment of pleasure.
- B) Adolescents develop their own set of morals and values and question the status quo.
- C) Adolescents undergo the process of developing their own set of morals at different rates.
- D) Adolescents are more interested in the spiritualism of their religion than in the actual practices of their religion.
- E) Adolescents can understand the concepts of right and wrong and are developing a conscience.
- F) Adolescents are able to understand and incorporate into their behavior the concept of the "golden rule."

Ans: B, C, D

Feedback:

It is during the adolescent years that teenagers develop their own set of values and morals at different rates. At the beginning of this stage, teenagers begin to question the status quo. The majority of their choices are based on emotions while they are questioning societal standards. Adolescents also begin to question their formal religious practices. As they progress through adolescence, teenagers become more interested in the spiritualism of their religion than in the actual practices of their religion. The toddler will base his or her actions on the avoidance of punishment and the attainment of pleasure. The preschool child can understand the concepts of right and wrong and is developing a conscience. The school-age child is able to understand and incorporate into his behavior the concept of the "golden rule."

Format: Multiple Select

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1039, Relationship with Parents, Box 29.1

10. The school nurse is conducting a seminar for parents of adolescents on how to communicate with teenagers. Which guidelines might the nurse recommend? Select all that apply.

- A) Talk face to face and be aware of body language.
- B) Ask questions to see why he or she feels that way.
- C) Do not give praise unless the adolescent deserves it.
- D) Speak to your child as an authority figure, not an equal.
- E) Don't admit that you make mistakes.
- F) Don't pretend you know all the answers.

Ans: A, B, F

Feedback:

In order to improve communication with teenagers, the parents should talk face to face and be aware of body language, ask questions to see why the teenager feels that way, not pretend they know all the answers, give praise and approval to the teenager often, speak to him or her as an equal (not talk down to him or her), and admit that they do make mistakes.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1039, Relationship with Parents

11. The nurse is teaching the parents of a 12-year-old boy about appropriate approaches when raising an adolescent. Which comment should be included in the discussion?

- A) "Find out if his friends are worthy of him."
- B) "Try to be open to his views."
- C) "Maintain a firm set of rules."
- D) "Remind him that he is still your little boy."

Ans: B

Feedback:

It is most important to be open to the child's views. This will encourage the child to consider parental concerns and promote communication. Being judgmental about his friends will make the child defensive about his choice of friends. Rules need to be flexible so they can apply to new situations. Avoid condescension. The child will appreciate being treated like a young man.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1039, Relationship with Parents, Box 29.1

12. The mother of a 14-year-old girl reports to the nurse that her daughter is moody, shuts herself in her room, and fights with her younger sister. Which comment is **most** valuable to the mother?

- A) "Calmly talk to her about your concerns."
- B) "This is normal for her age."
- C) "She may be hanging with a bad crowd."
- D) "Set some rules for family etiquette."

Ans: A

Feedback:

Getting the mother and daughter talking and sharing information is the most valuable advice. Telling the mother that this is normal does nothing for the family situation. Setting rules will alienate the child. Suggesting an underlying problem can cause a rift between the mother and daughter.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Remember

Integrated Process: Nursing Process

Page and Header: 1039, 1040, Self-Concept and Body Image

13. The adolescent continues to develop self-concept and self-esteem. What is **most** important to a teen's self-esteem?

- A) Strong authority figures
- B) Spirituality
- C) Morals and values
- D) Body image

Ans: D

Feedback:

Self-concept and self-esteem are tied to body image many times. Adolescents who perceive their body as being different than peers or as less than ideal may view themselves negatively. Sexual characteristics are important to the adolescent's self-concept and body image. Authority figures, spirituality, and morals and values play a role in development of self-esteem, but body image is most influential in the development of self-concept/self-esteem.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1042, Cultural Influences on Growth and Development

14. The nurse is performing risk assessments on adolescents in the school setting.

Which teen should the nurse screen for hypertension?

- A) An Asian female
- B) A white male
- C) An African-American male
- D) A Jewish male

Ans: C

Feedback:

It is important for the nurse to recognize the ethnic background of each adolescent.

Research has shown that certain ethnic groups are at higher risk for certain diseases.

For example, adolescent African Americans are at higher risk for developing hypertension.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1042, Cultural Influences on Growth and Development

15. The nurse knows that barriers to the adolescent's health and successful achievement of the tasks of adolescence exist. What is the major barrier to health for this population?

- A) Cultural
- B) Socioeconomic
- C) Marital status
- D) Racial

Ans: B

Feedback:

The major barrier to the adolescent's health and successful achievement of the tasks of adolescence is socioeconomic status. Adolescents at a lower socioeconomic level are at higher risk for developing healthcare problems and risk-taking behaviors; this may be due to their inability to access health care and to obtain needed services. In caring for adolescents, the nurse should also recognize the influence of their culture, ethnicity, and race upon them.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Cognitive Level: Remember

Integrated Process: Teaching/Learning

Page and Header: 1046, Promoting Safety

16. The nurse teaching safety to teens knows that which of these is the leading cause of death among adolescents?

- A) Drowning
- B) Poisoning
- C) Diseases
- D) Unintentional injuries

Ans: D

Feedback:

Unintentional injuries are the leading cause of death in adolescents (Curtin, Heron, Miniño, & Warner, 2018). Motor vehicle accidents are the leading cause of injury death followed by poisoning, primarily due to drug overdose from opioids (Curtin et al., 2018). Males are more likely than females to die of any type of injury (Curtin et al., 2018).

Format: Multiple Select

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1046, Promoting Safety

17. When assessing adolescents for health risks, the nurse must keep in mind the factors related to the prevalence of adolescent injuries. What accurately describes these factors? Select all that apply.

- A) Increased physical growth
- B) Insufficient psychomotor coordination
- C) Tiredness, lack of energy
- D) Lack of impulsivity
- E) Peer pressure
- F) Inexperience

Ans: A, B, E, F

Feedback:

Influencing factors related to the prevalence of adolescent injuries include increased physical growth, insufficient psychomotor coordination for the task, abundance of energy, impulsivity, peer pressure, and inexperience. Impulsivity, inexperience, and peer pressure may place the teen in a vulnerable situation between knowing what is right and wanting to impress peers. On the other hand, teens have a feeling of invulnerability, which may contribute to negative outcomes.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1049, Nutritional Needs

18. The nurse is helping the parents and their underweight adolescent collaborate on planning a healthy menu. Of which nutritional requirement of adolescents should the nurse be aware?

- A) Teenagers have a need for increased calories, zinc, calcium, and iron for growth.
- B) Teenage girls who are active require about 1,800 calories per day.
- C) Teenage boys who are active require between 2,000 and 2,500 calories per day.
- D) Adolescents require about 1,000 to 1,200 mg of calcium each day.

Ans: A

Feedback:

Teenagers have a need for increased calories, zinc, calcium, and iron for growth. However, the number of calories needed for adolescence depends on the teen's age and activity level as well as growth patterns. Teenage girls who are moderately active require about 2,000 calories per day. Teenage boys who are moderately active require between 2,200 and 2,800 calories per day. Adolescents require about 1,300 mg of calcium each day.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1043, Promoting Healthy Weight

19. The nurse is promoting nutrition to a 13-year-old boy who is overweight. Which comment should the nurse expect to include in the discussion?

- A) "You need to go on a low-fat diet."
- B) "Eat what your parents eat."
- C) "Go out for a sport at school."
- D) "Keep a food diary."

Ans: D

Feedback:

Having the boy keep a detailed food diary for 1 week will determine current patterns of eating. This can then be used to show him how to make small changes with results, especially if eating is done before periods of inactivity such as before going to bed or when he is bored. Speaking and thinking in terms of diet are negative and can lead to poor body image. If the parents have poor eating habits, telling the child to eat what his parents eat could be bad advice. The child could too easily choose the wrong sport or do poorly. It is best to offer solutions with more variety.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1049, Nutritional Needs, Box 29.3

20. The nurse is providing suggestions to a female adolescent about foods to help meet her nutritional requirements for iron. Which food would the nurse suggest as a good source of iron?

- A) Broccoli
- B) Yogurt
- C) Peanut butter
- D) White beans

Ans: C

Feedback:

Peanut butter is a good source of iron. Broccoli, yogurt, and white beans are good sources of calcium.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1039, 1040, Self-Concept and Body Image

21. During a health maintenance visit, a 15-year-old girl mentions that she is not happy with being overweight. Which approach is **best** for the nurse to take?

- A) "Good observation. Let's talk about diet and exercise."
- B) "Don't worry; you are within the weight and height guidelines."
- C) "What specifically have you been noticing?"
- D) "Tell me about your parents. Are they overweight?"

Ans: C

Feedback:

It is best to find out what caused the teenager to make the comment so that you can work with her about the issue. This is an assessment and must be done first.

Launching into a lecture on diet and exercise will be of no value if the teenager wants to talk about dealing with snide comments from her peers. Telling the teenager she is statistically in the normal range for weight and height may close the conversation prematurely. The focus is on the teenager, not her parents. Obtaining that information would be important, but not at this time.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1041, Dating

22. The school nurse knows that dating is a milestone for adolescents. Which statement accurately describes a trend in teen dating?

- A) Most late adolescents spend more time in activities with mixed-sex groups, such as dances and parties, than they do dating as a couple.
- B) Most teens have been involved in at least one romantic relationship by late adolescence.
- C) Teens that date frequently report slightly lower levels of self-esteem and decreased autonomy.
- D) Homosexual behavior as a teen usually indicates that the adolescent will maintain a homosexual orientation.

Ans: B

Feedback:

By age 18, 70% of adolescents report being in at least one romantic relationship in the past 18 months. Most early adolescents spend more time in activities with mixed-sex groups, such as dances and parties, than they do dating as a couple. Teens who date frequently report slightly higher levels of self-esteem and increased autonomy. Homosexual behavior as a teen does not necessarily indicate that the adolescent will maintain a homosexual orientation.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1040, Sexuality

23. During a health check-up without his parents, a 17-year-old tells the nurse he is gay. Which approach should the nurse take?

- A) "Tell me what makes you think you are gay."
- B) "This puts you in an at-risk category."
- C) "We need to talk about safe sex."
- D) "You're not gay; you're confused."

Ans: A

Feedback:

The nurse needs to get more information from the teenager (assessment) before making any comment and then proceed in a sensitive and caring way. Comments about being at risk or needing to know about safe sex are negative and should be replaced with health promotion comments. Denying the statement shows the teenager that you are not an ally.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1045, Promoting Learning

24. The nurse is promoting learning and school attendance to a 13-year-old girl.

Which factor will affect the child's attitude **most**?

- A) Her parents' values and desires
- B) The dramatic changes to her body
- C) Peer group behaviors and attitudes
- D) Desire for attention from boys

Ans: C

Feedback:

In this age group, children have a strong desire to conform to their peer group and to be accepted. It is important to know the peer group's attitude about school and learning. Early adolescence marks the beginning of separation from the family, including its values and desires. Physiologic changes and sexual attraction would not have significant or lasting influence in this matter.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1045, School

25. The school nurse is preparing a program on sexuality and birth control for a class of 14 to 16 year olds. Which behavior will have the **most** influence on how the information is presented?

- A) Teens are adjusting to new body images.
- B) Adolescents tend to take risks.
- C) Teenagers are able to think in the abstract.
- D) Adolescents understand that actions have consequences.

Ans: B

Feedback:

Adolescents are risk takers. This tendency enables them to overcome common sense and their own better judgment. Although adolescents are capable of abstract thinking and understand that actions have consequences, they are not yet committed to these attributes. Changing body image would not have significant influence on the presentation.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1046, Promoting Safety

26. The nurse is preparing a class for a group of adolescents about promoting safety.

What would the nurse plan to include as the leading cause of adolescent injuries?

- A) Motor vehicles
- B) Firearms
- C) Water
- D) Fires

Ans: A

Feedback:

Although firearms, water, and fires all pose a risk for injury for adolescents, most adolescent injuries are due to motor vehicle crashes.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1054, Promoting Appropriate Discipline

27. The nurse is discussing ways to promote discipline with parents who are becoming increasingly frustrated with their teenager. What would the nurse identify as **most** important?

- A) Establish rules and expectations.
- B) Collaborate to determine consequence.
- C) Make your responses consistent.
- D) Explain the rules to the adolescent.

Ans: C

Feedback:

Consistency and predictability are the cornerstones of discipline. Establishing rules and expectations, collaborating to determine the consequences, and explaining the rules are all important, but they are not as important as being consistent.

Format: Multiple Select

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1054, Suicide

28. The school nurse is teaching parents risk factors for suicide in adolescents. What would the nurse discuss? Select all that apply.

- A) Mental health changes
- B) History of previous suicide attempt
- C) Higher socioeconomic status
- D) Greatly improved school performance
- E) Family disorganization
- F) Substance abuse

Ans: A, B, E, F

Feedback:

Suicide is the third leading cause of death in adolescents 15 to 19 years of age. Risk factors for suicide include mental health changes, history of previous suicide attempt, family disorganization, and substance abuse. Other risk factors include poor school performance, crowded conditions/housing, low socioeconomic status, limited parental supervision, single-parent families/both parents in workforce, access to guns or cars, drug or alcohol use, low self-esteem, racism, peer or gang pressure, and aggression.

Format: Multiple Select

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1037, 1038, Table 29.2, Cognitive Development

29. The nurse is performing a cognitive assessment on a 16-year-old client. Which behaviors demonstrated will the nurse identify as middle formal operational, according to Piaget's theory? Select all that apply.

- A) Reporting that he smokes marijuana occasionally.
- B) Wanting to make decisions about health care independently
- C) Being very concerned with implications of the Affordable Care Act regarding healthcare benefits
- D) Wanting their friends to visit them in the hospital more than their parents
- E) Difficulty understanding the implications their diagnosis might present

Ans: A, B, C

Feedback:

During the middle years (age 14 to 17), Piaget recognizes that the adolescent has increased ability to think abstractly or in more idealistic terms, thinks he or she is invincible (leading to risky behaviors), and becomes involved/concerned with society and politics. In the early stages of formal operational reasoning, the adolescent's thinking is egocentric and lacks abstract thinking, as noted in the client being more concerned with peers than parents, and the adolescent does not understand the implications of his or her diagnosis.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1035, Physical Growth

30. A 12-year-old boy reports to the nurse that he is one of the shortest kids in his class. He asks the nurse if he will ever grow. What response by the nurse is **most** appropriate?

- A) "At your age, you are largely done growing taller."
- B) "Since you are the shortest now, you will likely always be the shortest in the class."
- C) "Boys do not have their growth spurt until about age 17."
- D) "There is no way to know how tall you will grow because you are still well within the window for growth."

Ans: D

Feedback:

Boys' growth spurt occurs later than girls' and usually begins between the ages of 10.5 and 16 years and ends sometime between the ages of 13.5 and 17.5 years.

Chapter 30

Format: Multiple Select

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1068, Introduction, Box 30.1

1.The nurse is providing atraumatic care to children in a hospital setting. What are principles of this philosophy of care? Select all that apply.

- A) Avoid or reduce painful procedures.
- B) Avoid or reduce physical distress.
- C) Minimize parent-child interactions.
- D) Provide child-centered care.
- E) Minimize child control.
- F) Use core primary nursing.

Ans: A, B, F

Feedback:

When using atraumatic care, the nurse would avoid or reduce painful procedures, avoid or reduce physical distress, use core primary nursing, maximize parent-child interactions, provide family-centered care, and provide opportunities for control, such as participating in care, attempting to normalize daily schedule, and providing direct suggestions.

Format: Multiple Select

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Understand

Integrated Process: Communication and Documentation

Page and Header: 1068, Utilizing the Child Life Specialist

2. The nurse is consulting with a child life specialist (CLS) to help minimize the stress of hospitalization for a child. Which services would the CLS provide? Select all that apply.

- A) Medical preparation for tests, surgeries, and other medical procedures
- B) Support before and after, but not during, medical procedures
- C) Activities to support normal growth and development
- D) Grief and bereavement support
- E) Emergency room interventions for children and families
- F) Only inpatient consultations with families

Ans: C, D, E

Feedback:

- The CLS would provide activities to support normal growth and development, grief and bereavement support, and emergency room interventions for children and families. The CLS would also provide nonmedical preparation for tests, surgeries, and other medical procedures; support during medical procedures; and outpatient consultation with families (American Academy of Pediatrics, Committee on Hospital Care and Child Life Council, 2014, reaffirmed 2018).

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1068, 1069, Introduction, Table 30.1

3.The nurse is implementing interventions to prevent physical stressors for a 9-year-old child receiving chemotherapy in the hospital. How will the nurse provide atraumatic care for this child?

- A) Use restraint or “holding down” of the child during the procedure to prevent injury.
- B) Have the parent stand near and/or rub the child’s feet during the procedure.
- C) Insert a saline lock if the child will require multiple doses of parenteral medications.
- D) Avoid using numbing techniques for multiple blood draws or IV insertion.

Ans: C

Feedback:

The nurse should insert a saline lock if the child will require multiple doses of parenteral medications. During painful or invasive procedures, the nurse should avoid traditional restraint or “holding down” of the child and use alternative positioning such as “therapeutic hugging.” If therapeutic hugging is not an option, the nurse could have the parent stand near the child’s head, not his feet to provide visual and verbal comfort. The nurse should also use numbing techniques for blood draws or IV insertion.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Understand

Integrated Process: Caring

Page and Header: 1068, Utilizing the Child Life Specialist

4.The nurse contacts a child life specialist (CLS) to work with children on a pediatric ward. What is the primary goal of the CLS?

- A) Decrease anxiety and fear during hospitalization and painful procedure.
- B) Keep children who are hospitalized distracted from pain.
- C) Perform medical procedures using atraumatic principles.
- D) Act as a liaison between the nurse and the child.

Ans: A

Feedback:

The CLS is a specially trained individual who provides programs that prepare children for hospitalization, surgery, and other procedures that could be painful (Child Life Council, 2010a, 2010b). The goal of the CLS is to decrease the anxiety and fear while improving and encouraging understanding and cooperation of the child. The CLS may use distraction techniques and act as a liaison, but that is not the primary goal of the CLS role. The CLS does not perform medical procedures.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1069, Minimizing Physical Stress During Procedures

5.The nurse is preparing a child and his family for a lumbar puncture. Which would be a primary intervention instituted to keep the child safe?

- A) Distraction methods
- B) Stimulation methods
- C) Therapeutic hugging
- D) Therapeutic touch

Ans: C

Feedback:

Therapeutic hugging (a holding position that promotes close physical contact between the child and a parent or caregiver) may be used for certain procedures or treatments where the child must remain still. Alternatively, distraction or stimulation (such as with a toy) can help to gain the child's cooperation, but therapeutic hugging would be used to keep the child safe during the procedure. Therapeutic touch is an energy therapy used to promote healing and decrease anxiety and stress and is not related to safety.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1069, Before the Procedure

6.The child life specialist (CLS) is preparing a 6-year-old child for a magnetic resonance imaging (MRI) scan. Which statement reflects the use of atraumatic principles when explaining the procedure?

- A) "You will be taken to a magnetic resonance imaging machine for an x-ray of your liver."
- B) "You may hear some loud noises when you are lying in the machine, but they won't hurt you."
- C) "You have nothing to worry about; the MRI machine is safe and will not cause you any pain."
- D) "Let's just get you to the x-ray department for your test and you'll see how simple it is."

Ans: B

Feedback:

When using atraumatic principles, the CLS would explain any sensations, such as noises that will be experienced. The language should be simple and at the child's developmental age; using the technical term for the machine might frighten the child. Telling the child there is nothing to worry about does not allay the child's fears. Allowing the child to experience the machine without explaining the sensations does not follow atraumatic principles.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Remember

Integrated Process: Nursing Process

Page and Header: 1072, Preventing or Minimizing Child and Family Separation:

Providing Child- and Family-Centered Care

7.The nurse uses family-centered care to provide care for children in a pediatric office. Upon what concept is family-centered care based?

- A) The family is the constant in the child's life and the primary source of strength.
- B) The care provider is the constant in the child's life and the primary source of strength.
- C) The child must be prepared to be his or her own source of strength during times of crisis.
- D) The wishes of the family should direct the nursing care plan for the child.

Ans: A

Feedback:

Family-centered care involves a partnership between the child, family, and healthcare providers in planning, providing, and evaluating care. Family-centered care enhances parents' and caregivers' confidence in their own skills and also prepares children and young adults for assuming responsibility for their own healthcare needs. It is based on the concept that the family is the constant in the child's life and the primary source of strength and support for the child.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Understand

Integrated Process: Communication and Documentation

Page and Header: 1073, Enhancing Communication

8.The nurse knows that effective communication with children and their parents is critical to providing atraumatic quality nursing care. Which statement accurately describes the communication patterns of children?

- A) Communication patterns are similar from one child to the next.
- B) Children often use more words than adults to describe their fears.
- C) Children rely more on nonverbal communication and silence.
- D) Parents more often require affective communication rather than neutral communication.

Ans: C

Feedback:

Children often use fewer words than adults and may rely more on nonverbal communication and silence. Communication patterns can vary greatly from one child to the next. Some children are very talkative, while others are quiet. Parents more often require neutral communication (i.e., verbal communication that is related to assessing and solving problems), whereas children more often desire affective communication (establishment of rapport and trust, giving comfort).

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1074, Box 30.3

9.The nurse is teaching the student nurse how to communicate effectively with children. Which method would the nurse recommend?

- A) Position self above the child's level to denote authority.
- B) If possible, communicate with the child apart from the parent.
- C) Direct questions and explanations to the child.
- D) Use the medical terms for body parts and medical care.

Ans: C

Feedback:

To communicate effectively with children, the nurse should direct questions and explanations to the child; position self at the child's level; allow the child to remain near the parent if needed, so the child can remain comfortable and relaxed; and use the child's or family's terms for body parts and medical care when possible.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 1074, Developmental Techniques for Communicating with Children

10. The nurse is implementing care for a hospitalized toddler. What communication technique would the nurse use with the child to reflect the child's developmental level?

- A) Allow the child extra time to complete thoughts.
- B) Communicate solely through play.
- C) Provide simple but honest and straightforward responses.
- D) Remain nonjudgmental to avoid alienation.

Ans: A

Feedback:

When working with toddlers and preschoolers, the nurse should allow them time to complete their thoughts. Though language acquisition at this age is exponential, it often takes longer for the young child to find the right words, particularly in response to a query. Infants communicate nonverbally and often through play. School-age children need simple but honest and straightforward responses, and nurses should be nonjudgmental with adolescents to avoid alienating them and to keep lines of communication open.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1074, 1075, Developmental Techniques for Communicating with Children, Table 30.3

11. The nurse is caring for a 4-year-old boy with Ewing sarcoma who is scheduled for a computed axial tomography (CAT) scan tomorrow. Which is the **best** example of therapeutic communication?

- A) Telling him he will get a shot when he wakes up tomorrow morning
- B) Telling him how cool he looks in his baseball cap and pajamas
- C) Using family-familiar words and soft words when possible
- D) Describing what it is like to get a CAT scan using words he understands

Ans: D

Feedback:

Describing what it is like to get a CAT scan using age-appropriate words is the best example of therapeutic communication. It is goal-directed, focused, and purposeful communication. Using family-familiar words and soft words is a good teaching technique. Telling him how cool he looks in his baseball cap and pajamas is not goal-directed communication. Telling the child he will get a shot when he wakes up could keep him awake all night.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1074, 1078, Developmental Techniques for Communicating with Children, Table 30.6

12. The nurse is caring for a 14-year-old boy with an osteosarcoma. Which communication technique would be least effective for him?

- A) Letting him choose juice or soda to take pills
- B) Seeking the teenager's input on all decisions
- C) Discussing the benefits of chemotherapy with him
- D) Avoiding undue criticism of noncompliance

Ans: A

Feedback:

Letting the child choose juice or soda to take pills is the least effective communication technique for an adolescent. It may provide some sense of control, but is not as effective as seeking his input on all care decisions, including him during discussions of the benefits of chemotherapy, and avoiding undue criticism of noncompliance.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Caring

Page and Header: 1074, Developmental Techniques for Communicating with Children

13. The nurse is educating a 16-year-old girl who has just been diagnosed with acute myelogenous leukemia. Which statement **best** demonstrates therapeutic communication?

- A) Discussing the treatment plan in detail for the next few weeks
- B) Using medical terms when describing the disease
- C) Assessing the adolescent's emotional status in private
- D) Talking about clothing and the stores where she shops

Ans: C

Feedback:

Therapeutic communication is goal directed and purposeful. Assessing the child's emotional status in private is goal directed and purposeful. Talking about clothing and shopping is not therapeutic communication unless its purpose is to find head coverings or wigs to mask hair loss and that information was not presented.

Discussing the treatment plan for the next few weeks in detail is too much information for someone who has just been diagnosed. Using medical terms when describing the disease does not promote understanding.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Culture and Spirituality

Page and Header: 1076, Tips for Communicating with Parents

14. The nurse is performing a cultural assessment of an Asian family that has a child hospitalized for leukemia. What is the **best** technique for providing culturally competent care for this family?

- A) Research the culture and base care on findings.
- B) Ask other Asians to explain their culture.
- C) Just ask the family about their culture and listen.
- D) Hire an interpreter to explain the family culture.

Ans: C

Feedback:

Understanding and respecting the family's culture helps foster good communication and improves child and family education about health care. The best way to assess the family's cultural practices is to ask and then listen. Determine the language spoken at home and observe the use of eye contact and other physical contact. Demonstrate a caring, nonjudgmental attitude and sensitivity to the child's and family's cultural diversity. An interpreter should be hired for a family who does not speak English.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1076, 1077, Teaching Children and Families, Table 30.4

15. The nurse is educating the parents of a 7-year-old girl who has just been diagnosed with epilepsy. Which teaching technique would be **most** appropriate?

- A) Assessing the parents' knowledge of the anticonvulsant medications
- B) Demonstrating proper seizure safety procedures
- C) Discussing the surgical procedure for epilepsy
- D) Giving the parents information in small amounts at a time

Ans: D

Feedback:

Parents, when given a life-altering diagnosis, need time to absorb information and to ask questions. Therefore, giving the parents information in small amounts at a time is best. The child has just been diagnosed with epilepsy, and surgical intervention is not used unless seizures persist in spite of medication therapy. Therefore, discussing surgery would be inappropriate at this time. Assessing the parents' knowledge of the anticonvulsant medications identifies a knowledge gap and need to learn, but it would be unreasonable to think that they would understand the medications when the diagnosis had just been made. Demonstrating proper seizure safety procedures is an effective way to present information to an adult.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1069, Minimizing Physical Stress During Procedures

16.The nurse is enlisting the parents' assistance for therapeutic hugging prior to an otoscopic examination. What should the nurse emphasize to the parents?

- A) "You will need to keep his hands down and his head still."
- B) "If this does not work, we will have to apply restraints."
- C) "If you are not capable of this, let me know so I can get some assistance."
- D) "I may need you to leave the room if your son will not remain still."

Ans: A

Feedback:

The nurse needs to provide a specific explanation of the parents' role and what body parts to hold still in a safe manner. Implying that the parents may not be capable or may have to leave the room is inappropriate. Telling the parents that restraints may be required is not helpful, does not teach, and may be perceived as a threat.

Format: Multiple Select

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1069, 1071, Box 30.2, During the Procedure

17. The nurse is preparing to perform a dressing change on a 13-year-old client who is being treated for burns he received 2 weeks ago. The client prefers not to take pain medication before the dressing change because it causes drowsiness. What nursing interventions would provide atraumatic care? Select all that apply.

- A) The nurse asks the client if he would like the television on during the dressing change.
- B) The nurse asks the client if a small group of nursing students can observe the dressing change.
- C) The nurse encourages the client to wear headphones to listen to music during the dressing change.
- D) The nurse encourages the parent to talk to the child about taking pain medication prior to the procedure.
- E) The nurse tells the client that the dressing change will not be performed unless pain medication is taken.

Ans: A, C

Feedback:

Minimizing stress prior to and during a procedure helps provide atraumatic care. Since the child chooses to not take pain medication, watching television or using headphones during the procedure provides distraction to the discomfort of the procedure. Students observing does not provide distraction. The child has chosen for the last 2 weeks to not receive pain medication, so having the parent talk to the child again does not provide atraumatic care. The nurse cannot force the child to take pain medication.

Format: Multiple Select

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 1074, Developmental Techniques for Communicating with Children

18.The nurse is admitting a 7-year-old child to the medical-surgical unit. The child answers questions with very short answers, makes little eye contact with the nurse, and looks to the parent to answer most questions. Which interventions would be appropriate during this admission assessment? Select all that apply.

- A) Tell the child that you are going to be their nurse so it would be best if they answered your questions.
- B) When asking questions, look at the child as well as the parent.
- C) Sit at the child's eye level during the admission questioning process.
- D) Stop asking questions for the present time and return later when the child feels more comfortable.
- E) Ask the child if they are always nervous around new people.

Ans: B, C

Feedback:

The goal is to establish rapport with the client and encourage communication. It is common for young children to be shy, so it is acceptable for the nurse to ask both the child and parent questions until the child feels comfortable talking with the nurse. Sitting at eye level is less intimidating and may help in establishing a trusting relationship. Telling the child that they need to answer the questions appears as condemning the child's behavior. Admission questions are important and can't be delayed until a later time. Asking the child if they are nervous around new people is intimidating and may further block communication.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1068, Introduction, Table 30.1

19. The nurse is caring for a child who is scheduled to begin chemotherapy. When planning education for the parents, what action by the nurse is **most** correct?

- A) Obtain a large classroom to allow the nurse to stand at the front and present information.
- B) Obtain a small conference room and arrange the chairs in a circle for both the nurse and family members to sit.
- C) Provide written information to the family and allow them to review it, with instructions to contact the nurse if there are additional questions.
- D) Provide a video of information to the family, with instructions to contact the nurse if there are additional questions.

Ans: B

Feedback:

Teaching is an important function of the nurse. When providing education, it is important to offer the information in an environment that is conducive to learning. A circular set of chairs will allow the nurse to face the parents during the exchange. A large class that has the nurse standing and the parents sitting does not provide the ability for a personal interaction needed for this session. Giving the parents information in writing should be done in conjunction with a face-to-face teaching session. Video information may be beneficial but does not replace the face-to-face teaching session.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Caring

Page and Header: 1074, 1075, Developmental Techniques for Communicating with Children

20. The nurse is caring for a teen who will be hospitalized for physical rehabilitation for an extended period of time after an auto accident. When working to promote a good working relationship with the teen, what action by the nurse will be **most** beneficial?

- A) Allow the teen to control the daily schedule.
- B) Keep your word with regard to promises and statements made to the teen.
- C) Allow the teen to make decisions about the plan of care.
- D) Include the teen in the weekly interdisciplinary care conferences

Ans: B

Feedback:

When working with teens, the establishment of trust and rapport is of the highest priority. Establishing trust can best be done by demonstrating consistency and keeping promises made to the teen. Control of the daily schedule may not be feasible. The teen can be allowed to have an impact on some elements of the plan of care but this does not have a greater importance than the establishment of trust. The teen may be able to attend care conferences, but this is not of the highest priority.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Caring

Page and Header: 1069 Minimizing Physical Stress During Procedures

21. A nurse is preparing to start an intravenous (IV) line in a child with severe pneumonia. The nervous child asks the nurse to wait until later to do the procedure. How should the nurse proceed?

- A) Inform the child that the procedure will have to happen immediately.
- B) Explain to the child why the IV is needed and find creative games to utilize while inserting the IV.
- C) Call the health care provider to see if the medication can be given in liquid form by mouth.
- D) Ask the parent to hold the child down so that the procedure can be completed.

Ans: B

Feedback:

When a procedure is necessary the nurse should use a firm, positive, and confident approach that provides the child with a sense of security. The child should be allowed to express feelings of anger, anxiety, fear or frustration but also know the procedure is necessary. In atraumatic care, the nurse should use a topical anesthetic at the IV site prior to the IV insertion to minimize pain. The parents should not be used as a restraint. This causes severe anxiety for the parent and the child. If an IV is prescribed to be placed, then most likely IV medications will be needed. Just because the child does not want the IV, the child should not be allowed to dictate care.

Format: Multiple Select

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Caring

Page and Header: 1069 Table 30.1 Suggestions for Atraumatic Care

22. A nurse is providing care for a child hospitalized with a diagnosis of aplastic anemia. In planning the child's care, which intervention(s) will assist the child in adapting to being hospitalized? Select all that apply.

- A) Provide opportunities for the parents to participate in the child's care.
- B) Encourage the parents to bring personal items to make the child feel more at home.
- C) Make the child's room off limits to invasive procedures.
- D) Discuss the plan of care out of earshot of the child.

- E) Answer any questions the child may have in generalized terms.

Ans: A, B, C

Feedback:

Atraumatic care is important to a child's well-being during hospitalization. Examples of this include providing opportunities for the parents and the child to participate in care, encouraging parents to bring personal items, and maintaining the child's room as a safe place, off limits to invasive procedures. It is important to be honest with the child and include the child in all plan of care discussions.

Format: Multiple Select

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Caring

Page and Header: 1069 Table 30.1 Suggestions for Atraumatic Care

23. A nurse is assisting the health care provider with suturing a laceration on a preschooler's leg. What distraction methods can the nurse perform to promote atraumatic care? Select all that apply.

- A) Ask the child to squeeze the nurse's hand.
- B) Sing a song and have the child sing along.
- C) Have the child blow bubbles.
- D) Allow the child to play with surgical instruments.
- E) Let the child suture a doll.

Ans: A, B, C

Feedback:

Distraction methods for preschoolers include asking the child to squeeze the nurse's hand, encouraging the child to count aloud, singing a song and having the child sing along, pointing out any pictures on the ceiling, having the child blow bubbles, and playing music appealing to the child. Suturing a doll or playing with surgical instruments would be activities better suited for school-age children.

Format: Multiple Select

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Caring

Page and Header: 1069 Table 30.1 Suggestions for Atraumatic Care

24. A 10-year-old child with sickle-cell anemia is frequently in the pediatric center of a hospital. What intervention can the nurse provide that will allow the child the sense of control that meets the goals promotes atraumatic care?

- A) Advocate for minimal laboratory blood draws.
- B) Promote family-centered care.
- C) Provide appropriate pain management.
- D) Maintain the child's home routine related to activities of daily living.

Ans: D

Feedback:

To promote a sense of control that meets the goals of atraumatic care, the nurse would attempt to maintain the child's home routine related to activities of daily living. In the hospital, the nurse would use primary nursing. The nurse would encourage the child to have a security item present if desired. Other measures include involving the child and family in planning care from the moment of the first encounter, empowering them by providing knowledge, allowing them choices when available, and making the environment more inviting and less intimidating. The nurse could advocate for minimum blood draws, but with the child's disease this will likely not happen. The nurse can help the child with reassurance and topical pain medication for laboratory draws to prevent the discomfort of multiple needle sticks. These actions, however, do not offer the child a sense of control.

Chapter 31

Format: Multiple Select

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1082, Principles of Health Supervision

1.The nurse is caring for children in a healthcare provider's office where health supervision is practiced. Which are some points of focus of health supervision? Select all that apply.

- A) Making referrals for all healthcare needs
- B) Monitoring disease incidence
- C) Optimizing the child's level of functioning
- D) Monitoring quality of care provided
- E) Teaching parents to prevent injury
- F) Providing care developed from national guidelines

Ans: C, E, F

Feedback:

Health supervision involves providing services proactively, with the goal of optimizing the child's level of functioning. It ensures the child is growing and developing appropriately and it promotes the best possible health of the child by teaching parents and children about preventing injury and illness (e.g., proper immunizations and anticipatory guidance). The framework for the health supervision visit is developed from national guidelines available through the U.S. Department of Health and Human Services (DHHS), the American Medical Association (AMA), and the American Academy of Pediatrics (AAP). Making referrals and monitoring disease incidence and quality of care provided may occur with this model, but they are not key focal points.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1082, Medical Home, Box 31.1

2.The nurse is providing care for children in a pediatric medical home. What is a characteristic of care in these types of facilities?

- A) All insurance except Medicaid is accepted.
- B) Ambulatory care is not provided
- C) A centralized database contains all child information.
- D) Continuity of care is provided from infancy through adulthood.

Ans: C

Feedback:

In a medical home, a centralized database contains all pertinent information. All insurance including Medicaid is accepted in the medical home and ambulatory care is provided. Continuity of care is also provided from infancy to adolescence.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1082, Wellness

3.The nurse is preparing a presentation to a local parent group about pediatric health supervision. Which would the nurse emphasize as the focus?

- A) Injury prevention
- B) Wellness
- C) Health maintenance
- D) Developmental surveillance

Ans: B

Feedback:

The focus of pediatric health supervision is wellness. Injury and disease prevention, health maintenance and promotion, and developmental surveillance are all critical components of wellness.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1082, Medical Home

4.A large portion of the nurse's efforts is dedicated to health supervision for children who use the facility as their primary medical contact. At which facility does the nurse work?

- A) An urgent care center
- B) A pediatric practice
- C) A mobile outreach immunization program
- D) A dermatology practice

Ans: B

Feedback:

A pediatric practice is most likely to fulfill the characteristics for primary care, also known as a medical home. An urgent care center does not provide preventative care activities. Mobile outreach would not provide for any care requiring hospitalization. A dermatology practice is unlikely to provide service outside its area of specialization.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Culture and Spirituality

Page and Header: 1083, Cultural Influences on Health Supervision

5.The nurse strives to provide culturally competent care for children in a health clinic that follows the principles of health supervision. Which nursing action reflects this type of care?

- A) The nurse treats all children the same regardless of their culture.
- B) The nurse negotiates a care plan with the child and family.
- C) The nurse researches the child's culture and provides care based on the findings.
- D) The nurse provides future-based care for culturally diverse children.

Ans: B

Feedback:

Optimal wellness for the child requires the nurse and the family to negotiate a mutually acceptable plan of care. The nurse must consider the culture of children because if the goals of the healthcare plan are not consistent with the health belief system of the family, the plan has little chance for success. Researching the culture is helpful, but the nurse should not assume all children follow cultural directives and base the care plan solely on the research. Most health promotion and disease prevention strategies in the United States have a future-based orientation; however, significant numbers of children belong to cultures with a present-based orientation. For these children, health promotion activities need shorter-term goals and outcomes to be useful.

Format: Multiple Select

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1083, 1084, Community Influences on Health Supervision

6.The nurse is aware that the community affects the health of its members. Which statements accurately reflect a community influence of health care? Select all that apply.

- A) A community can be a contributor to a child's health or be the cause of his or her illnesses.
- B) The child's health should be separated from the health of the surrounding community.

- C) Community support and resources are necessary for children with significant problems.
- D) Poverty has not been linked to an increase in health problems in communities.
- E) The breakdown of community and family support systems can lead to depression and violence.
- F) Ideally, the child's medical home is located outside the community.

Ans: A, C, E

Feedback:

A community can be a contributor to a child's health or be the cause of his or her illnesses. Community support and resources are necessary for children with significant problems since a close working relationship between the child's healthcare provider and community agencies is an enormous benefit to the child. Children from communities suffering the large-scale breakdown of family relationships and loss of support systems will be at increased risk for depression, violence and abuse, substance abuse, and HIV infection. The child's health cannot be totally separated from the health of the surrounding community. Poverty has been linked to low birthweight and premature birth, among other health problems. Ideally the child's medical home is within the family's community to reduce barriers such as lack of transportation, expense of travel, and time away from the parents' workplace.

Format: Multiple Select

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1084, Health Supervision and the Child with Chronic Illness

7.The nurse is conducting a psychosocial assessment of a child with asthma brought to the healthcare provider's office for a check-up. Which psychosocial issues may be assessed? Select all that apply.

- A) Health insurance coverage
- B) Transportation to healthcare facilities
- C) School's response to the chronic illness
- D) Past medical history

- E) Future treatment plans
- F) Health maintenance needs

Ans: A, B, C

Feedback:

Comprehensive health supervision includes frequent psychosocial assessments. Issues to be covered include health insurance coverage, transportation to healthcare facilities, financial stressors, family coping, and the school's response to the chronic illness. These are often stressful and emotionally charged issues. Past medical history, future treatment plans, and health maintenance needs would also be assessed; however, these are not psychosocial issues.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1084, Health Supervision and the Child Adopted Internationally

8.The nurse is examining a 2-year-old child who was adopted from Guatemala. What would be a **priority** screening for this child?

- A) Screening for congenital defects
- B) Screening for abuse
- C) Screening for childhood illnesses
- D) Screening for infectious diseases

Ans: D

Feedback:

Although all the screenings are important, health supervision of the internationally adopted child must include comprehensive screening for infectious disease. In 2017, approximately 4,714 children were adopted from countries outside the United States, many from areas with a high prevalence of infectious diseases (Intercountry Adoption, Bureau of Consular Affairs, U.S. Department of State, 2018). Health supervision of the internationally adopted child must include comprehensive screening for infectious diseases, disorders of growth and development, along with vision and hearing and any further testing based on diseases common in their country

of origin (Wilson & Simms, 2016). Proper screening is important not only to the child's health but also to the adopting family and the larger community.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 1085, Developmental Surveillance and Screening

9.The father of a 13-year-old boy reports his family has a strong history of depression. He questions screening for his son. What information should be provided by the nurse?

- A) "Are you having concerns about depression in your son?"
- B) "Screening in at risk teens should be completed annually after age 14."
- C) "Children should be screened for depression every year beginning at age 11."
- D) "If you notice that your son is having mood issues, we can certainly refer him for an evaluation with a therapist."

Ans: C

Feedback:

Academy of Pediatrics recommended screening tool [CRAFFT] and a depression screening is recommended annually beginning at age 11. It is clear that the parent is voicing concerns for his son's risk factors. The question asked does not provide the information being requested.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Create

Integrated Process: Communication and Documentation

Page and Header: 1085, Developmental Surveillance and Screening

10. During the health history, the mother of a 4-month-old child tells the nurse she is concerned that her baby is not doing what he should be at this age. What is the nurse's **best** response?

- A) "I'll be able to tell you more after I do his physical."
- B) "Fill out the questionnaire and then I can let you know."
- C) "Tell me what concerns you."
- D) "All mothers worry about their babies. I'm sure he's doing well."

Ans: C

Feedback:

Asking about the mother's concerns is assessment and is the first thing the nurse should do. The mother has intimate knowledge of the infant and can provide invaluable information that can help structure the nurse's assessment. Relying on the physical assessment ignores the value of the mother's input. A screening questionnaire is no substitute for a developmental assessment. Minimizing the mother's concerns reduces communication between the mother and the nurse.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1089, 1090, Hearing Screening, Table 31.3

11. A 3-year-old child is scheduled for a hearing screening. The nurse would prepare the child for screening by which method?

- A) Auditory brainstem response
- B) Evoked otoacoustic emissions
- C) Visual reinforcement audiometry
- D) Conditioned play audiometry

Ans: D

Feedback:

For children between the ages of 2 and 4 years, conditioned play audiometry would be an appropriate method for hearing screening. Auditory brainstem response and

evoked otoacoustic emissions are appropriate hearing screening methods for newborns through age 6 months. Visual reinforcement audiometry is appropriate for children ages 6 months to 2 years.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1089, Hearing Screening

12.A 2-week-old child responds to a bell during an initial health supervision examination. The child's records do not show that a newborn hearing screening was done. Which is the **best** action for the nurse to take?

- A) Do nothing because responding to the bell proves he does not have a hearing deficit.
- B) Immediately schedule the infant for a newborn hearing screening.
- C) Ask the mother to observe for signs that the infant is not hearing well.
- D) Screen again with the bell at the 2-month-old health supervision visit.

Ans: B

Feedback:

Guidelines for infant hearing screening recommend universal screening with an auditory brainstem response (ABR) or evoked otoacoustic emissions (EOAE) test by 1 month of age. All the other answers rely on behavioral observation. Studies have shown that behavioral observations are not a reliable method of screening for hearing loss.

Format: Multiple Select

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1085, Developmental Surveillance and Screening

13. The nurse is performing developmental surveillance for children at a medical home. Which infants are **most** at risk for developmental delays? Select all that apply.

- A) A child whose birthweight was 1,600 g
- B) A child whose parent has a mental illness
- C) A child raised by a single parent
- D) A child with a lead level above 10 mg/dL
- E) A child with hypertonia or hypotonia
- F) A child with gestational age more than 33 weeks

Ans: B, C, D, E

Feedback:

Risk factors for developmental delays include having a single parent, a parent with developmental disability or mental illness, hypertonia or hypotonia, birthweight less than 1,500 g, lead level above 5 mg/dL, and gestational age less than 33 weeks.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1085, Developmental Surveillance and Screening

14. The nurse is examining a 15-month-old child who was able to walk at the last visit and now can no longer walk. What would be the nurse's **best** intervention in this case?

- A) Schedule a full evaluation since this may indicate a neurologic disorder.
- B) Note the regression in the child's chart and recheck in another month.
- C) Document the findings as a developmental delay since this is a normal occurrence.
- D) Ask the parents if they have changed the child's schedule to a less active one.

Ans: A

Feedback:

Any child who "loses" a developmental milestone—for example, the child able to sit without support who now cannot—needs an immediate full evaluation, since this indicates a significant neurologic problem.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1107, Promoting Oral Health Care

15. During a physical assessment of a 5-month-old child, the nurse observes the first tooth has just erupted and uses the opportunity to advise the mother to schedule a dental examination for her baby. When is the correct time for the dentist visit?

- A) By the first birthday
- B) By the second birthday
- C) By entry into kindergarten
- D) By entry into first grade

Ans: A

Feedback:

The American Academy of Pediatric Dentistry recommends that a dentist examines the infant by his or her first birthday. Besides assessing routine oral health care, establishing a dental contact by the first birthday provides a resource for emergency dental care if it is needed.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1085, Components of Health Supervision

16. A mother and her 4-week-old infant have arrived for a health maintenance visit. Which activity will the nurse perform?

- A) Assess the child for an upper respiratory infection.
- B) Take a health history for a minor injury.
- C) Administer a varicella injection.
- D) Plot the child's head circumference on a growth chart.

Ans: D

Feedback:

The nurse will plot the head circumference of the child as part of developmental surveillance and screening. Assessing for an infection and taking a health history for an injury are not part of a health maintenance visit. Administering a vaccination for varicella would not occur until 12 months of age.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1085, 1088, Developmental Surveillance and Screening, Table 31.2

17. The nurse is screening a 6-year-old child for mental ability. Which test would the nurse use to assess intelligence?

- A) Denver Articulation Screening
- B) Denver PRQ
- C) Goodenough--Harris Drawing Test
- D) Parents' Evaluation of Developmental Status (PEDS)

Ans: C

Feedback:

The Goodenough--Harris Drawing Test is a nonverbal screen for mental ability (intelligence). The Denver Articulation Screening screens for articulation disorders. The Denver PRQ assesses personal-social, fine motor-adaptive, language, and gross motor skills. The PEDS screens for a wide range of developmental, behavioral, and family issues.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1091, Take Note!

18. When assessing the vision of a 2-month-old, what would the nurse use?

- A) Black-and-white checkerboard
- B) Red and blue circles
- C) Gray and blue animal drawings
- D) Green and yellow letters

Ans: A

Feedback:

For infants younger than 6 months of age, objects such as a black-and-white checkerboard or concentric circles are best because an infant's vision is more attuned to these high-contrast patterns than to colors. High-contrast animal figures such as pandas or Dalmatians also work well.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1087, Screening Tests

19. The nurse is performing a risk assessment of a 5-year-old and determines the child has a risk factor for cystic fibrosis. What type of screening would the nurse perform to confirm or rule out this disease?

- A) Universal screening
- B) Selective screening
- C) Hyperlipidemia screening
- D) Developmental screening

Ans: B

Feedback:

Selective screening is done when a risk assessment indicates the child has one or more risk factors for the disorder. In universal screening, an entire population is screened regardless of the child's individual risk. Selectively screening children at high risk for hyperlipidemia can reduce their lifelong risk of coronary artery disease; it does not screen for cystic fibrosis. Developmental screening is performed to detect developmental delays.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1089, 1091, Hearing Screening, Box 31.3

20. The nurse is caring for an infant who had hyperbilirubinemia requiring exchange transfusion. Based on this information, this infant is at risk for what type of disorder?

- A) Vision loss
- B) Hearing loss
- C) Hypertension
- D) Hyperlipidemia

Ans: B

Feedback:

There are many conditions that place an infant at risk for hearing loss, including an exchange transfusion with hyperbilirubinemia. A risk factor for vision loss is history of ocular structural abnormalities. Risk factors for systemic hypertension include preterm birth, very low birthweight, renal disease, organ transplant, congenital heart disease, or other illnesses associated with hypertension. A risk factor for hyperlipidemia is family history.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1091, Vision Screening

21.The nurse is performing a vision screening for a 4-year-old child. Which screening chart would be **best** for determining the child's visual acuity?

- A) Snellen
- B) Ishihara
- C) Allen figures
- D) Color Vision Testing Made Easy (CVTME)

Ans: C

Feedback:

The Allen figures chart is reliable for assessing visual acuity for a preschool child. The Snellen chart requires that the child has a good knowledge of the alphabet. This is not an expectation for a 4-year-old child. The Ishihara and CVTME charts are designed to assess color vision discrimination and not visual acuity.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1095, Principles of Immunization

22.The nurse is explaining the difference between active and passive immunity to the student nurse. Which statement accurately describes a characteristic of the process of immunity?

- A) Active immunity is produced when the immunoglobulins of one person are transferred to another.
- B) Passive immunity can be obtained by injection of exogenous immunoglobulins.
- C) Active immunity can be transferred from mothers to infants via colostrum or the placenta.

D) Passive immunity is acquired when a person's own immune system generates the immune response.

Ans: B

Feedback:

Passive immunity can be obtained by injection of exogenous immunoglobulins. Passive immunity is produced when the immunoglobulins of one person are transferred to another. Passive immunity can also be transferred from mothers to infants via colostrum or the placenta. Active immunity is acquired when a person's own immune system generates the immune response.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Remember

Integrated Process: Nursing Process

Page and Header: 1104, Hepatitis B Vaccine

23. The nurse is administering a hepatitis B vaccine to a child. What is the classification of this type of vaccine?

- A) Killed vaccines
- B) Toxoid vaccines
- C) Conjugate vaccines
- D) Recombinant vaccines

Ans: D

Feedback:

Recombinant vaccines use genetically engineered organisms. The hepatitis B vaccine is produced by splicing a gene portion of the virus into a gene of a yeast cell. The yeast cell is then able to produce hepatitis B surface antigen to use for vaccine production. Killed vaccines contain whole dead organisms; they are incapable of reproducing but are capable of producing an immune response. Toxoid vaccines contain protein products produced by bacteria called toxins. The toxin is heat-treated to weaken its effect, but it retains its ability to produce an immune response. Conjugate vaccines are the result of chemically linking the bacterial cell wall polysaccharide (sugar-based) portions with proteins.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1097, 1098, Haemophilus Influenzae Type B Vaccines

24. The nurse is discussing vaccination for *Haemophilus influenzae* type B (Hib) with the mother of a 6-month-old child. Which comment provides the **most** compelling reason to get the vaccination?

- A) "These bacteria live in every human."
- B) "Young children are especially susceptible to these bacteria."
- C) "You have a choice of two excellent vaccines."
- D) "Your child needs this final dose for protection."

Ans: B

Feedback:

The most compelling reason for vaccination is that the highest rate of illness from influenza is in children. The fact that Hib is an opportunistic bacterium that lives in humans and only causes disease when resistance is lowered may be difficult for the parent to understand. A choice of two vaccines conveys no benefits to the mother. Need for the final dose is vague.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1104, Hepatitis B Vaccine

25. The mother of a 15-month-old child is questioning the nurse about the need for the hepatitis B vaccination. Which comment provides the **most** compelling reason for the vaccine?

- A) "The most common side effect is injection site soreness."
- B) "This is a recombinant or genetically engineered vaccine."

- C) "Immunizations are needed to protect the general population."
- D) "This protects your child from infection that can cause liver disease."

Ans: D

Feedback:

Up to 90% of neonates infected with hepatitis B develop chronic carrier status and will be predisposed to cirrhosis and hepatic cancer. The mother is not questioning side effects, safety, or disease prevention in general. Therefore, it is best to speak to her concerns.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1104, Varicella Vaccine

26. After teaching the mother about follow-up immunizations for her daughter, who received the varicella vaccine at age 14 months, the nurse determines that the teaching was successful when the mother states that a follow-up dose should be given at which time?

- A) When the child is 20 to 36 months of age
- B) When the child is 4 to 6 years of age
- C) When the child is 11 to 12 years of age
- D) When the child is 13 to 15 years of age

Ans: B

Feedback:

A second dose of varicella vaccine should be given when the child is 4 to 6 years of age. Hepatitis A vaccine should be given to infants at age 12 months, with a repeat dose given in 6 to 12 months. The human papillomavirus (HPV) vaccine should be given to children beginning at age 11 to 12 years, with catch-up doses to begin at 13 to 14 years of age.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1107, Health Promotion

27.The nurse working in a community clinic attempts to establish a free vaccination program to refer low-income families. What is the key strategy for success when implementing a health promotion activity?

- A) Partnership development
- B) Funding for projects
- C) Finding an audience
- D) Adequate staffing

Ans: A

Feedback:

Partnership development is the key strategy for success when implementing a health promotion activity. Identifying key stakeholders from the community allows problems to be solved and provides additional venues for disseminating information. Funding, finding an audience, and staffing a project are elements of a public health promotion activity, but developing a partnership helps empower children and families at the individual and community levels to develop resources to optimize their health.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1108, Promoting Healthy Weight

28.The nurse is providing anticipatory guidance to an obese teenager. Which intervention would be **most** likely to promote healthy weight in teenagers?

- A) Make the focus of the program weight centered.
- B) Begin directly advising children about their weight at age 6.
- C) Focus physical activity on competitive sports and activities.

D) Obtain nutritional histories directly from the school-age child and adolescent.

Ans: D

Feedback:

Before providing education to school-age and teenage children, it is important to obtain nutritional histories directly from them because increasingly they are eating meals away from the family table. The focus of healthy weight promotion should be health centered, not weight centered. Linking success to numbers on a scale increases the possibility of developing eating disorders, nutritional deficiencies, and body hatred. The nurse can begin directly advising children on healthy foods starting at age 3. The focus of physical activity should be on noncompetitive, fun activities.

Format: Multiple Select

Client Needs: Psychosocial Integrity

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1084, Health Supervision and the Child with Chronic Illness

29. A mother of three brings her children in for their vaccinations. The mother tells the nurse that her mother recently died and her husband just lost his job due to his company downsizing. Which parenting behaviors is the nurse likely to observe? Select all that apply.

- A) The mother rarely looks at her infant when the nurse is assessing the child.
- B) The mother voices pride in the academic accomplishments of her 7-year-old child.
- C) The mother becomes very frustrated and tells the nurse she can't handle her toddler's temper tantrum.
- D) The mother asks if the nurse has suggestions on ways to potty train her toddler.
- E) The mother utilizes the correct size of infant car seat for her 3-month-old child.

Ans: A, C

Feedback:

When the family is faced with excessive stressors, the nurse may be able to ascertain the stress by observing the parent-child interaction during the health supervision visit. The nurse can learn much about the family dynamic by observing the family for behavioral clues. Lack of eye contact and care of the infant is a clue to family stress, as well as effective parenting techniques for behaviors such as temper tantrums.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Teaching/learning

Page and Header: 1092, Lead Screening

30. Three children in a family, ages 7 months, 4 years, and 9 years have been tested for lead poisoning. The two younger children's tests reflect elevated lead levels and they will be undergoing treatment. The children's mother questions why her younger children were not "spared" as their older sibling was. What response by the nurse is **most** correct?

- A) "Some children are better able to metabolize toxins such as lead after exposure."
- B) "Your older child has a stronger liver and kidneys, which have helped her to better rid her body of the lead."
- C) "Younger children are often impacted because of their play behaviors place them on the floors and they often put things into their mouths."
- D) "It is likely your older child may have had elevated levels earlier in life but has gotten over the condition."

Ans: C

Feedback:

Lead poisoning is a problem that affects children younger than age 6 the most due to the fact that they are crawling on the ground and putting things in their mouths, and their developing neurologic system is more sensitive to the effects of lead. The liver and kidney development is not an influence on the degree of lead found in children's blood specimens. Metabolism is not the greatest influence on the reason why only the younger children have been impacted by lead poisoning.

Chapter 32

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1118, Approaching the Child

1. The nurse is conducting a health history for a 9-year-old child with stomach pains.

What is a recommended guideline when approaching the child for information?

- A) Wear a white examination coat when conducting the interview.
- B) Allow the child to control the pace and order of the health history.
- C) Use quick deliberate gestures to get your point across.
- D) Do not make physical contact with the child during the interview.

Ans: B

Feedback:

The nurse should elicit the child's cooperation by allowing him or her control over the pace and order of the health history, or anything else that the child can control while still allowing the nurse to obtain the information needed. A white examination coat or all-white uniform may be frightening to children, who may associate the uniform with painful experiences or find it too unfamiliar. The nurse should use slow deliberate gestures rather than very quick or grand ones, which may be frightening to shy children. The nurse should make physical contact with the child in a nonthreatening way at first by briefly cuddling newborns before returning them to caregivers, laying a hand on the head or arm of toddlers and preschoolers, and warmly shaking the hand of older children and teens to convey a gentle demeanor.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Analyze

Integrated Process: Nursing Process

2. For which children would the nurse conduct an immediate comprehensive health history?

- A) A child who is brought to the emergency room with labored breathing
- B) A child who is a new client in a pediatric office
- C) A child who is a routine client and presents with signs of a sinus infection
- D) A child whose condition is improving

Ans: B

Feedback:

The purpose of the examination will determine how comprehensive the history must be. A comprehensive history would be performed for a new child in a pediatric office or a child who is admitted to the hospital. Also, if the healthcare provider or nurse practitioner rarely sees the child or if the child is critically ill, a complete and detailed history is in order, no matter what the setting. The child who has received routine health care and presents with a mild illness may need only a problem-focused history. In critical situations, some of the history taking must be delayed until after the child's condition is stabilized.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

3. The nurse is performing a health history on a 6-year-old boy who is having trouble adjusting to school. Which question would be **most** likely to elicit valuable information?

- A) "Do you like your new school?"
- B) "Are you happy with your teacher?"
- C) "Do you enjoy reading a book?"
- D) "What are your new classmates like?"

Ans: D

Feedback:

A careful conversation and interview with the child and/or the caregiver will provide important information about the child's health. Depending on the intent of the health assessment, many of the questions will be direct, and many will require the caregiver or child to answer simply "yes" or "no." In other than emergency situations, though, asking open-ended questions such as "What are your classmates like?" offers an excellent opportunity to learn more about the child's life.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1122, Review of Systems, Table 32.1

4. The nurse performing a health history on a child asks the parents if their child has experienced increased appetite or thirst. What body system is the nurse assessing with this question?

- A) Endocrine
- B) Genitourinary
- C) Hematologic
- D) Neurologic

Ans: A

Feedback:

Indicators of problems with the endocrine system include increased thirst, excessive appetite, delayed or early pubertal changes, and problems with growth. For the genitourinary system, the nurse would assess urinary patterns and genitals. For the hematologic system, the nurse would assess lymph nodes, skin color, and bruising. Signs of neurologic problems include numbness, tingling, difficulty learning, altered mood or ability to stay alert, tremors, tics, and seizures.

Format: Multiple Select

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1122, Functional Assessment

5.The nurse is questioning the parents of a 2-year-old child to obtain a functional history. Which topics might the nurse include? Select all that apply.

- A) The child's toileting habits
- B) Use of car seats and other safety measures
- C) Problems with growth and development
- D) Prenatal and perinatal histories
- E) The child's race and ethnicity
- F) Use of supplements and vitamins

Ans: A, B, F

Feedback:

The functional history should contain information about the child's daily routine, such as toileting habits, safety measures, and nutrition. Problems with growth and development would be covered in the developmental history. Prenatal and perinatal history is assessed in the past health history and the child's race and ethnicity is part of the demographics.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1122, Physical Examination

6.The nurse is conducting a physical examination of a child following a comprehensive health history. What should be the focus of the physical examination?

- A) The child
- B) The parents
- C) Chief complaint

D) Developmental age

Ans: C

Feedback:

The next step after the health history is the physical examination. It should focus on the chief complaint or any of the systems that engaged the nurse's critical thinking while obtaining the history. The child and parents are involved in the assessment, but the focus is on the health problem. The nurse should conduct a physical examination with the child's developmental age in mind.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1118, Communicating with the Child During the Health History

7. The nurse is teaching the student nurse how to perform a physical assessment based on the child's developmental stage. Which statement accurately describes a recommended guideline for setting the tone of the examination for a school-age child?

- A) Keep up a running dialogue with the caregiver, explaining each step as you do it.
- B) Include the child in all parts of the examination; speak to the caregiver before and after the examination.
- C) Speak to the child using mature language and appeal to his or her desire for self-care.
- D) Address the child by name; speak to the caregiver and do the most invasive parts last.

Ans: B

Feedback:

For a school-age child, the nurse should include the child in all parts of the examination and speak to the caregiver before and after the examination. For a newborn, the nurse should keep up a running dialogue with the caregiver, explaining each step as it is done. The nurse should speak to the early teen using mature language and appeal to his or her desire for self-care. For an infant, the nurse should address the child by name, and speak to the caregiver and do the most invasive parts last.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1125, Take Note!

8. Which would be least effective in gaining the cooperation of a toddler during a physical examination?

- A) Tell the child that another child the same age wasn't afraid.
- B) Allow the child to touch and hold the equipment when possible.
- C) Permit the child to sit on the parent's lap during the examination.
- D) Offer immediate praise for holding still or doing what was asked.

Ans: A

Feedback:

Toddlers are egocentric and telling the toddler how well another child behaved or cooperated probably will not help gain this child's cooperation. Allowing the child to touch and hold the equipment, permitting the child to sit on the parent's lap during the examination, and offering praise immediately for cooperating would foster cooperation.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

9.The nurse is performing a physical examination on a sleeping newborn. Which body system should the nurse examine **last**?

- A) Heart
- B) Abdomen
- C) Lungs
- D) Throat

Ans: D

Feedback:

If the infant is asleep, the nurse should auscultate the heart, lungs, and abdomen first while the baby is quiet. The nurse performs the assessment in a head-to-toe manner, leaving the most traumatic procedures, such as examination of the ears, nose, mouth, and throat, until last.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1125, 1126, Steps of the Physical Examination

10.The nurse is teaching the student nurse the sequence for performing the assessment techniques during a physical examination. What is the appropriate order?

- A) Inspection, palpation, percussion, auscultation
- B) Inspection, percussion, palpation, auscultation
- C) Palpation, percussion, inspection, auscultation
- D) Inspection, auscultation, palpation, percussion

Ans: A

Feedback:

The physical examination of children, just as for adults, begins with a systematic inspection: checking color, warmth, characteristics, and texture visually and smelling for any odor. Palpation follows inspection to validate observations. Next, percussion is used to determine the location, size, and density of organs or masses. The stethoscope is used last to auscultate the heart, lungs, and abdomen.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 1126, General Appearance

11. The nurse is examining the posture of a male toddler and notes lordosis. What would be the appropriate reaction of the nurse to this finding?

- A) Explain that the child will need a back brace.
- B) Refer the toddler to a physical therapist.
- C) Do nothing; this is a normal condition for toddlers.
- D) Notify the primary care healthcare provider about the condition.

Ans: C

Feedback:

The toddler demonstrates lordosis (swayback) and bowlegs, with a relatively large head and protuberant belly. This is a normal condition and requires no further attention.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1126, Temperature

12. The nurse is assessing the temperature of a diaphoretic toddler who is crying and being uncooperative. What would be the **best** method to assess temperature in this child?

- A) Oral thermometer
- B) Axillary method
- C) Temporal scanning
- D) Rectal route

Ans: B

Feedback:

The axillary method may be used for children who are uncooperative, neurologically impaired, or immunosuppressed or have injuries or surgery to the oral cavity. Since the child is crying and uncooperative, the oral method would not be a good choice. The accuracy of the temporal method may be affected by excessive sweating. The rectal route is invasive, not well accepted by children or parents, and probably unnecessary with the modern alternative methods now available.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1126, 1127, Temperature, Nursing Procedure 32.1

13. The nurse is preparing to take a tympanic temperature reading of a 4-year-old. In order to get an accurate reading, what does the nurse need to do?

- A) Pull the earlobe back and down.
- B) Direct the infrared sensor at the tympanic membrane.
- C) Pull the earlobe down and forward.
- D) Remove any visible cerumen from inside the ear canal.

Ans: B

Feedback:

The accuracy of tympanic temperature reading is dependent on appropriate technique. The nurse needs to be sure to direct the infrared sensor at the tympanic membrane. Since the child is older than age 3, the earlobe does not need to be pulled back and down. The nurse would not remove earwax from inside the ear canal.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1126, Temperature

14. A mother brings her 3-year-old daughter to the emergency department because the child has been vomiting and having diarrhea for the past 36 hours. When assessing this child's temperature, which method would be least appropriate?

- A) Oral
- B) Tympanic
- C) Rectal
- D) Axillary

Ans: C

Feedback:

Obtaining the child's temperature via the rectal route would be least appropriate because the child has diarrhea, and insertion of the thermometer might traumatize the rectal mucosa. Additionally, the rectal route is highly invasive and a child of this age fears body invasion. Using the oral route might be problematic due to the child's age and inability to cooperate, especially in light of the child's vomiting. However, it would not be as dangerous as obtaining a rectal temperature. The tympanic or axillary method would be the most appropriate method.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1128, Pulse, Table 32.3

15. The nurse is assessing heart rate for children on the pediatric ward. What is a normal finding based on developmental age?

- A) An infant's rate is 90 bpm.
- B) A toddler's rate is 150 bpm.
- C) A preschooler's rate is 130 bpm.
- D) A school-age child's rate is 50 bpm.

Ans: A

Feedback:

The normal heart rate for an infant is 80 to 150 bpm, for a toddler is 70 to 120 bpm, for a preschooler is 65 to 110 bpm, and for a school-age child is 60 to 100 bpm.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1128, Pulse, Table 32.3

16. The nurse is assessing the heart rate of a healthy school-age child. The nurse expects that the child's heart rate will be in what ranges?

- A) 80 to 150 bpm
- B) 70 to 120 bpm
- C) 65 to 110 bpm
- D) 60 to 100 bpm

Ans: D

Feedback:

The normal heart rate for a school-age child is 60 to 100 bpm, for an infant is 80 to 150 bpm, for a toddler is 70 to 120 bpm, and for a preschooler is 65 to 110 bpm.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1128, Pulse

17. The nurse is preparing to assess the pulse of an 18-month-old child. Which pulse would be **most** difficult for the nurse to palpate?

- A) Radial
- B) Brachial
- C) Pedal
- D) Femoral

Ans: A

Feedback:

In a child younger than 2 years of age, the radial pulse is very difficult to palpate, whereas the pedal, brachial, and femoral pulses are usually easily palpated.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Communication and Documentation

Page and Header: 1147, Table 32.5

18. While auscultating the heart of a 5-year-old child, the nurse notes a murmur that is soft and quiet and heard each time the heart is auscultated. The nurse documents this finding as what grade?

- A) Grade 1
- B) Grade 2
- C) Grade 3
- D) Grade 4

Ans: B

Feedback:

A grade 2 murmur is soft and quiet and is heard each time the chest is auscultated. A grade 1 murmur is barely audible and is heard at some times and not at other times. A grade 3 murmur is audible with intermediate intensity. A grade 4 murmur is audible and accompanied by a palpable thrill.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1147, Inspection

19. The parents of a 2-day-old girl are concerned because her feet and hands are slightly blue. How should the nurse respond?

- A) "Your daughter has acrocyanosis; this is causing her blue hands and feet."
- B) "Let's watch her carefully to make sure she does not have a circulatory problem."
- C) "This is normal; her circulatory system will take a few days to adjust."
- D) "This is a vasomotor response caused by cooling or warming."

Ans: C

Feedback:

The nurse should tell the parents that this is normal and that the baby's circulatory system is adjusting to extrauterine life. Using the technical term "acrocyanosis" would most likely scare the parents. Telling the parents that the child may have a circulatory problem is inaccurate as this is a normal variation. Acrocyanosis and the mottling caused by cooling and warming are two different variations.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1147, Palpation

20. A nurse is assessing the fontanelles of a crying newborn and notes that the posterior fontanel pulsates and briefly bulges. What do these findings indicate?

- A) Increased intracranial pressure
- B) Overhydration
- C) Dehydration
- D) These are normal findings

Ans: D

Feedback:

It is common to see the fontanel pulsate or briefly bulge if a baby cries.

Overhydration or increased intracranial pressure would cause a persistent bulging.

Dehydration would cause the fontanel to be sunken.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk -Potential

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1138, Neck

21. The nurse is assessing the neck of an 8-year-old child with Down syndrome.

Which finding would the nurse expect during the examination?

- A) Webbing
- B) Excessive neck skin
- C) Lax neck skin
- D) Shortened neck

Ans: C

Feedback:

Lax neck skin may occur with Down syndrome. Webbing or excessive neck skin folds may be associated with Turner syndrome. A shortened neck is expected in a child younger than age 4.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1148, Take Note!

22.The nurse is conducting a routine health assessment of a 3-month-old boy and notices a flat occiput. The nurse provides teaching and emphasizes the importance of tummy time. Which response by the mother indicates a need for further teaching?

- A) "I should have him sleep on his tummy."
- B) "I need to watch him during his tummy time."
- C) "I need to change his head position while he is in an upright chair."
- D) "His head has flattened due to the pressure of his head position."

Ans: A

Feedback:

The nurse needs to emphasize that the boy must be observed and awake during the recommended "tummy time" and to remind the mother that the baby should still sleep on his back. The other statements are correct.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1125, Take Note!

23.The nurse is measuring the blood pressure of a 12-year-old boy with an oscillometric device. The boy's reading is greater than the 90th percentile for gender and height. What is the appropriate nursing action?

- A) Repeat the reading with the oscillometric device.
- B) Repeat the blood pressure reading using auscultation.
- C) Measure the blood pressure in all four extremities.
- D) Measure the blood pressure with a Doppler.

Ans: B

Feedback:

The nurse should repeat the reading using auscultation. The nurse should not use the Doppler ultrasound method in this circumstance. The nurse would only measure the blood pressure in all four extremities with a child presenting with cardiac complaints.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1137, Hair and Nails

24. The nurse is inspecting the fingernails of an 18-month-old girl. What finding indicates chronic hypoxemia?

- A) Nails that curve inward
- B) Clubbing of the nails
- C) Nails that curve outward
- D) Dry, brittle nails

Ans: B

Feedback:

Clubbing of the nails indicates chronic hypoxemia related to either respiratory or cardiac disease. Nails that curve inward or outward may be hereditary or linked with injury, infection, or iron-deficiency anemia. Dry, brittle nails may indicate a nutritional deficiency.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1128, Measuring Oxygen Saturation

25. The nurse is using pulse oximetry to measure oxygen saturation in a 3-year-old girl. The nurse understands that falsely high readings may be associated with which situation or condition?

- A) A nonsecure connection
- B) Cold extremities
- C) Hypovolemia
- D) Anemia

Ans: D

Feedback:

Falsely high readings may be associated with anemia. Falsely low readings may be associated with cold extremities, hypovolemia, and a nonsecure connection.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1132, Body Measurements

26. Assessment reveals that a child weighs 73 lb and is 4 ft 1 in tall. The nurse calculates this child's body mass index as:

- A) 19.1
- B) 20.7
- C) 21.4
- D) 24.5

Ans: C

Feedback:

Body mass index is determined by dividing the child's weight (in pounds) by the child's height (in inches) squared and then multiplying this figure by 703. Thus, 73 lb divided by 49 in \times 49 in equals 0.0304 multiplied by 703 equals 21.37 or 21.4.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1144, Breasts

27.The nurse is teaching the student nurse about abnormal findings when assessing the breasts of children. What may be associated with renal disorders?

- A) Swollen nipples upon inspection of a newborn's breasts
- B) Tender nodule palpated under the nipple of a 10-year-old
- C) Observation of enlarged breast tissue in a male adolescent
- D) Observation of a supernumerary nipple along the mammary ridge

Ans: D

Feedback:

Supernumerary nipples are usually of no concern as they do not change over time, but they may be associated with renal disorders. Newborns of both genders may have swollen nipples from the influence of maternal estrogen, but by several weeks of age the nipples should be flat. A tender nodule palpated just under the nipple confirms pubertal changes and is a normal finding. Adolescent boys may develop gynecomastia (enlargement of the breast tissue) due to hormonal pubertal changes. When the hormone levels stabilize, male adolescents then have flat nipples.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1149, Genitalia and Anus

28.The nurse is inspecting the genitals of a prepubescent girl. Which is a normal sign of the onset of puberty?

- A) Appearance of pubic hair around 11 to 13 years old
- B) Swelling or redness of the labia minora
- C) Presence of labial adhesions
- D) Lesions on the external genitalia

Ans: A

Feedback:

Infants and young girls (particularly those of dark-skinned races) may have a small amount of downy pubic hair. Otherwise, the appearance of pubic hair indicates the onset of pubertal changes, sometimes prior to breast changes. Pubic hair generally begins to appear by age 11 years, with age 13 being the latest. Redness or swelling of the labia may occur with infection, sexual abuse, or masturbation. Lesions on the external genitalia may indicate sexually transmitted infection.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1118, Communicating with the Child During the Health History

29. A teenage client tells the nurse that she is being abused by her boyfriend, but she doesn't want her parents to know because they won't let her see him any longer.

What is the **best** response by the nurse?

- A) "It's my responsibility to tell your parents if you are in danger."
- B) "I understand your fear, but I am obligated to be sure your parents know you are in danger. Would you like for us to talk to them together?"
- C) "I won't tell them this time, but I must inform you that legally I must inform your parents if abuse is occurring. Next time it happens, I will have to tell them."
- D) "You need to tell them because the abuse isn't going to get any better. It will only escalate no matter what your boyfriend says."

Ans: B

Feedback:

The most empathetic and informative response is recognizing the teen's fear. This response also establishes trust by letting the client know what the nurse's responsibility is while also offering support by talking to the parents with the teen. Responding that the nurse won't inform the parents this time is incorrect because the nurse is legally bound to notify the parents if the child is in danger, as in the case of abuse.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Analyze

Integrated Process: Communication and Documentation

Page and Header: 1118, Approaching the Parent or Caregiver

30. The nurse is collecting information from the parents of a 3-year-old child about her sleeping patterns. Which question by the nurse will **best** elicit information from the parents?

- A) "How are things going at home?"
- B) "Is your child sleeping well at night?"
- C) "How many hours does your child sleep at night?"
- D) "What time does your child go to bed at night?"

Ans: C

Feedback:

Asking an open-ended question will provide the most opportunity for data to be collected from the parents. Asking how things are going at home is vague and may or may not give the needed information. Asking if the child is sleeping well is problematic, as the term "well" is subjective and may be interpreted differently by different individuals. Asking when the child goes to bed is a broad question that may not provide the needed information about the quantity of sleep being achieved by the child each night.

Chapter 33

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1159, Emergency Departments

1.The nurse educator working in the emergency room monitors the admission of children. For which admission diagnosis, should the nurse educator encourage the emergency room staff to be the **most** prepared?

- A) Mental health problems
- B) Injuries
- C) Respiratory disorders
- D) Gastrointestinal disorders

Ans: B

Feedback:

A major cause for illness and hospitalization in children is injuries from accidents; the top 10 nonfatal injuries are all unintentional (Centers for Disease Control and Prevention [CDC], 2019). Many times, a family's first experience with the acute care setting is the emergency department.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1165, Children's Reactions to Illness and Hospitalization

2.The nurse is caring for a 7-year-old girl hospitalized in isolation. The nurse notices that she has begun sucking her thumb and changing her speech patterns to those of a toddler. What condition is the girl manifesting?

- A) Regression
- B) Suppression
- C) Repression
- D) Denial

Ans: A

Feedback:

Sucking the thumb and changing of speech pattern (such as to baby talk) are signs of regression, a defense mechanism used by children to deal with unpleasant experiences by returning to a previous stage that may be more comfortable to the child. Suppression is a conscious inhibition of an idea or desire. Repression is an unconscious inhibition of an idea or desire. Denial would be exhibited by expressions of resignation instead of true contentment, not thumb sucking or baby talk.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1165, Separation Anxiety

3.The nurse is caring for an 8-year-old boy hospitalized for a bone marrow transplant. His parents are in and out of his room throughout the day. Which behaviors of the child would alert the nurse that he is in the second stage of separation anxiety?

- A) He ignores his parents when they return to his room.
- B) He cries uncontrollably whenever they leave.
- C) He forms superficial relationships with his caregivers.
- D) He sits quietly and is uninterested in playing and eating.

Ans: D

Feedback:

Separation anxiety consists of three stages—protest, despair, and detachment. In the protest stage, the child reacts aggressively to separation and exhibits great distress by crying, expressing agitation, and rejecting others who attempt to offer comfort. In the despair phase the child displays hopelessness by withdrawing from others, becoming quiet without crying, and exhibiting apathy, depression, lack of interest in play and food, and overall feelings of sadness. In the detachment stage the child shows interest in the environment, starts to play again, and forms superficial relationships with the nurses and other children. If the parents return, the child ignores them. A child in this phase of separation anxiety exhibits resignation, not contentment.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1167, Preschoolers

4. The nurse is caring for a 4-year-old girl who has been hospitalized for over a week with severe burns. Which would be a **priority** intervention to help satisfy this preschool child's basic needs?

- A) Encourage friends to visit as often as possible.
- B) Suggest that a family member be present with her 24 hours a day.
- C) Explain necessary procedures in simple language that she will understand.
- D) Allow her to make choices about her meals and activities as much as permitted.

Ans: C

Feedback:

Preschoolers fear mutilation and are afraid of intrusive procedures since they do not understand the body's integrity. They interpret words literally and have an active imagination; therefore, procedures should be demonstrated and/or explained in simple terms. Adolescents typically do not experience separation anxiety from being away from their parents; instead, their anxiety comes from being separated from friends, and therefore encouraging friends to visit is a priority intervention. Toddlers are especially susceptible to separation anxiety and would benefit from a family member being present as much as possible. School-age children are accustomed to controlling self-care and typically are highly social; they would benefit from being involved in choices about meals and activities.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 1183, Caring for Hospitalized Adolescents

5.The nurse is caring for a hospitalized 13-year-old girl, who is questioning everything the medical staff is doing and is resistant to treatment. How should the nurse respond?

- A) "Let's work together to plan your day along with your treatments."
- B) "The sooner you cooperate, the sooner you are going to leave."
- C) "If you are more cooperative, perhaps we can arrange a visit from friends."
- D) "Please don't make me call your parents about this."

Ans: A

Feedback:

Collaborating with the adolescent will provide the teen with increased control. The nurse should work with the teen to provide a mutually agreeable schedule that allows for the teen's preferences while incorporating the required nursing care. Threatening to call the parents will most likely promote further resistance. The nurse should try to immediately engage the girl, rather than making the nurse's cooperation conditional upon the girl's cooperation. Telling the girl that the sooner she cooperates, the sooner she will leave is inappropriate. The nurse is incorrectly implying that her behavior, rather than her medical needs, is going to determine when she will be discharged from the hospital.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1166, Loss of Control

6.The nurse is caring for a 10-year-old boy who is in traction. The boy has a nursing diagnosis of deficient diversional activity related to confinement in bed that is evidenced by verbalization of boredom and lack of participation in play, reading, and schoolwork. What would be the **best** intervention?

- A) Offer the child reading materials.
- B) Enlist the aid of a child life specialist.
- C) Encourage the child to complete his homework.
- D) Ask for the parents' assistance.

Ans: B

Feedback:

The nurse should enlist the aid of a child life specialist to provide suggestions for appropriate activities. Offering the child reading materials or encouraging him to complete his homework would most likely be met with resistance as he has already verbalized his boredom and disinterest in play, reading, and schoolwork. The parents could offer the child life specialist ideas about the boy's likes and dislikes; however, the child life specialist could offer expertise in assisting hospitalized children.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1166, Loss of Control

7.The nurse is caring for a 13-year-old girl hospitalized for complications from type 1 diabetes. The girl has a nursing diagnosis of powerlessness related to lack of control

of multiple demands associated with hospitalization, procedures, treatments, and changes in usual routine. How can the nurse help promote control?

- A) Ask the child to identify her areas of concern.
- B) Encourage participation of parents in care activities.
- C) Offer the girl as many choices as possible.
- D) Enlist the family's assistance in creating a time schedule.

Ans: C

Feedback:

The nurse needs to offer the girl as many choices as possible, such as options for food and drink (as her diet allows), hygiene, activities, or clothing options to promote feelings of individuality and control. Two of the other options engage the parents in the process. A 13-year-old girl is capable of making her own choices regarding activities, schedules, and routine, but she may not be able to identify her areas of concern.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1186, Therapeutic Play

8.The nurse is caring for an 8-year-old girl who requires numerous venipunctures and injections daily. The nurse understands that the child is exhibiting signs of sensory overload and enlists the assistance of the child life specialist. What should the therapeutic play involve to **best** deal with the child's stressors?

- A) Puppets and dolls

- B) Drawing paper and crayons
- C) Wooden hammer and pegs
- D) Sewing puppets with needles

Ans: D

Feedback:

The nurse understands that the child may benefit from supervised needle play to assist the child undergoing frequent blood work, injections, or intravenous procedures. The child life specialist can determine what form of therapeutic play is best, but the nurse can recommend interventions based on his or her knowledge of the specific child.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1186, Therapeutic Play

9. After teaching a group of students about therapeutic play, the instructor determines that additional teaching is needed when the students identify what as a characteristic of therapeutic play?

- A) Focus on coping
- B) Use of a highly structured format
- C) Dramatization of emotions
- D) Expression of feelings

Ans: B

Feedback:

Therapeutic play is nondirected play, focused on helping the child cope with feelings and fears. Real-life stressors and emotions can be acted out or dramatized, allowing the child to express his or her feelings.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 1185, Teaching Guidelines 33.2

10. The mother of a hospitalized child reports that her daughter, who is having some difficulty eating, just had a 4-ounce cup of ice chips. The nurse documents this on the child's intake flow sheet as how much?

- A) 2 ounces
- B) 4 ounces
- C) 6 ounces
- D) 8 ounces

Ans: A

Feedback:

Ice chips are included as fluid intake, and the amount is approximately equivalent to half the same amount of water. Therefore, the nurse would document this fluid intake as 2 ounces.

Format: Multiple Select

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1178, Hospitalization in Childhood

11. The nurse is preparing a nursing care plan for a child hospitalized for cardiac surgery. Which are examples of interventions that nurses perform in the "building a trusting relationship" stage? Select all that apply.

- A) Gathering information about the child using the child's own toys
- B) Preparing the child for a procedure by playing games
- C) Explaining in simple terms what will happen during surgery
- D) Allowing the child to devise an exercise plan following surgery
- E) Praising the child for how well he is doing following instructions
- F) Giving the child a favorite toy to cuddle following a painful procedure

Ans: B, C

Feedback:

The introduction phase involves the initial contact with children and their families, and it establishes the foundation for a trusting relationship. A trusting relationship can be built by using appropriate language, games, and play such as singing a song during a procedure, preparing the child adequately for procedures, and providing explanations and encouragement. In the decision-making phase, the nurse gives some control over to the child by allowing him to participate in making certain decisions, such as devising an exercise. Finally, the comfort and reassurance phase uses techniques such as praising the child and providing opportunities to cuddle with a favorite toy.

Format: Multiple Select

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1180, Preparing Children and Families for Hospitalization

12. The nurse is preparing a hospitalized 7-year-old girl for a lumbar puncture. Which actions would help reduce her stress related to the procedure? Select all that apply.

- A) Pretend to perform the procedure on her doll.
- B) Explain the procedure to her in medical terms.
- C) Do not allow her to see or touch the equipment.
- D) Teach her the steps of the procedure.
- E) Tell her not to pay attention to any sounds she might hear.
- F) Introduce her to the health care personnel.

Ans: A, D, F

Feedback:

Useful techniques for reducing stress in children include the following: perform nursing care on stuffed animals or dolls and allow the child to do the same, teach the child the steps of the procedure or inform him or her exactly what will happen during the hospital stay, introduce the child to the health care personnel with whom he or she will come in contact, avoid the use of medical terms, allow the child to handle some equipment, show the child the room where he or she will be staying, explain the sounds the child may hear, and let the child sample the food that will be served.

Format: Multiple Select

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1182, Communicating with the Child and Family

13. The nurse is completing an admission of a 10-year-old boy. Which actions will help the nurse establish a trusting and caring relationship with the child and his family? Select all that apply.

- A) The nurse should not minimize the child's fears by smiling.
- B) The nurse should initiate introductions.
- C) The nurse should not use formal titles at the introduction.
- D) The nurse should maintain eye contact at the appropriate level.
- E) The nurse should start communication with the child first and then move on to the family.
- F) The nurse should use age-appropriate communication with the child.

Ans: B, D, F

Feedback:

Regardless of the site of care, nursing care must begin by establishing a trusting, caring relationship with the child and family. The nurse should smile, start introductions, give his or her title, and let the child and family know what will happen and what is expected of them. The nurse should also maintain eye contact at the appropriate level, communicate with children at age-appropriate levels, and, with a younger child, start with the family first so the child can see that the family trusts you.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 1167, 1182, School-Age, Box 33.6

14. The nurse is caring for an 11-year-old girl preparing to undergo a magnetic resonance imaging (MRI) scan. Which statement would **best** help prepare the girl for the diagnostic test and decrease anxiety?

- A) "You won't hear a sound if you wear your headphones."
- B) "The machine makes a very loud rattle; however, headphones will help."
- C) "There are a variety of loud sounds you will hear."
- D) "The MRI scanner sounds like a machine gun."

Ans: B

Feedback:

The nurse should acknowledge that an MRI is loud and briefly describe the noises the machine makes. Then, the nurse should immediately offer a solution: headphones. Telling the girl she won't hear a sound is untrue. Telling her that there are loud sounds isn't enough and could increase anxiety. Comparing the MRI scanner to the sound of a machine gun is not appropriate imagery for a child.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1182, Caring for the Child in Isolation

15.The nurse is caring for a 10-year-old girl who is in an isolation room. Which intervention would be a **priority** intervention for this child?

- A) Reduce noise as much as possible.
- B) Provide age-appropriate toys and games.
- C) Discourage visits from family members.
- D) Put on mask prior to entering the room.

Ans: B

Feedback:

Children in this setting may experience sensory deprivation due to the limited contact with others and the use of personal protective equipment such as gloves, masks, and gowns. The nurse should stimulate the child by playing with her with age-appropriate toys/games. Reducing noise would be appropriate for sensory overload. The nurse should encourage the family to visit often, introduce himself or herself before entering the room, and allow the child to view his or her face before applying a mask.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1173, 1174, Providing Preoperative Teaching, Table 33.1

16.An adolescent is scheduled for outpatient arthroscopic surgery on his knee next week. As part of preparing him for the procedure, which action would be **most** appropriate?

- A) Discussing the events with the adolescent and his mother upon arrival the morning of the procedure
- B) Providing detailed explanations of the procedure at least a week in advance of the procedure
- C) Encouraging the parent to stay with the adolescent as much as possible before the procedure
- D) Answering the adolescent's questions with simple answers, encouraging him to ask the surgeon

Ans: B

Feedback:

The adolescent needs a detailed explanation about the procedure at least 7 to 10 days beforehand. Waiting until the morning of the procedure would be inappropriate. However, information could be clarified, and additional questions could be answered at this time. Having the parent stay with the adolescent is something that the adolescent would need to decide; he may or may not want a parent present. Referring the adolescent to the surgeon for his questions is inappropriate and ignores the adolescent's desire for control and information.

Format: Multiple Select

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1176, 1183, Table 33.2, Caring for Hospitalized Toddlers

17. The nurse is providing developmentally appropriate care for a toddler hospitalized for observation following a fall down the steps. Which measures might the nurse consider when caring for this child? Select all that apply.

- A) Use the en face position when holding the toddler.
- B) Use a bed for toddlers who have an adult present.
- C) Avoid leaving small objects that can be swallowed in the bed.
- D) Explain activities in concrete, simple terms.
- E) Allow the child to select meals and activities.
- F) Encourage parents to stay to prevent separation anxiety.

Ans: C, F

Feedback:

For a toddler, the nurse would avoid leaving small objects that can be swallowed in the bed and encourage parents to stay to prevent separation anxiety. The nurse would use the en face position when holding an infant and use a bed only for the older toddler who has an adult present in the room at all times. The nurse would explain activities in concrete, simple terms for a preschooler and allow a school-age child to select meals and activities.

Format: Multiple Select

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1176--1178, Restraining Children to Maintain Safety

18. The nurse is ordered to apply restraints to a toddler who keeps pulling at the tubes in his arm. Which criteria must occur to ensure proper use of these restraints? Select all that apply.

- A) The nurse must check the restraints every 15 minutes while they are in place.
- B) Secure the restraints with ties to the side rails, not the bed or crib frame.
- C) Assess the temperature of the affected extremities, pulses, and capillary refill every 15 minutes after placement.
- D) Use a clove-hitch type of knot to secure the restraints with ties.
- E) Remove the restraint every 2 hours to allow for range of motion and repositioning.
- F) Encourage parent participation, providing continuous explanations about the reasons and time frame for restraints.

Ans: D, E, F

Feedback:

The nurse should use a clove-hitch type of knot to secure the restraints with ties, remove the restraint every 2 hours to allow for range of motion and repositioning, and encourage parent participation, providing continuous explanations about the reasons and time frame for the restraints. The nurse must check restraints 15 minutes following initial placement and then every hour for proper placement and secure the restraints with ties to the bed or crib frame, not the side rails. The nurse should also assess the temperature of the affected extremities, pulses, and capillary refill, initially after 15 minutes and then every hour after placement.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1174, Use of Restraints

19. The nurse is caring for a 7-year-old boy who needs his left leg immobilized. What is the **priority** nursing intervention?

- A) Enlist the assistance of a child life specialist.
- B) Explain to the boy that he must keep his leg very still.
- C) Apply a clove-hitch restraint to the boy's left leg.
- D) Explain that a restraint will be applied if he cannot hold still.

Ans: B

Feedback:

An explanation about the desired goal is necessary and appropriate for a 7-year-old child to understand what is required. In many cases, this will be all that is needed. Explaining that a restraint will be applied if the boy cannot hold still will likely be perceived as a threat or punishment. All alternative measures need to be tried before the use of restraints. Enlisting the assistance of the child life specialist is not a priority.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1178, Providing Safe Transportation Within the Hospital

20. The nurse is transporting a 6-month-old with a suspected blood disorder to the nursery. What is the **most** appropriate method of transporting the child by the nurse?

- A) A wagon with rails

- B) Cradle hold
- C) A crib with rails
- D) Over-the-shoulder

Ans: D

Feedback:

Transportation of all children should utilize age-appropriate equipment to ensure the safety of the client. A 6-month-old should be transported in a crib with the rails in the highest possible position. A wagon with rails is for an older child.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1184, Providing Oral Hygiene

21. The nurse is caring for an immunosuppressed 3-year-old girl and is providing teaching to the mother about proper oral hygiene. Which response from the mother indicates a need for further teaching?

- A) "I really need to carefully check for skin breakdown."
- B) "I must really scrub her teeth and gums well."
- C) "I must use a soft toothbrush."
- D) "I can use a soft gauze sponge to care for her gums."

Ans: B

Feedback:

The nurse should caution the mother that overly vigorous brushing should be avoided as it can injure or irritate the gums. The other statements are recommended guidelines for care.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 1174--1176, Use of Restraints

22. When preparing to apply a restraint to a child, what would be **most** important for the nurse to do?

- A) Expect to keep the restraint on for at least 8 hours.
- B) Explain that safety, not punishment, is the reason for the restraint.
- C) Plan to use a square knot to secure the restraint to the side rails.
- D) Use a limb restraint rather than a jacket restraint for most issues.

Ans: B

Feedback:

Before applying a restraint, the nurse needs to explain the reason for the restraint to the child, emphasizing that the restraint is for safety, not to punish the child. The least restrictive type of restraint should be used, and it should be applied for the shortest time necessary. A clove-hitch knot is used to secure the restraint with ties to the bed or crib frame, not the side rails.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1188, Preparing the Child and Family for Discharge

23. The nurse is providing discharge planning for a 12-year-old boy with multiple medical conditions. What would be the **best** teaching method for this child and his family?

- A) Demonstrate the care and ask for a return demonstration.
- B) Provide and review educational booklets and materials.
- C) Provide a written schedule for the child's care.
- D) Provide a trial period of home care.

Ans: D

Feedback:

Parents of children with multiple medical needs may benefit from a trial period of home care. This occurs while the child is still in the hospital, but the parents or caregivers provide all of the care that the child requires. The other options are also important teaching methods, but a trial period is the best solution for a child with multiple medical conditions.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1157, Community Health Nursing

24.The nurse is working as a community health care nurse. What would be the nurse's focus when providing care of the child?

- A) Providing care to the individual and family in acute care settings
- B) Providing care to the indigent in family care settings
- C) Providing care in geographically and culturally diverse settings
- D) Providing care for particular age groups or particular diagnoses

Ans: C

Feedback:

Community health nurses work in geographically and culturally diverse settings. They address current and potential health needs of the population or community.

Community-based nursing focuses more on providing care to the individual or family (which, of course, impacts the community) in settings outside of acute care. They promote and preserve the health of a population and are not limited to particular age groups, income levels, or diagnoses.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1157, Community Health Nursing

25.The nurse working in community nursing uses epidemiology as a tool. What information can be obtained using this process?

- A) Health needs of a population

- B) Cultural needs of a population
- C) Income levels of a population
- D) Mortality rates of a population

Ans: A

Feedback:

Epidemiology can help determine the health and health needs of a population and assist in planning health services. Community health nurses perform epidemiologic investigations in order to help analyze and develop health policy and community health initiatives. The nurse provides culturally competent care but does not use epidemiology to determine culture, income levels, or mortality rates of children.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1161, Schools

26. When speaking to a group of parents at a local elementary school, the nurse describes school nursing as a specialized practice of nursing based on the fact that a healthy child has a better chance to succeed in school. What **best** describes the strategy school nurses use to achieve student success?

- A) They coordinate all school health programs.
- B) They link community health services.
- C) They work to minimize health-related barriers to learning.
- D) They promote student health and safety.

Ans: C

Feedback:

School nurses work to remove or minimize health barriers to learning to give students the best opportunity for academic success. Coordinating school health programs, linking community health programs, and promoting health and safety are individual components within the ultimate goal of removing or minimizing health barriers.

Format: Multiple Select

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1162, 1163, Home Health Care

27. The nurse referring a child to home care services discusses the advantages and disadvantages with the child's family. What are disadvantages of this method of health care? Select all that apply.

- A) The nurse is performing care of the child in the family's home.
- B) The home care nurse is not always equipped to perform technical care.
- C) The out-of-pocket cost of home care is more expensive.
- D) The technical procedures may be overwhelming for the family.
- E) The financial burden may cause more stress for the family.
- F) The child does not receive continuity of care provided in the hospital setting.

Ans: A, C, D, E

Feedback:

There are some disadvantages to home care. The presence of health care professionals in the home can be an intrusion on family privacy. Financial issues can become a large burden: families may have higher out-of-pocket costs if their insurance does not reimburse for home care. Having one parent at home full time and not earning an income can contribute to increased financial strain, not to mention social isolation of that parent. All of these can lead to increased stress on family members. Also, caring for children with complex medical needs can be overwhelming for some families. The home care nurse should arrange for continuity of care for the child.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1157, Shifting Responsibilities From Hospital-Based to Community-Based Nursing Care

28. The nurse working with children in a hospital setting notes that they are being discharged earlier and earlier. Which is a primary reason for this trend?

- A) Nursing shortages
- B) Increased funding for home care
- C) National healthcare initiatives
- D) Cost containment

Ans: D

Feedback:

Over the past century changes in health care, such as strained healthcare funding, shorter hospital stays, and cost containment, have led to a shift in responsibilities of care for children from the hospital to homes and communities. Nursing shortages influence the delivery of health care. National healthcare initiatives may or may not affect earlier discharge to home health care.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1165, Separation Anxiety

29. The nurse caring for a child on a pediatric intensive care unit notices that when the parents go to work the child is very angry and cries easily. What does the nurse suspect is occurring with this client?

- A) Protest phase of separation anxiety
- B) Regressive behavior
- C) Detachment from the parents
- D) Despair

Ans: A

Feedback:

The first phase of separation anxiety, protest, occurs when the child is separated from the parents or primary caretaker. This phase may last from a few hours to several days and is characterized by crying, expressing agitation, rejecting others who attempt to offer comfort, anger, and inconsolable grief.

Chapter 34

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1198, 1199, Providing Ongoing Follow-Up of the Former Premature Infant

1. The nurse is teaching a group of parents with premature infants about the various medical and developmental problems that may occur. The nurse determines that additional teaching is needed when the group identifies what as a problem?

- A) Sudden infant death syndrome
- B) Hydrocephalus
- C) Peptic ulcer
- D) Bronchopulmonary dysplasia

Ans: C

Feedback:

Gastroesophageal reflux disease, not peptic ulcer, is a medical problem that commonly affects premature infants. Myriad problems may occur, including sudden infant death syndrome, hydrocephalus, bronchopulmonary dysplasia, cardiac changes, growth retardation, nutrient deficiencies, bradycardia, rickets, inguinal or umbilical hernias, visual problems, hearing deficits, delayed dentition, and growth delays.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1195, Effects of Special Needs on the Child

2.The nurse is caring for a toddler with special needs. Which developmental tasks related to toddlerhood might be delayed in the child with special needs?

- A) Developing body image
- B) Developing peer relationships
- C) Developing language and motor skills
- D) Learning through sensorimotor exploration

Ans: C

Feedback:

In special needs children, developmental delays may occur in all stages. In particular, motor and language skill development may be delayed if the toddler is not given adequate opportunities to test his or her limits and abilities. Development of body image may be hindered in the preschooler due to painful exposures and anxiety. Development of peer relationships may be delayed in the school-age and adolescent child. The infant's ability to learn through sensorimotor exploration may be impaired due to lack of appropriate stimulation, confinement to a crib, or increased contact with painful experiences.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1196, Stressors of Daily Living

3.The nurse is providing home care for a 1-year-old girl who is technologically dependent. Which intervention will **best** support the family process?

- A) Finding an integrated health program for the family
- B) Teaching modifications of the medical regimen for vacation
- C) Assessing family expectations for the special needs child
- D) Creating schedules for therapies and interventions

Ans: D

Feedback:

Coordinating care with the schedules and capabilities of the parents provides the greatest support for the family. It gives them a sense of order and control. Integrated healthcare programs may not be available in the family's area. Teaching therapy modifications for travel and assessing family expectations are not supportive interventions.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1196, Vulnerable Child Syndrome

4.The nurse is caring for families with vulnerable child syndrome. Which situation would be **most** likely to predispose the family to this condition?

- A) Having a postterm infant
- B) Having an infant who is reluctant to feed properly
- C) Having a child diagnosed with impetigo at age 10
- D) Having a child with juvenile diabetes

Ans: B

Feedback:

"Vulnerable child syndrome" is a clinical state in which the parents' reactions to a serious illness or event in the child's past continue to have long-term psychologically harmful effects on the child and parents for many years (Fortin, & Downes, 2019). Risk factors for the development of vulnerable child syndrome include preterm birth, congenital anomaly, newborn jaundice, handicapping condition, an accident or illness that the child was not expected to recover from or crying or feeding problems in the first 5 years of life.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1196, Stressors of Daily Living

5.A 7-year-old boy has reentered the hospital for the second time in a month. Which intervention is particularly important at this time?

- A) Assessing his parents' coping abilities
- B) Seeking his parents' input about their child's needs
- C) Educating his family about the procedure

D) Notifying the care team about his hospitalization

Ans: A

Feedback:

Transition times, such as when the child reenters the hospital, create additional stress on the parents and child. Assessing the parents' coping abilities is particularly important at this time. Seeking parental input, educating about a procedure, and notifying the care team are basic activities of family-centered care and care coordination.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1201, Providing Resources to the Child and Family

6.The nurse is caring for a special needs infant. Which intervention will be **most** important in helping the child reach his or her maximum developmental potential?

- A) Directing her parents to an early intervention program
- B) Monitoring her progress in elementary school
- C) Serving on an individualized education program committee
- D) Preparing a plan for her to transition to college

Ans: A

Feedback:

Early intervention is critical to maximizing the child's developmental potential by laying the foundation for health and development. While important, intervention in

elementary or secondary school does not have the impact of early intervention. When the time arrives, it is important to have a written plan for transition to college, if this is a possibility for the grown child.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1195, Effects of Special Needs on the Child

7.The nurse is caring for a 4-year-old girl with special care needs in the hospital.

Which intervention would have the **most** positive effect on this child?

- A) Taking her on an adventure down the hall
- B) Helping her do a simple craft project
- C) Introducing her to children in the playroom
- D) Limiting the staff providing care for her

Ans: A

Feedback:

Preschool-age children need to develop a sense of initiative and helping the child to explore her area of the hospital would help accomplish this developmental need. Craft projects and introducing the child to other children would help build a sense of industry and peer relationships, both of which are needs of the school-age, not preschool, child. Limiting the number of people providing care is a trust-building intervention, beginning in infancy.

Format: Multiple Select

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1200, Identifying and Managing Failure to Thrive and Feeding Disorders in Children with Special Needs

8.The nurse is caring for infants with failure to thrive (FTT). Which infants would be at risk for this condition? Select all that apply.

- A) A newborn baby with tetralogy of Fallot
- B) An infant with a cleft palate
- C) An infant born to a diabetic mother
- D) An infant born to an impoverished mother
- E) An infant with bronchopulmonary dysplasia
- F) An infant born to a teenage mother

Ans: A, B, D, E

Feedback:

Infants and children with cardiac or metabolic disease, chronic lung disease (bronchopulmonary dysplasia), cleft palate, or gastroesophageal reflux disease are at particular risk for FTT. Also, poverty is a known contributing risk factor. An infant born to a diabetic mother or an infant born to a teenage mother does not have increased risk for FTT.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1200, Identifying and Managing Failure to Thrive and Feeding Disorders in Children with Special Needs

9. The nurse is weighing an underweight infant diagnosed with failure to thrive (FTT) and notes that the baby does not make eye contact and is less active than the other infants. What would be a probable cause for the FTT related to the infant's body language?

- A) Congenital heart defect
- B) Cleft palate
- C) Gastroesophageal reflux disease
- D) Maternal abuse

Ans: D

Feedback:

Infants with FTT related to maternal neglect may avoid eye contact and be less interactive than other infants. Inorganic causes of FTT include neglect, abuse, behavioral problems, lack of appropriate maternal interaction, poor feeding techniques, lack of parental knowledge, or parental mental illness.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1197, 1198, Early Discharge Planning, Box 34.2

10. Which would be least appropriate to include in the discharge plan for a medically fragile child?

- A) Assisting with referrals for financial support
- B) Arranging for necessary care equipment and supplies
- C) Assessing the family's home environment
- D) Encouraging passive caregiving

Ans: D

Feedback:

As part of the discharge plan for a medically fragile child, the nurse would encourage active caregiving by the parents to help them increase their self-confidence in the child's care. Assisting with referrals, arranging for equipment and supplies, and determining the adequacy of the home environment are important aspects of the discharge plan.

Format: Multiple Select

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1201, Educational Opportunities for the Special Needs Child

11. The nurse is looking into the Individuals with Disabilities Education Improvement Act of 2004 to help provide resources for a client with multiple chronic diseases. What are mandates of this legislation? Select all that apply.

- A) The law mandates government-funded care coordination and special education for children up to 8 years of age.
- B) This early intervention program is a state-funded program run at the federal level.
- C) This federal law allows each state to define “developmental disability” differently.
- D) An evaluation of the child’s physical, language, emotional, and social capabilities is performed to determine eligibility.
- E) The primary care nurse manages the developmental services and special education that the child requires.
- F) The goal is to maintain a natural environment, so most services occur in the home or day care center.

Ans: C, D, F

Feedback:

The Individuals with Disabilities Education Improvement Act of 2004 mandates government-funded care coordination and special education for children up to 3 years of age. Federal law allows each state to define “developmental disability” differently, but in general an evaluation of the child’s physical, language, emotional, and social capabilities is performed by qualified personnel to determine eligibility. The goal of the program is that the child receives services in a “natural environment,” so most services occur in the home or day care center. This early intervention program is administered through each state. Children who qualify for services receive care coordination, and the service coordinator manages the developmental services and special education that the child requires.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1203, 1204, Assisting the Adolescent with Special Health Needs
Making the Transition to Adulthood

12. The nurse is reviewing the Adolescent Health Transition Project's recommended schedule for transition planning. According to the schedule, at what age should the nurse explore healthcare financing for young adults?

- A) 12 years old
- B) 14 years old
- C) 17 years old
- D) 19 years old

Ans: C

Feedback:

By age 14, the nurse should ensure that a transition plan is initiated and that the individualized education plan (IEP) reflects post--high school plans. By age 17, the nurse should explore healthcare financing for young adults. The nurse should check the teen's eligibility for Supplemental Security Income (SSI) the month the child turns 18. By age 21, the nurse should ensure that the young adult has registered with the Division of Developmental Disabilities for adult services if applicable.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1203, Assisting the Adolescent with Special Health Needs Making the Transition to Adulthood

13. The nurse is caring for a 14-year-old girl with special health needs. What is the **priority** intervention for this child?

- A) Encouraging the parents to promote the child's self-care
- B) Assessing the child for signs of depression
- C) Discussing how her care will change as she grows
- D) Monitoring for compliance with treatment

Ans: D

Feedback:

The priority intervention is monitoring for compliance with treatment. The girl is struggling to fit in with her peers and may try to hide or ignore her illness. Monitoring for depression and encouraging self-care have a lesser impact on the child's physical health. A transition plan to adulthood may be initiated some time in midadolescence.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1203, 1204, Assisting the Adolescent with Special Health Needs Making the Transition to Adulthood

14. The nurse is helping a 20-year-old woman transition to adult care. Which would be the **most** important role of the nurse following a successful transition?

- A) Teacher
- B) Consultant
- C) Care provider
- D) Advocate

Ans: B

Feedback:

Transition planning involves multidisciplinary care coordination; acknowledgement of the changing roles among the youth, family, and healthcare professionals; and fostering of the youth's self-determination skills. Prior to transition, educating the client is the most important role of the nurse. After the transition, the nurse serves as a consultant to the adult office in relation to the teen's needs. The nurse consults with a transition services coordinator or other service agency as available in the local community.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1204, The Dying Child

15. The nurse caring for young children in a hospice setting is aware of the following statistics related to the occurrence of death in children. Which statement accurately reflects one of these statistics?

- A) Each year, about 50,000 children die in the United States; of those, about 15,000 are infants.

- B) It is unusual for a child's chronic illness to progress to the point of becoming a terminal illness.
- C) Despite strides made, diabetes remains the leading cause of death from disease in all children older than the age of 1 year.
- D) Congenital defects and traumatic injuries are the more common causes of diseases leading to death.

Ans: D

Feedback:

Diseases can lead to terminal illness in children, with congenital defects and traumatic injuries being the more common causes. Each year, the death rate for infants is 5.87 per 1,000 live births (Xu, et al., 2018). In many cases, a child's chronic illness may progress to the point of becoming a terminal illness. Cancer remains the leading cause of death from disease in all children older than the age of 1 year (CDC, 2019).

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1204, End-of-Life Decision Making

16. The nurse is providing home care for the family of an 8-year-old boy who is dying of leukemia. Which action will be **most** supportive to the parents of the child?

- A) Encouraging organ and tissue donation
- B) Being patient with parental indecision
- C) Getting prior authorization for treatments

D) Explaining how anorexia is a natural process

Ans: B

Feedback:

It is critical to be patient with parents who may vacillate when making decisions. Give them the information and time they need to make decisions and avoid being judgmental. Explaining about anorexia and encouraging organ donation may be discussed when the parents indicate they are concerned. Getting prior authorization facilitates care delivery and is not a supportive intervention.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1205, Hospice Care

17. The nurse is providing palliative care for a 9-year-old boy in hospice. Which is unique to hospice care for children?

- A) Encouraging visits from friends and family
- B) Educating parents about terminal dehydration
- C) Prolonging treatment that might possibly help
- D) Treating constipation to relieve abdominal pain

Ans: C

Feedback:

Hospice for children allows for continuation of hopeful treatment so long as certain criteria are met. This is different from adult hospice. Encouraging visits from friends

and family, educating parents about terminal dehydration, and treating constipation are common to family-centered care.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1206, Nursing Management of the Dying Child

18. When providing care to a dying child and his family, which would be **most** important?

- A) Focusing on the family as the unit of care
- B) Teaching the family appropriate care measures
- C) Offering the child support and encouragement
- D) Assisting the parents in decision making

Ans: A

Feedback:

When caring for a dying child and his family, the most important aspect of care is focusing on the family as the unit of care. Teaching, offering support, and assisting in decision making are important, but these actions must be implemented while focusing on the family as the unit of care.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1206, Providing Nutrition

19. The parents of an 11-year-old boy who is dying from cancer are concerned that he is not eating. Which intervention would serve both the parents' and child's needs?

- A) Urging the child to eat one good meal per day
- B) Serving small meals of things the child likes
- C) Straightening up around the child before meals
- D) Administering antiemetics as ordered for nausea

Ans: B

Feedback:

The child is more likely to eat small amounts of foods of his choosing. This accommodates the child's reduced appetite, reassures his parents that he is not starving, and gives the child a sense of control. Straightening up the child's area before meals provides a more pleasant eating environment. The use of antiemetics controls nausea but may not increase appetite. Urging the child to eat a substantial meal is unnecessary and creates stress.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1205, Organ or Tissue Donation

20. The nurse is caring for a child involved in an automobile accident whose family has been informed that the child is brain dead. What teaching might the nurse provide the family regarding organ donation?

- A) The nurse should ask about organ donation when the family is informed of their child's condition.
- B) The nurse should explain that written consent is necessary for the organ donation.
- C) The nurse should make sure the parents know that procurement of organs may mar their child's appearance.
- D) The nurse should make sure the parents know that they will be responsible for expenses related to organ procurement.

Ans: B

Feedback:

Written consent is necessary for organ donation, so the family must be appropriately informed and educated. The discussion of organ donation should be separate from the discussion of impending death or brain death notification. Families need to know that procurement of the organs does not mar the child's appearance, so that an open casket at the child's funeral is still possible if the family desires. All expenses for organ procurement are borne by the recipient's family, not the donor's.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1207, Meeting the Dying Child's Needs According to Developmental Stage

21. The nurse is caring for a preschool child who is receiving palliative care for end-stage cancer. What would be the focus of age-appropriate interventions for this child?

- A) Providing unconditional love and trust
- B) Providing a familiar and consistent routine
- C) Teaching the child that death is not punishment
- D) Providing specific, honest details of death

Ans: C

Feedback:

Spirituality in the preschool years focuses on the concept of right versus wrong. The 3- to 5-year-old may see death as punishment for wrongdoing, and the nurse must correct this misunderstanding. For the infant, unconditional love and trust are of utmost importance. The toddler, 1 to 3 years old, thrives on familiarity and routine; the nurse should maximize the toddler's time with parents, be consistent, provide favorite toys, and ensure physical comfort. The school-age child has a concrete understanding of death. Children who are 5 to 10 years old need specific, honest details (as desired).

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1207, Meeting the Dying Child's Needs According to Developmental Stage

22.The nurse is caring for a 5-year-old boy who is terminally ill. Which intervention would **best** meet the needs of this dying child?

- A) Offer the child decision-making opportunities.
- B) Provide the child with specific details.
- C) Assure the child that he did nothing wrong.
- D) Act as a confidant for the child's concerns.

Ans: C

Feedback:

The magical thinking of preschool-age children may cause him to think that dying is punishment for doing something wrong. Assuring him that he did nothing wrong is very important. School-age children would benefit from receiving specific details and being given decision-making opportunities. They may also use nurses as their confidants.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1206, Managing Pain and Discomfort

23.What would the nurse include in the plan of care for a dying child with pain?

- A) Administering analgesics as needed
- B) Using measures the nurse finds comforting
- C) Playing the television or radio so the child can hear it
- D) Changing the child's position frequently but gently

Ans: D

Feedback:

Pain management includes changing the child's position frequently but gently to minimize discomfort. Analgesics are given around the clock rather than as needed. The nurse would use measures that the child finds comforting to provide additional relief. A calm environment with minimal noise and light is helpful.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Culture and Spirituality

Page and Header: 1205, Organ or Tissue Donation

24. When describing organ donation to the family of a dying child, what would the nurse include in the discussion?

- A) Telling them that further harm may occur to the child through the process
- B) Tell them that their cultural and religious beliefs will be considered
- C) Including this topic in the discussion of impending death
- D) Informing the family that organ donation will delay the funeral

Ans: B

Feedback:

During organ donation, the family's cultural and religious beliefs must be considered, and the team discussing organ donation with the family must do so in a sensitive and ethical manner. The donating child will not suffer further because of organ donation. The topic of organ donation should be separated from the discussion of impending

death or brain death notification. Organs are harvested in a timely fashion after the declaration of death, so the family need not worry about delay of the wake or funeral.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1197, Early Discharge Planning

25. A child is admitted to the hospital with a spinal cord injury resulting in paralysis below the level of the waist. When should the nurse begin planning with the parents for rehabilitation placement for this child after acute hospitalization?

- A) After hospitalization when the parents are ready
- B) As soon after the patient is admitted as possible
- C) When the child starts showing improvement in their condition
- D) Once the child and the parent feel it is time to seek extended care

Ans: B

Feedback:

It is important to begin planning for discharge to a rehabilitation facility as soon as possible so that all necessary arrangements can be made prior to discharge. Waiting until the parent or child feel the time is right or waiting until improvement is noted may not leave enough time for thorough discharge planning.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Analyze

Integrated Process: Caring

Page and Header: 1195, Effects on Parents

26. The parents of a child with a developmental disability tell the nurse that they feel guilty because they sometimes find themselves feeling sad and wondering how their child would be without the disability. Which response by the nurse **best** shows empathy and encourages the parents to vent their feelings?

- A) "I'm sure it must be difficult to have a child developmentally delayed."
- B) "There are lots of parents that are experiencing the difficulty and feelings of hopelessness and grief you're having. Maybe if you talk to someone it might help you both."
- C) "I can only imagine how hard it is for you. You should know that it is common for parents to have these feelings when having a child with special needs."
- D) "It's important to focus on the positives that can come from the experience of being the parents of a child that has these issues."

Ans: C

Feedback:

Showing empathy by stating, "I can only imagine how hard it is for you" is important when developing rapport and supporting the parents and letting them know that they are not alone in the feelings they are experiencing allows them to feel less guilty. Just stating, "I'm sure it must be difficult to have a child developmentally delayed" may convey empathy but it does not allow for open conversation. "There are lots of parents that are experiencing the difficulty and feelings of hopelessness and grief you're having. Maybe if you talk to someone it might help you both" doesn't convey empathy. "It's important to focus on the positives that can come from the experience

of being the parents of a child that has these issues" does not address the parents' feelings.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 1201, 1202, Educational Opportunities for the Special Needs Child

27.The parents of a child with physical and developmental special needs state, "We wish our child could get some kind of educational experience." How should the nurse respond?

- A) "This must be difficult for you. Let's talk with the social worker to see what programs are available for your child."
- B) "I am sure it must be difficult to know that your child will never be able to go to school like other children."
- C) "Since all children can attend school regardless of their special need, I suggest you talk with your local school about enrolling your child."
- D) "It would be very difficult for your child to attend school with all of their disabilities. It's unfortunate, but it is reality."

Ans: A

Feedback:

Education is federally mandated. Contacting the social worker gives the parents the support they need to find and choose the appropriate school. Telling them to contact their local school is not supportive of the parent's needs.

Format: Multiple Select

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1202, 1203, Complementary Therapies

28.The nurse is meeting with the parents of a 7-year-old boy with Down syndrome. The child's mother reports an interest in hippotherapy. The child's father reports that this seems to be a waste of money. The parents then ask the nurse for additional information. What information may be included in the nurse's response? Select all that apply.

- A) Hippotherapy has limited research demonstrating its actual effectiveness.
- B) This type of therapy is most helpful for teens.
- C) A variety of conditions including Down syndrome have used hippotherapy with success.
- D) Self-esteem may be improved with hippotherapy.
- E) The benefits of hippotherapy are both physical and psychological.

Ans: C, D, E

Feedback:

Hippotherapy refers to the use of horseback riding for the handicapped, therapeutic horseback riding, or equine-facilitated psychotherapy. Individuals with almost any cognitive, physical, or emotional disability may benefit from therapeutic riding or other supervised interaction with horses. The unique movement of the horse under the child helps the child with physical disabilities to achieve increased flexibility, balance, and muscle strength. Children with mental or emotional disabilities may experience increased self-esteem, confidence, and patience as a result of the unique relationship with the horse.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Analyze

Integrated Process: Caring

Page and Header: 1195, 1196, Effects on Parents

29. The mother of a 7-year-old boy with autism tearfully reports feeling as if she is not qualified to care for her child. Which initial action by the nurse is **most** appropriate?

- A) Tell the child's mother that this is a common feeling when caring for a special needs child.
- B) Encourage the child's mother to keep a journal to best identify areas needing improvement in the home routine.
- C) Recognize the mother's positive accomplishments in caring for her child.
- D) Recommend the child's mother seek counseling.

Ans: C

Feedback:

Caring for a special needs child can be overwhelming for the parents. Feeling overwhelmed is not uncommon. Recognition of positive outcomes and activities should be performed. The child's mother may indeed benefit from counseling or participation in a support group, but it is not of the highest priority. Explaining to the child's mother that others feel the same way does not address her personal concerns. Keeping a journal may be effective but suggestions that this will help improve her performance are not meeting her immediate needs.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing process

Page and Header: 1196, Vulnerable Child Syndrome

30. The nurse is reviewing the therapist's documentation in the medical record of an assigned client who has cerebral palsy. The therapist has noted the parents may be experiencing vulnerable child syndrome. Which observation of the family unit **best** supports this potential diagnosis?

- A) The parents regularly attend a support group for parents of special needs children.
- B) The child has been diagnosed with pneumonia twice in the past year.
- C) The parents report they feel their child requires more therapy than the care team has indicated will be needed.
- D) The child is schooled at home with a private tutor.

Ans: C

Feedback:

Vulnerable child syndrome is a clinical state in which the parents' reactions to a serious illness or event in the child's past continue to have long-term psychologically harmful effects on the child and members of the family unit. The parents view the child as being at higher risk for medical, developmental, or behavioral problems. Parents exhibit excessive unwarranted concerns and seek health care for their child very frequently. Requests for additional therapy would be consistent with this syndrome. Attendance at a support group is important and does not indicate any underlying pathology. Pneumonia in a child with this diagnosis is not extremely unusual and does not have an increase in likelihood that the vulnerable child

syndrome may be involved. Home schooling does not indicate the presence of vulnerable child syndrome.

Chapter 35

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1216, Oral Administration

1.The nurse caring for a 6-year-old client enters the room to administer an oral medication in the form of a pill. The dad at the bedside looks at the pill and tells the nurse that his daughter has a hard time swallowing pills. What is the **best** response by the nurse?

- A) Ask the child to try swallowing the pill and offer a choice of drinks to take with it.
- B) Crush the pill and add it to applesauce.
- C) Request that the healthcare provider prescribe the medication in liquid form.
- D) Call the pharmacy and ask if the pill can be crushed.

Ans: D

Feedback:

The father is the best source of knowledge on medication administration for the child. The pharmacy should be called to determine if the pill might be crushed. Asking the child to try swallowing the pill disregards the information the father has just given. Requesting that the healthcare provider order the medication in liquid form is not necessary at this point.

Format: Multiple Select

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1213, Medication Administration, Box 35.1

2.The nurse is administering acetaminophen PRN to a 9-year-old child on the pediatric ward of the hospital. Which answers reflect nursing actions that follow the rules of the rights of pediatric medication administration? Select all that apply.

- A) The nurse identifies the child by checking the name on the child's chart.
- B) The nurse makes sure the medication is given within the hour of the ordered time.
- C) The nurse checks the documented time of the last dosage administered.
- D) The nurse calculates the dosage according to the child's weight.
- E) The nurse explains the therapeutic effects of the medication to the child and parents.
- F) The nurse administers the medication even though the child is adamant about not taking it.

Ans: C, D, E

Feedback:

Following the “right patient” rule, the nurse checks the documented time of the last dosage administered. For the “right dose,” the nurse calculates the dosage according to the child's weight. For the “right to be educated,” the nurse explains the therapeutic effects of the medication to the child and parents. To ensure the “right patient,” the nurse confirms the child's identity and then checks with the caregivers for further identification. To administer at the “right time,” the nurse gives the

medication within 20 to 30 minutes of the ordered time, and to protect the child's "right to refuse," the nurse respects the child's or parents' option to refuse.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1213, Differences in Pharmacodynamics and Pharmacokinetics

3.The nurse is teaching the student nurse the factors that affect the pharmacodynamics of the medications being administered. What is a factor affecting this property of medication in children?

- A) Immature body systems
- B) Weight
- C) Body surface
- D) Body composition

Ans: A

Feedback:

Although a drug's mechanism of action is the same in any individual, the physiologic immaturity of some body systems in a child can affect a drug's pharmacodynamics (behavior of the medication at the cellular level). The child's age, weight, body surface area, and body composition also can affect the drug's *pharmacokinetics* (movement of drugs throughout the body via absorption, distribution, metabolism, and excretion).

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1213, 1214, Differences in Pharmacodynamics and Pharmacokinetics

4. When describing the differences affecting the pharmacokinetics of drugs administered to children, which would the nurse include?

- A) Oral drugs are absorbed more quickly in children than adults.
- B) Absorption of intramuscularly administered drugs is fairly constant.
- C) Topical drugs are absorbed more quickly in young children than adults.
- D) Absorption of drugs administered by subcutaneous injection is increased.

Ans: C

Feedback:

Topical absorption of drugs is increased in infants and young children because the stratum corneum is thinner and well hydrated. The absorption of oral drugs is slowed by slower gastric emptying, increased intestinal motility, a proportionately larger small intestine surface area, high gastric pH, and decreased lipase and amylase secretion. The absorption of drugs given intramuscularly or subcutaneously is erratic and may be decreased.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1237, Promoting Growth and Development

5.The nurse is providing teaching for the mother of an infant who receives all of his nutrition through a nasogastric feeding tube. The nurse is reviewing interventions to promote growth and development. Which response from the mother indicates a need for further teaching?

- A) "I will give him a pacifier during feeding time."
- B) "We need to keep feeding time very quiet."
- C) "We need to make sure he doesn't lose the desire to eat by mouth."
- D) "Sucking produces saliva, which aids in digestion."

Ans: B

Feedback:

The nurse needs to emphasize that it is important to talk, play music, cuddle, and rock the infant to promote a normalized feeding time. The other statements are correct.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1215, Dose Determination by Body Weight

6.The nurse is preparing to administer oral ampicillin to a child who weighs 40 kg. The safe dose for children is 50 to 100 mg/kg/day divided in doses administered every 6

hours. What would be the low single safe dose and high single safe dose per day for this child?

- A) 50 to 100 mg per dose
- B) 100 to 500 mg per dose
- C) 500 to 1,000 mg per dose
- D) 1,000 to 5,000 mg per dose

Ans: C

Feedback:

To calculate the dosage, the nurse would set up a proportion to calculate the low dose as follows: $50 \text{ mg}/1 \text{ kg} = x \text{ mg}/40 \text{ kg}$; solve for x by cross-multiplying: $1 \times x = 50 \times 40$; $x = 2,000 \text{ mg}$ divided by 4 doses per day = 500 mg. Then calculate the high safe dose range using the following proportion: $100 \text{ mg}/1 \text{ kg} = x \text{ mg}/40 \text{ kg}$; solve for x by cross-multiplying: $1 \times x = 100 \times 40$; $x = 4,000 \text{ mg}$ divided by 4 doses per day = 1,000 mg.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1215, Dose Determination by Body Weight

7. The nurse is preparing to administer a medication to a 5-year-old who weighs 35 lb. The prescribed single dose is 1 to 2 mg/kg/day. Which is the appropriate dose range for this child?

- A) 8 to 16 mg

- B) 16 to 32 mg
- C) 35 to 70 mg
- D) 70 to 140 mg

Ans: B

Feedback:

The nurse should convert the child's weight in pounds to kilograms by dividing the child's weight in pounds by 2.2. ($35 \text{ lb} \div 2.2 = 16 \text{ kg}$). The nurse would then multiply the child's weight in kilograms by 1 mg for the low end ($16 \text{ kg} \times 1 \text{ mg} = 16 \text{ mg}$) and then by 2 mg for the high end ($16 \text{ kg} \times 2 \text{ mg} = 32 \text{ mg}$).

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1216, Oral Administration

8. The nurse is administering a crushed tablet to an 18-month-old infant. What is a recommended guideline for this intervention?

- A) Mix the crushed tablet with a small amount of applesauce.
- B) Place the crushed tablet in the infant's formula.
- C) Mix the crushed tablet with the infant's cereal.
- D) Crushed tablets should only be mixed with water.

Ans: A

Feedback:

If a tablet or capsule is the only oral form available for children younger than 6 years, it needs to be crushed or opened and mixed with a pleasant-tasting liquid or a small amount (generally no more than a tablespoon) of a nonessential food such as applesauce. The crushed tablet or inside of a capsule may taste bitter, so it should never be mixed with formula or other essential foods. Otherwise, the child may associate the bitter taste with the food and later refuse to eat it.

Format: Multiple Select

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1216, 1217, Oral Administration, Box 35.3

9.The nurse is preparing to administer medication to a child with a gastrostomy tube in place. What is a recommended guideline for this procedure? Select all that apply.

- A) Verify proper tube placement prior to instilling medication.
- B) Mix liquid medications with a small amount of water and add directly into the tube.
- C) Mix powdered medications well with cold water first.
- D) Crush tablets and mix with warm water to prevent tube occlusion.
- E) Open up capsules and mix the contents with warm water.
- F) Flush the tube with water after administering medications.

Ans: A, D, E, F

Feedback:

The correct procedure includes checking proper tube placement prior to instilling medication, crushing tablets and mixing with warm water to prevent tube occlusion, opening up capsules and mixing the contents with warm water, and flushing the tube with water after administering medications. The nurse should give liquid medications directly into the tube and mix powdered medications well with warm water first.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1220, Intramuscular Administration

10. The nurse is administering immunizations to children in a neighborhood clinic.

What is the **most** frequent route of administration?

- A) Oral
- B) Intradermal
- C) Intramuscular
- D) Topical

Ans: C

Feedback:

Intramuscular (IM) administration delivers medication to the muscle. In children, this method of medication administration is used infrequently because it is painful, and children often lack adequate muscle mass for medication absorption. However, IM administration is used to administer certain medications, such as many immunizations.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1221, Subcutaneous and Intradermal Administration

11. The nurse is preparing to administer insulin to a diabetic child. Which would be the recommended route for this administration?

- A) Subcutaneous
- B) Intradermal
- C) Intramuscular
- D) Oral

Ans: A

Feedback:

Subcutaneous (SQ) administration distributes medication into the fatty layers of the body. It is used primarily for insulin administration, heparin, and certain immunizations, such as MMR. Intradermal administration is used primarily for tuberculosis screening and allergy testing. Intramuscular administration is used to administer certain medications, such as many immunizations. Insulin is not administered orally.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1216, 1217, Oral Administration

12. The nurse is caring for an 8-year-old girl who requires medication that is only available in an enteric tablet form. The nurse is teaching the mother how to help the girl swallow the medication. Which statement indicates a need for further teaching?

- A) "I can encourage her to place it on the back of her tongue."
- B) "I can pinch her nose to make it easier to swallow."
- C) "We cannot crush this type of pill as it will affect the delivery of the medication."
- D) "We can place the tablet in a spoonful of applesauce."

Ans: B

Feedback:

The mother should be advised to never pinch the child's nose as it increases the risk for aspiration. The other statements are correct.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1219, Nasal Administration

13. The nurse is providing teaching on how to administer nasal drops. Which response by the parents indicates a need for further teaching?

- A) "We need to be careful not to stimulate a sneeze."
- B) "She needs to remain still for at least 10 minutes after administration."

- C) "Our daughter should lie on her back with her head hyperextended."
- D) "We must not let the dropper make contact with the nasal membranes."

Ans: B

Feedback:

Once the drops are instilled, the child should remain in hyperextension for at least 1 minute to ensure the drops have come in contact with the nasal membranes. Ten minutes would be excessive. The other statements are correct.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1216, Oral Administration

14. The nurse is administering a liquid medication to a 3-year-old using an oral syringe. Which action would be **most** appropriate?

- A) Direct the liquid toward the anterior side of the mouth.
- B) Keep the child's hand away from the oral syringe when squirting the medication.
- C) Give all of the drug in the syringe at one time with one squirt.
- D) Allow the child time to swallow the medication in between amounts.

Ans: D

Feedback:

When using an oral syringe to administer liquid medications, give the drug slowly in small amounts and allow the child to swallow before placing more medication in the

mouth. The syringe is directed toward the posterior side of the mouth. The toddler or young preschooler may enjoy helping by squirting the medication into his or her mouth.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1218, Ophthalmic Administration

15. After administering eye drops to a child, the nurse applies gentle pressure to the inside corner of the eye at the nose for which reason?

- A) To promote dispersion over the cornea
- B) To enhance systemic absorption
- C) To ensure the medication stays in the eye
- D) To stabilize the eyelid

Ans: C

Feedback:

Punctal occlusion, or gentle pressure to the inside corner of the eye at the nose, helps to slow systemic absorption and ensure that the medication stays in the eye. Having the head lower than the body aids in dispersing the medication over the cornea. Placing the heel of the hand on the child's forehead and then retracting the lower lid helps to stabilize it.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1220, Intramuscular Administration

16. The nurse is preparing to administer an intramuscular injection to an 8-month-old infant. Which site would the nurse select?

- A) Rectus femoris
- B) Vastus lateralis
- C) Dorsogluteal muscle
- D) Deltoid

Ans: B

Feedback:

The preferred injection site in infants is the vastus lateralis muscle. An alternative site is the rectus femoris. The dorsogluteal site is not used in children until the child has been walking for at least 1 year. The deltoid muscle is used as a site in children after the age of 4 or 5 years.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1225, 1226, Peripheral Access Devices, Central Access Devices

17.The nurse is caring for children who are receiving IV therapy in the hospital setting. For which children would a central venous device be indicated?

- A) A child who is receiving an IV push
- B) A child who is receiving chemotherapy for leukemia
- C) A child who is receiving IV fluids for dehydration
- D) A child who is receiving a one-time dose of a medication

Ans: B

Feedback:

Although central venous access devices can be used short term, the majority are used for moderate- to long-term therapy, such as chemotherapy. Central venous access devices are indicated when the child lacks suitable peripheral access, requires IV fluid or medication for more than 3 to 5 days, or is to receive specific treatments, such as the administration of highly concentrated solutions or irritating drugs that require rapid dilution. Peripheral IV devices are used for most other IV therapies.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1228, 1229, IV Fluid Administration

18.The nurse is determining the amount of IV fluids to administer in a 24-hour period to a child who weighs 40 kg. How many milliliters should the nurse administer?

- A) 1,000 mL
- B) 1,500 mL

C) 1,750 mL

D) 1,900 mL

Ans: D

Feedback:

Typically, the amount of fluid to be administered in a day (24 hours) is determined by the child's weight (in kg) using the following formula:

100 mL per kg of body weight for the first 10 kg (1,000)

50 mL per kg of body weight for the next 10 kg (500)

20 mL per kg of body weight for the remainder of body weight in kg (400).

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1234, 1235, Administering Enteral Feedings

19.A nurse has just administered medication via an orogastric tube. What is the **priority** nursing action following administration?

A) Check tube placement.

B) Retape the tube.

C) Flush the tube.

D) Remove the tube.

Ans: C

Feedback:

After administration, the nurse should flush the tube to maintain patency and ensure that the entire amount of medication has been given. The tube should be checked prior to administering the medication. It is not necessary to retape the tube following administration. It is not appropriate to remove the tube unless it has been specifically ordered.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1236, Providing Skin and Insertion Site Care

20. A nurse is caring for a 14-year-old with a gastrostomy tube. The girl has skin breakdown and irritation at the insertion site. Which would be the **most** appropriate method to clean and secure the gastrostomy tube?

- A) Make sure the tube cannot be moved in and out of the child's stomach.
- B) Use adhesive tape to tape the tube in place and prevent movement.
- C) Place a transparent dressing over the site whether there is drainage or not.
- D) If any drainage is present, use a presplit 2 × 2 and place it loosely around the site.

Ans: D

Feedback:

Skin around the gastrostomy or jejunostomy insertion site may become irritated from movement of the tube, moisture, leakage of stomach or intestinal contents, or the adhesive device holding the tube in place. Keeping the skin clean and dry is important and will help prevent most of these problems. If any drainage is present, a presplit 2

× 2 can be placed loosely around the site and changed when soiled. If no drainage is present, the nurse should not place a dressing as it can cause undue pressure and trap moisture, leading to skin irritation. Preventing movement of the tube helps reduce skin irritation; however, the tube should be able to move slightly in and out of the child's stomach.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1237, 1238, Administering TPN, Comparison Chart 35.1

21. The nurse is explaining to the student nurse the therapeutic effects of total parenteral nutrition (TPN). What accurately describes the use of TPN?

- A) It is used short term to supply additional calories and nutrients as needed.
- B) It is delivered via the peripheral vein to allow rapid dilution of hypertonic solution.
- C) It is a highly concentrated solution of carbohydrates, electrolytes, vitamins, and minerals.
- D) It is usually used when the child's nutritional status is within acceptable parameters.

Ans: C

Feedback:

TPN is a highly concentrated solution of carbohydrates, electrolytes, vitamins, and minerals. TPN provides all nutrients to meet a child's needs. It is delivered via central venous access to allow rapid dilution of hypertonic solution. It is usually used in a

child with a nonfunctioning gastrointestinal (GI) tract, such as a congenital or acquired GI disorder; a child with severe failure to thrive or multisystem trauma or organ involvement; and preterm newborns.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1237, 1238, Administering TPN

22. The nurse is caring for a 6-year-old child who has multisystem trauma due to a motor vehicle accident. The child is receiving total parenteral nutrition (TPN). What is a recommended nursing intervention for children on TPN?

- A) Initially, check blood glucose levels frequently, such as every 4 to 6 hours, to evaluate for hyperglycemia.
- B) Be vigilant in monitoring the infusion rate, change the rate as necessary, and report any changes to the healthcare provider or nurse practitioner.
- C) If for any reason the TPN infusion is interrupted or stops, begin an infusion of a 10% saline at the same infusion rate as the TPN.
- D) Administer TPN continuously over an 8-hour period, or after initiation it may be given on a cyclic basis, such as over a 12-hour period during the night.

Ans: A

Feedback:

Initially, the nurse should check blood glucose levels frequently, such as every 4 to 6 hours, to evaluate for hyperglycemia. Throughout TPN therapy, the nurse should be vigilant in monitoring the infusion rate and report any changes in the infusion rate to

the healthcare provider or nurse practitioner immediately. Adjustments may be made to the rate, but only as ordered by the healthcare provider or nurse practitioner. If for any reason the TPN infusion is interrupted or stops, the nurse should begin an infusion of a 10% dextrose solution at the same infusion rate as the TPN. TPN can be administered continuously over a 24-hour period, or after initiation it may be given on a cyclic basis, such as over a 12-hour period during the night.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1239, Preventing Complications

23. The nurse is caring for a child who is receiving total parenteral nutrition (TPN) for failure to thrive. Which nursing action might the nurse take to prevent complications from this therapy?

- A) Adhere to clean technique when caring for the catheter and administering TPN.
- B) Ensure that the system remains an open system at all times.
- C) Secure all connections and open the catheter during tubing and cap changes.
- D) Use occlusive dressings and chlorhexidine-impregnated sponge dressings.

Ans: D

Feedback:

The nurse should use occlusive dressings and chlorhexidine-impregnated sponge dressings to help prevent infection. The nurse should always follow agency or

institution policy and procedures, adhere to strict aseptic technique when caring for the catheter and administering TPN, ensure that the system remains a closed system at all times, and secure all connections and clamp the catheter or have the child perform the Valsalva maneuver during tubing and cap changes.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1213, Medication Administration, Box 35.1

24. A healthcare provider orders a medication dosage that is above the normal dosage. The nurse administers the medication without questioning the dosage. What error did the nurse make?

- A) The nurse violated one of the "rights" of medication administration.
- B) The nurse performed an act outside the scope of practice for nursing.
- C) The nurse has not made an error, but the healthcare provider did by ordering the wrong dosage of medication.
- D) The nurse has committed an act of maleficence by administering the medication.

Ans: A

Feedback:

The nurse violated one of the "rights" of medication administration, the right dosage, because the nurse is responsible for being aware and questioning an incorrect dosage of medication. Medication administration is within the scope of nursing practice.

Maleficence is performing a harmful act intentionally.

Format: Multiple Select

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1234, Administering Enteral Feedings

25.The nurse notes that a child with a swallowing difficulty is receiving a continuous tube feeding. The child is very active, and the feeding frequently gets interrupted because the tube becomes disconnected. What should the nurse discuss with the healthcare provider about the tube feeding?

- A) The nurse should ask the healthcare provider if the client could receive total parenteral nutrition.
- B) The nurse should ask the healthcare provider if the client could receive bolus rather than continuous tube feedings.
- C) The nurse should ask the healthcare provider if the client could receive the tube feedings during the night rather than continuously during all hours.
- D) The nurse should ask the healthcare provider if the client could be given oral rather than tube feedings.
- E) The nurse should ask the healthcare provider if the client could be given a sedative in order to prevent disruption of the tube feedings.

Ans: B, C

Feedback:

A bolus feeding is a specified amount of feeding solution that is given at specific intervals, usually over a short period of time such as 15 to 30 minutes, and is given via a syringe, feeding bag, or infusion pump. Continuous feedings are given at a

slower rate over a longer period of time. In some cases, the feeding may be given during the night so that the child can be free to move about and participate in activities during the day. Either of these methods could help in the disruption of the feedings. Total parenteral nutrition is intravenous feeding and cannot be given for extended periods of time, nor would it help the active child. The child has a swallowing difficulty so oral feedings are not possible at this time. Sedatives would be considered a chemical restraint if given for this purpose.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1237, 1238, Administering TPN

26. The parents of a child receiving total parenteral nutrition ask the nurse why their child must have their blood glucose monitored so frequently since they are not diabetic. What is the **best** response by the nurse?

- A) "We like to keep a close check on the blood glucose for all children receiving total parenteral nutrition."
- B) "It is important to monitor the blood glucose level because the solution has a high concentration of carbohydrates that convert to glucose."
- C) "This is a good time for us to monitor your child in case they start developing signs of diabetes related to receiving total parenteral nutrition."
- D) "I would suggest you ask the healthcare provider why blood glucose checks have been ordered so frequently."

Ans: B

Feedback:

Total parenteral nutrition has a high concentration of carbohydrates, which convert to glucose. Informing the parents that this is the reason for frequent monitoring of the blood glucose adequately addresses their question. It is routine for any client receiving total parenteral nutrition to have frequent monitoring of blood glucose, but this does not answer the parent's question. There is no need to monitor a child for diabetes without reason. There is no reason to suggest asking the healthcare provider when this question can be answered by the nurse.

Format: Multiple Select

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1218, Ophthalmic Administration

27.The student nurse is preparing to administer eye drops to a 2-year-old child. Which actions indicate the need for additional instruction? Select all that apply.

- A) The student nurse explains the medication regimen to the child's parents.
- B) The nurse holds the medication bottle 3 inches from the child's nose during administration.
- C) The child is instructed to look down during the instillation of the medication in the eyes.
- D) The student nurse seeks assistance to hold the child during the medication administration.
- E) The child is turned so the medication flows toward the outer corner of the eye.

Ans: B, C, E

Feedback:

When preparing to administer medications to a child, the nurse will teach the parents and the child (based upon the child's ability to comprehend) about the medication and about the procedure that will be used. When a child is under the age of 3, assistance should be obtained from another healthcare provider. The bottle should be held one inch from the child's nose. The child should be instructed to look up and to the side for the administration. The medication should flow toward the nose.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1229, Maintaining IV Fluid Therapy

28. The nurse is monitoring the output for a 10-year-old child. The medical record indicates the child weighs 78 lb (35 kg). How much urine can be anticipated for this child for a 12-hour period?

- A) 300 to 1200 mL
- B) 360 to 900 mL
- C) 420 to 840 mL
- D) 600 to 1200 mL

Ans: C

Feedback:

Urinary output for a child will vary. As a general rule, output anticipated will be approximately 1.0 to 2.0 mL/kg/hour for children and adolescents. In a child who weighs 78 lb, this will calculate as follows:

1. $1 \text{ mL} \times 35\text{kg} = 35 \text{ mL/hr}$ and $2 \text{ mL} \times 35 = 70 \text{ mL/hr}$
2. $35 \text{ mL} \times 12 \text{ hours} = 420 \text{ mL}$
3. $70 \text{ mL} \times 12 \text{ hours} = 840 \text{ mL}$

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing process

Page and Header: 1232--1235, Checking Tube Placement, Box 35.4

29. The nurse is checking placement on a child's feeding tube. When the pH is checked, it is 5.3. What action by the nurse is indicated?

- A) Remove the tube.
- B) Document the findings as normal.
- C) Contact the healthcare provider.
- D) Reevaluate the pH again in 2 hours.

Ans: C

Feedback:

Gastric pH may be used to evaluate feeding tube placement. Normal gastric pH is less than 5.0. Findings greater than 5.0 indicate the need for further action. The nurse cannot remove the tube. The findings cannot be documented as normal. Evaluating the gastric pH again in 2 hours is not appropriate as the matter warrants more immediate action.

Format: Short Answer

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing process

Page and Header: 1213, 1214, Differences in Pharmacodynamics and Pharmacokinetics

30. The nurse will be administering a medication to a child that is primarily excreted by the kidney. The nurse is aware that this action is especially dangerous until the child reaches what age? Record your answer in years.

Ans: 2

Feedback:

The immaturity of the kidneys until the age of 1 to 2 years affects renal blood flow, glomerular filtration, and active tubular secretion. This results in a longer half-life and increases the potential for toxicity of drugs primarily excreted by the kidneys.

Chapter 36

Format: Multiple Select

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1244, 1245, Transmission

1.The nurse is teaching the student nurse the physiology involved in pain transmission. Which statements accurately describe a physiologic event in the nervous system related to pain transmission? Select all that apply.

- A) Thermal stimulation may involve the release of mediators, such as histamine, prostaglandins, leukotrienes, or bradykinin.
- B) When nociceptors are activated by noxious stimuli, the stimuli are converted to electrical impulses that are relayed to the spinal cord and brain.
- C) Myelinated A-delta fibers are large fibers that conduct the impulse at very rapid rates; unmyelinated small C fibers transmit the impulse slowly.
- D) Once in the dorsal horn of the spinal cord, the nerve fibers divide and then cross to the opposite side and rise upward to the thalamus.
- E) The point at which the person first feels the highest intensity of the painful stimulus is termed the pain threshold.
- F) Peripheral sensitization allows the nerve fibers to react to a stimulus that is of lower intensity than would be needed to cause pain.

Ans: B, C, D, F

Feedback:

When nociceptors are activated by noxious stimuli, the stimuli are converted to electrical impulses that are relayed along the peripheral nerves to the spinal cord and brain. Myelinated A-delta fibers are large fibers that conduct the impulse at very rapid rates; unmyelinated small C fibers transmit the impulse slowly. Once in the dorsal horn of the spinal cord, the nerve fibers divide and then cross to the opposite side and rise upward to the thalamus. Peripheral sensitization allows the nerve fibers to react to a stimulus that is of lower intensity than would be needed to cause pain. Chemical stimulation may involve the release of mediators, such as histamine, prostaglandins, leukotrienes, or bradykinin. The point at which the person first feels the lowest intensity of the painful stimulus is termed the pain threshold.

Format: Multiple Select

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1246, Chronic Pain

2. The nurse is managing children who have chronic diseases in a neighborhood clinic. What are some examples of chronic conditions? Select all that apply.

- A) Diabetes mellitus
- B) Myocardial infarction
- C) Rheumatoid arthritis
- D) Compound fracture
- E) Acute asthma
- F) Bronchopneumonia

Ans: A, C, E

Feedback:

Chronic pain is defined as pain that continues past the expected point of healing for injured tissue. Diabetes, arthritis, and asthma are examples of chronic pain. Acute pain is defined as pain that is associated with a rapid onset of varying intensity. It usually indicates tissue damage and resolves with healing of the injury. Examples include heart attack, fractures, and bronchopneumonia.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1246, Nociceptive Pain

3.The nurse is caring for a child who is recovering from an appendectomy. What is the appropriate term for the pain this child is experiencing?

- A) Nociceptive pain
- B) Neuropathic pain
- C) Chronic pain
- D) Superficial somatic pain

Ans: A

Feedback:

Nociceptive pain reflects pain due to noxious stimuli that damages normal tissues or has the potential to do so if the pain is prolonged. Nociceptive pain ranges from sharp or burning; to dull, aching, or cramping; to deep aching or sharp stabbing. Examples of conditions that result in nociceptive pain include chemical burns, sunburn, cuts, appendicitis, and bladder distention. Neuropathic pain is pain due to malfunctioning

of the peripheral or central nervous system. Chronic pain is defined as pain that continues past the expected point of healing for injured tissue. Superficial somatic pain, often called cutaneous pain, involves stimulation of nociceptors in the skin, subcutaneous tissue, or mucous membranes.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Remember

Integrated Process: Nursing Process

Page and Header: 1246, Somatic Pain

4. The nurse is conducting an assessment of a high school track athlete. The client tells the nurse he is experiencing pain along his outer thigh. He describes it as tight, achy, and tender, particularly after he runs. The nurse understands that he is most likely experiencing what kind of pain?

- A) Cutaneous
- B) Neuropathic
- C) Visceral
- D) Deep somatic

Ans: D

Feedback:

Deep somatic pain typically involves the muscles, tendons, joints, fasciae, and bones. It can be localized or diffuse and is usually described as dull, aching, or cramping with tenderness. It can also be due to overuse injuries commonly experienced by athletes. Cutaneous pain usually involves the skin and is described as sharp or burning.

Neuropathic pain is due to a malfunctioning of the peripheral nervous system and is described as burning or tingling. Visceral pain is pain that develops within organs.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1248, Situational Factors

5.The nurse is caring for a child who is experiencing pain related to chemotherapy treatment. What is a behavioral factor that might affect the child's pain experience?

- A) Knowledge of the therapy
- B) Fear about the outcome of therapy
- C) Participation in normal routine activities
- D) Ability to identify pain triggers

Ans: C

Feedback:

Participation in normal routine activities is a behavior factor. Knowledge of the therapy and ability to identify pain triggers are cognitive factors. Fear about the outcome of therapy is an emotional factor. Situational factors involve factors or elements that interact with the child and his or her current situation involving the experience of pain.

Format: Multiple Select

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Remember

Integrated Process: Nursing Process

Page and Header: 1248, Infants

6.The nurse caring for infants in the neonatal intensive care unit (NICU) relies on the use of behavioral and physiologic indicators for determining pain. Which examples are behavioral indicators? Select all that apply.

- A) The infant grimaces.
- B) The infant's heart rate is elevated.
- C) The infant flails his arms and legs.
- D) The infant's respiratory rate is elevated.
- E) The infant is crying uncontrollably.
- F) The infant's oxygen saturation is low.

Ans: A, C, E

Feedback:

In preterm and term newborns, behavioral and physiologic indicators are used for determining pain. Behavioral indicators include facial expression, body movements, and crying. Physiologic indicators include changes in heart rate, respiratory rate, blood pressure, oxygen saturation levels, vagal tone, palmar sweating, and plasma cortisol or catecholamine levels.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1265, 1266, Nonopioid Analgesics, Drug Guide 36.1

7.A nurse is providing teaching to the mother of an adolescent girl about how to manage menstrual pain nonpharmacologically. Which statement by the mother indicates a need for further teaching?

- A) "I need to help her learn techniques to distract her; card games, for example."
- B) "I need to be able to identify the subtle ways she shows pain."
- C) "I need to follow these instructions exactly for them to work properly."
- D) "I need to encourage her to practice and utilize these techniques."

Ans: C

Feedback:

The mother does not need to follow the instructions exactly; she needs to review the methods and modify them in a way that works best for her daughter. The other statements are correct.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1249, 1250, Common Fallacies and Myths About Pain in Children, Table 36.1

8.The nurse is counseling the parents of a 9-year-old boy who is receiving morphine for postoperative pain. Which statement from the nurse accurately reflects the pain experience in children?

- A) "You can expect that your child will tell you when he is experiencing pain."
- B) "Your child will learn to adapt to the pain he is experiencing."
- C) "Your child will experience more adverse effects to narcotics than adults."
- D) "It is very rare that children become addicted to narcotics."

Ans: D

Feedback:

Addiction to narcotics when used in children is very rare. Often children deny pain to avoid a painful situation or procedure, embarrassment, or loss of control. Repeated exposure to pain or painful procedures can result in an increase in behavioral manifestations. The risk of adverse effects of narcotic analgesics is the same for children as for adults.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Remember

Integrated Process: Nursing Process

Page and Header: 1249, 1250, Common Fallacies and Myths About Pain in Children

9.The nurse is using the acronym QUESTT to assess the pain of a child. Which is an accurate descriptor of this process?

- A) Question the child's parents.
- B) Understand the child's pain level.

- C) Establish a caring relationship with the child.
- D) Take the cause of pain into account when intervening.

Ans: D

Feedback:

The acronym QUESTT stands for the following: Question the child. Use a reliable and valid pain scale. Evaluate the child's behavior and physiologic changes to establish a baseline and determine the effectiveness of the intervention. The child's behavior and motor activity may include irritability and protection as well as withdrawal of the affected painful area. Secure the parent's involvement. Take the cause of pain into account when intervening. Take action.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1251, 1252, Using Pain Rating Scales

10. When the nurse is assessing a child's pain, which action by the nurse is **most** important?

- A) Obtaining a pain rating from the child with each assessment
- B) Using the same tool to assess the child's pain each time
- C) Documenting the child's pain assessment
- D) Asking the parents about the child's pain tolerance

Ans: B

Feedback:

Although obtaining a pain rating, documenting the assessment, and asking the child's parents about the pain are important, the most important aspect of pain assessment is to use the same tool each time so that appropriate comparisons can be made and effective interventions can be planned and implemented. Consistency allows the most accurate assessment of the child's pain.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Remember

Integrated Process: Nursing Process

Page and Header: 1253, Visual Analog and Numeric Scales

11. Which tool would be the least appropriate scale for the nurse to use when assessing a 4-year-old child's pain?

- A) FACES pain rating scale
- B) Oucher pain rating scale
- C) Poker chip tool
- D) Numeric pain intensity scale

Ans: D

Feedback:

The numeric pain intensity scale can be used with children as young as 5 years of age, but the preferred minimum age for using this tool is 8 years. The FACES and Oucher pain rating scales and the poker chip tool are appropriate pain assessment tools for a 4-year-old.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1257, 1258, r-FLACC Behavioral Scale for Pain in Nonverbal Young Children and Children with Cognitive Impairment, Table 36.7

12. The nurse uses the FLACC behavioral scale to assess a 6-year-old's level of postoperative pain and obtains a score of 9. The nurse interprets this to indicate that the child is experiencing:

- A) little to no pain.
- B) mild pain.
- C) moderate pain.
- D) severe pain.

Ans: D

Feedback:

With the FLACC behavioral scale, five parameters are measured and scored as 0, 1, or 2. They are then totaled to achieve a maximum score of 10. The higher the score, the greater the pain. A score of 9 indicates severe pain.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1257, Riley Infant Pain Scale

13. The nurse is assessing the pain of a postoperative newborn. The nurse measures the infant's facial expression, body movement, sleep, verbal or vocal ability, consolability, and response to movements and touch. Which behavioral assessment tool is being used by the nurse?

- A) Riley Infant Pain Scale
- B) Pain Observation Scale for Young Children
- C) CRIES Scale for Neonatal Postoperative Pain Assessment
- D) FLACC Behavioral Scale for Postoperative Pain in Young Children

Ans: A

Feedback:

The Riley Infant Pain Scale measures six parameters: facial expression, body movement, sleep, verbal or vocal ability, consolability, and response to movements and touch. The Pain Observation Scale for Young Children (POCIS) measures seven parameters: facial expression, cry, breathing, torso, arms and fingers, legs and toes, and state of arousal. The CRIES tool assesses five parameters: cry, oxygen required for saturation levels less than 95%, increased vital signs, facial expression, and sleeplessness. The FLACC tool measures five parameters: facial expression, legs, activity, cry, and consolability.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Understand

Integrated Process: Caring

Page and Header: 1263, Distraction

14. The nurse tells a joke to a 12-year-old to distract him from a painful procedure. What pain management technique is the nurse using?

- A) Relaxation
- B) Distraction
- C) Imagery
- D) Thought stopping

Ans: B

Feedback:

Distraction involves having the child focus on another stimulus, thereby attempting to shield him from pain. Humor has been demonstrated to be an effective distracting technique for pain management.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1263, Thought Stopping

15. The nurse is providing instructions to a mother on how to use thought stopping to help her child deal with anxiety and fear associated with frequent painful injections. Which statement indicates the mother understands the technique?

- A) "We will imagine that we are on the beach in Florida."
- B) "We can talk about our favorite funny movie and laugh."
- C) "She can let her body parts go limp, working from head to toe."
- D) "We'll repeat 'quick stick, feel better, go home soon' several times."

Ans: D

Feedback:

Thought stopping is a technique that involves the use of short, concise phrases of positive ideas. Doing so helps to promote the child's sense of control. Imagining a favorite beach in Florida is using imagery. Talking about a favorite funny movie involves humor. Letting body parts go limp is a relaxation technique.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1264, Heat and Cold Applications

16. The student nurse is learning about the effects of heat and cold when used in a pain management plan. What accurately describes one of these effects?

- A) Cold results in vasodilation.
- B) Cold alters capillary permeability.
- C) Heat results in vasoconstriction.
- D) Heat decreases blood flow to the area.

Ans: B

Feedback:

Cold results in vasoconstriction and alters capillary permeability, leading to a decrease in edema at the site of the injury. Heat results in vasodilation and increases blood flow to the area.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1265, The Nurse's Role in Nonpharmacologic Pain Intervention,
Teaching Guidelines 36.1

17. The nurse is teaching an 8-year-old child and his family how to manage cancer pain using nonpharmacologic methods. Which parent statement signifies successful child teaching?

- A) "I will avoid using descriptive words like pinching, pulling, or heat."
- B) "I will not use positive reinforcement until the technique is perfected."
- C) "I will begin using the technique before he experiences pain."
- D) "I will be honest and tell him that the procedure will hurt a lot."

Ans: C

Feedback:

The parents should begin using the technique chosen before the child experiences pain or when the child first indicates he is anxious about, or beginning to experience, pain. The parents should use descriptive terms like pushing, pulling, pinching, or heat and avoid overly descriptive or judgmental statements such as, "This will really hurt a lot" or "This will be terrible." They should offer praise, positive reinforcement, hugs, and support for using the technique even when it was not effective.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1265, Nonopioid Analgesics

18. For which child would nonopioid analgesics be recommended?

- A) A child with juvenile arthritis
- B) A child with end-stage cancer
- C) A child with a broken arm
- D) A child with severe postoperative pain

Ans: A

Feedback:

Nonopioid analgesics may be used to treat mild to moderate pain, often for conditions such as arthritis; joint, bone, and muscle pain; headache; dental pain; and menstrual pain. Opioid analgesics are typically used for moderate to severe pain as can occur with cancer, broken bones, and postoperative healing.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1267, Opioid Analgesics

19. Prior to administering morphine to a 10-year-old child, the nurse reviews the adverse effects of the drug. Which system is primarily affected by the drug, causing most of the adverse effects?

- A) Central nervous system
- B) Peripheral nervous system
- C) Digestive system
- D) Musculoskeletal system

Ans: A

Feedback:

Opioid agonists, such as morphine, are associated with numerous adverse effects, resulting primarily from their depressant action on the central nervous system.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1268, Drug Administration Methods

20. The nurse is administering pain medication to a child with continuous pain from internal injuries. Which method would be ordered to dispense the medication?

- A) Administer the medication PRN (as needed).
- B) Administer the medication when pain has peaked.
- C) Administer the medication around the clock at timed intervals.
- D) Administer the medication when the child reports pain.

Ans: C

Feedback:

With any medication administered for pain management, the timing of administration is vital. Timing depends on the type of pain. For continuous pain, the current recommendation is to administer analgesia around the clock at scheduled intervals to achieve the necessary effect. As-needed or PRN dosing is not recommended for continuous pain. This method can lead to inadequate pain relief because of the delay before the drug reaches its peak effectiveness. For pain that can be predicted or considered temporary, such as with a procedure, analgesia is administered so that the peak action of the drug matches the time of the painful event. It is not recommended to wait until the child reports pain because therapeutic levels will be difficult to reach at this point.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1269, Topical Forms, Box 36.1

21. The nurse has applied EMLA cream as ordered. How does the nurse assess that the cream has achieved its purpose?

- A) Assess the skin for redness.
- B) Note any blanching of skin.
- C) Lightly tap the area where the cream is.
- D) Gently poke the child with a needle.

Ans: C

Feedback:

The nurse should verify that sensation is absent by lightly tapping or scratching the area. Blanching or redness indicates that the medication has penetrated the skin adequately but does not indicate that sensation is absent. Using a needle to poke the skin would likely frighten the child.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1269, 1270, Topical Forms

22. The nurse is preparing to administer a topical anesthetic for a 10-year-old girl with a chin laceration. The nurse would expect to apply which medication as ordered in preparation for sutures?

- A) TAC (tetracaine, epinephrine, cocaine)
- B) Iontophoretic lidocaine
- C) EMLA
- D) Vapocoolant spray

Ans: A

Feedback:

TAC (tetracaine, epinephrine, cocaine) is commonly used for lacerations that require suturing. The agent can be applied directly to the wound with a cotton ball or swab for 20 to 30 minutes until the area is numb. EMLA and iontophoretic lidocaine are applied to intact skin, not to open wounds or lacerations. A vapocoolant spray, which should not be applied over a wound, is only effective for 1 to 2 minutes.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1274, The Nurse's Role in Managing Chronic Pain

23.The nurse is caring for a child who reports chronic pain. What is the **priority** nursing assessment?

- A) How the pain impacts the child's and family's stress level
- B) The pain's history, onset, intensity, duration, and location
- C) The child's and parents' feeling of anxiety and depression
- D) The child's cognitive level and emotional response

Ans: B

Feedback:

Assessment of the child's pain is key; it is the priority assessment and is the only answer that focuses on the child's physiologic need. Assessment of how the pain impacts the child's and family's stress, feelings of anxiety, hopelessness, and depression, as well as the child's cognitive level and emotional response, are secondary after the pain is explored.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1270, 1271, Epidural Analgesia

24.The nurse is monitoring a child who has received epidural analgesia with morphine. The nurse is careful to monitor for which adverse effect of the medication?

- A) Epidural hematoma
- B) Arachnoiditis
- C) Spinal headache
- D) Respiratory depression

Ans: D

Feedback:

The nurse needs to monitor for signs of respiratory depression, a potential adverse effect of the opioid medication. Epidural hematoma, arachnoiditis, and spinal headache are potential adverse effects of the insertion of the epidural catheter.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1273, The Nurse's Role in Managing Procedure-Related Pain

25.The nurse is providing teaching to the parents of a newborn prior to a heelstick. The nurse is describing the procedure and recommending various methods for the parents to help comfort their baby. Which statement by the parents indicates a need for further teaching?

- A) "It's better if we are not in the room for this."
- B) "We can use kangaroo care before and after."

- C) "We hope you are using a very tiny needle."
- D) "We can offer him nonnutritive sucking to calm him."

Ans: A

Feedback:

Unless contraindicated, the parents should be encouraged to be present before, during, and after the procedure to provide comforting support to the child. Kangaroo care, small-gauge needles, and nonnutritive sucking are other methods to provide atraumatic care.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1265--1267, Nonopioid Analgesics

26. The nurse is conducting a pain assessment of a 10-year-old boy who has been taking acetaminophen for chronic knee pain. The assessment indicates that the recommended dose is no longer providing adequate relief. What is the appropriate nursing action?

- A) Increase the dosage of the acetaminophen.
- B) Tell the child he is experiencing the ceiling effect.
- C) Use guided imagery to help his pain.
- D) Obtain an order for a different medication.

Ans: D

Feedback:

Increasing the dose of the acetaminophen will not help his pain because he has reached as high a dose of that medication that will work. This is known as the ceiling effect but explaining that to him will not help his pain. Guided imagery is not the best therapy for his pain, so the healthcare provider needs to order a different medication to manage his pain.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1269, Topical Forms

27. The nurse is preparing a child for a lumbar puncture. How far ahead of the procedure should the nurse apply the EMLA cream?

- A) 30 minutes
- B) 1 hour
- C) 3 hours
- D) 4 hours

Ans: C

Feedback:

For a deeper procedure such as a lumbar puncture, the nurse needs to apply the cream 2 to 3 hours before the procedure. For a superficial procedure, the EMLA cream should be applied at least 1 hour before the procedure.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1264, Heat and Cold Applications

28. The nurse is explaining the effects of heat application for pain relief. Which effect would the nurse be likely to include?

- A) Decreased blood flow to the area
- B) Increased pressure on nociceptive fibers
- C) Possible release of endogenous opioids
- D) Altered capillary permeability

Ans: B

Feedback:

Heat causes an increase in blood flow. This alters capillary permeability, leading to a reduction in swelling and pressure on nociceptive fibers. Heat also may trigger the release of endogenous opioids, which mediate the pain response.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1267, Opioid Analgesics

29. Pentazocine is prescribed for a child with moderate pain. The nurse identifies this drug as an example of which type?

- A) Nonsteroidal anti-inflammatory drug (NSAID)
- B) Prostaglandin inhibitor
- C) Opioid
- D) Mixed opioid agonist–antagonist

Ans: D

Feedback:

Pentazocine is classified as a mixed opioid agonist–antagonist. Ibuprofen, ketorolac, and naproxen are examples of NSAIDs that inhibit prostaglandin synthesis. Morphine, codeine, and fentanyl are examples of opioids.

Format: Multiple Select

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1262, Behavioral-Cognitive Strategies

30. The nurse is researching behavioral-cognitive pain relief strategies to use on a 5-year-old child with unrelieved pain. Which methods might the nurse choose? Select all that apply.

- A) Relaxation
- B) Distraction
- C) Thought stopping
- D) Massage

E) Sucking

Ans: A, B, C

Feedback:

Common behavioral-cognitive strategies include relaxation, distraction, imagery, thought stopping, and positive self-talk. Sucking and massage are examples of biophysical interventions.

Chapter 37

1. The nurse is caring for a neonate who is suspected of having sepsis. Which assessment findings would the nurse interpret as **most** indicative of sepsis?
A. Rash on face
B. Edematous neck
C. Hypothermia
D. Coughing

Answer: C

Rationale: Hypothermia is a sign of sepsis in neonates. A rash on the face is a symptom of scarlet fever. An edematous neck is a sign of diphtheria. Paroxysmal coughing is a symptom of pertussis.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1298-1299

2. The nurse is preparing a plan of care for a 5-year-old boy with chickenpox. Which nursing intervention should be questioned?
A. Administer antipyretics as ordered.
B. Keep the child's fingernails short.
C. Monitor fluid intake and output.
D. Provide alcohol baths as needed.

Answer: D

Rationale: Treatments such as sponging the child with alcohol or cold water are not appropriate interventions for fever management. Rather, the nurse would use tepid sponge baths and cool compresses. Administering antipyretics, keeping the child's fingernails short, and monitoring intake and output are appropriate.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 1308

3. The nurse is developing a teaching plan for the mother of a 4-year-old girl with cold and fever. What would the nurse include in this teaching plan?
A. Keeping the child covered and warm

- B. Calling the doctor if the child's fever lasts more than 36 hours
- C. Ensuring fluid intake to prevent dehydration
- D. Observing for changes in alertness resulting from brain damage

Answer: C

Rationale: Teaching the mother to ensure fluid intake is important because fever can cause dehydration. The child should be dressed lightly. There is no need to call the doctor unless the child's fever lasts more than 3 to 5 days or the fever is greater than 105°F. A rapid rise to a high fever can cause a febrile convulsion, but it does not lead to brain damage.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1285

4. After teaching a mother how to remove a tick from her 6-year-old boy's arm, the nurse determines that additional teaching is needed when the mother makes what statement?
- A. "I'll protect my fingers with a paper towel."
 - B. "I'll grasp the tick and pull it away quickly."
 - C. "I should put the tick in a plastic bag in the freezer."
 - D. "I need to grasp the tick close to the child's skin."

Answer: B

Rationale: Grasping the tick and pulling it away quickly would indicate the need for additional teaching. When removing a tick, the mother should use fine-tipped tweezers while protecting her fingers with a tissue, paper towel, or latex gloves. The mother should grasp the tick as close to the skin as possible and pull upward with steady, even pressure. Once removed, the mother should place the tick in a sealable plastic bag in the freezer in case the child becomes sick and identification of the tick is needed.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1316

5. The nurse is performing a physical examination of an 8-year-old girl who was bitten by her kitten. Which assessment would lead the nurse to suspect cat-scratch disease?

- A. Swollen lymph nodes
- B. Strawberry tongue
- C. Infected tonsils
- D. Swollen neck

Answer: A

Rationale: Lymph nodes, especially under the arms, can become painful and swollen due to cat-scratch disease. Strawberry tongue is typical of scarlet fever. Infected tonsils and an edematous neck are symptoms of diphtheria.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1314

6. A group of nursing students are reviewing the six links in the chain of infection and the nursing implications for each. The students demonstrate understanding of the information when they identify which precaution as helping to break the chain of infection to the susceptible host?

- A. Keeping linens dry and clean
- B. Maintaining skin integrity
- C. Washing hands frequently
- D. Coughing into a handkerchief

Answer: B

Rationale: Maintaining the integrity of the child's skin and mucous membranes is a precaution that will break the chain of infection at the susceptible host. Keeping linens dry and clean is a precaution to take at the reservoir link. Washing hands frequently breaks the chain at the mode of transmission. Coughing into a handkerchief is a precaution for the portal of exit.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Understand

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Integrated Process: Teaching/Learning

Reference: p. 1288

7. The nurse is performing a physical examination on a 9-year-old boy who has experienced a tick bite on his lower leg and is suspected of having Lyme disease. Which assessment finding would the nurse expect to find?

- A. Swelling in the neck
- B. Confusion and anxiety
- C. Ring-like rash on lower leg
- D. Hypersalivation

Answer: C

Rationale: A ring-like rash at the site of the tick bite is characteristic for Lyme disease. Swelling in the neck is a symptom of mumps. Confusion, anxiety, and hypersalivation are symptoms of rabies.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1315

8. The nurse determines that it is necessary to implement airborne precautions for children with which infection?

- A. Measles
- B. Streptococcus group A
- C. Rubella
- D. Scarlet fever

Answer: A

Rationale: Airborne precautions are designed to reduce the risk of infectious agents transmitted by airborne droplet nuclei or dust particles such as for children with measles, varicella, or tuberculosis. Droplet precautions would be used for children with streptococcal group A infections, rubella, and scarlet fever.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Integrated Process: Nursing Process

Reference: p. 1289

9. A child is diagnosed with scarlet fever. The nurse is reviewing the child's medical record, expecting which medication to be prescribed for this child?

- A. Ibuprofen
- B. Acyclovir
- C. Penicillin V
- D. Doxycycline

Answer: C

Rationale: Penicillin V is the antibiotic of choice for the treatment of scarlet fever. Ibuprofen is used to treat fever. Acyclovir is used to treat viral infections. Doxycycline, a tetracycline, is the drug of choice for treating Rocky Mountain spotted fever.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Understand

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Nursing Process

Reference: p. 1301

10. A mother brings her 8-year-old son for evaluation because of a rash on his lower leg. Which finding would support the suspicion that the child has Lyme disease?

- A. Playing in the woods about a week ago
- B. Rash is papular and vesicular
- C. High fever occurring about 4 days before the rash
- D. Reports of extreme pruritus with visible nits

Answer: A

Rationale: Lyme disease is caused by the bite of an infected tick, with a rash appearing 7 to 14 days after the tick bite. Ticks are commonly found in wooded areas. Therefore, reports of the child playing in the woods about 7 days ago would support the diagnosis of Lyme disease. A papular and vesicular rash is commonly associated with varicella (chickenpox). A high fever for 3 to 5 days before a rash suggests roseola. Extreme pruritus with visible nits would suggest pediculosis.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Understand

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1315

11. After teaching the parents of a child with chickenpox (varicella zoster), the nurse determines that the parents have understood the teaching when they state that their child can return to school at which time?

- A. After day 5 of the rash
- B. When the rash is completely healed
- C. Once the rash appears
- D. After the lesions have crusted

Answer: D

Rationale: Children with chickenpox (varicella zoster) can return to school once the lesions have crusted.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1308

12. After teaching a class on the role of white blood cells in infection, the instructor determines that the teaching was successful when the class identifies which type of white blood cells as important in combating bacterial infections?

- A. Neutrophils
- B. Eosinophils

- C. Basophils
- D. Lymphocytes

Answer: A

Rationale: Elevations in certain portions of the white blood cell count reflect different processes occurring in the body. Neutrophils function to combat bacterial infection. Eosinophils function in allergic disorders and parasitic infections. Basophils combat parasitic infections and some allergic disorders. Lymphocytes function in viral infections.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Remember

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Integrated Process: Teaching/Learning

Reference: p. 1285

13. A nursing instructor is teaching a group of students about the action of antipyretic agents in children. The instructor determines that the teaching has been successful when the students identify which action as the primary action?

- A. Cause vasodilation to promote heat loss
- B. Decrease the temperature set point
- C. Block release of histamine
- D. Promote prostaglandin production

Answer: B

Rationale: Antipyretics act to decrease the temperature set point in children with elevated temperatures by inhibiting the production of prostaglandins, which leads to heat loss through vasodilation and sweating. Antihistamines block the release of histamine.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Understand

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Integrated Process: Teaching/Learning

Reference: p. 1285-1286

14. A nurse is instructing a parent on how to obtain a stool culture for ova and parasites from a child with diarrhea. What would the nurse include in the teaching plan?

- A. "Give the child bismuth and then collect the next specimen."
- B. "Obtain the specimen from the toilet after the child has a bowel movement."
- C. "Keep the specimen from coming into contact with any urine."
- D. "Bring the specimen to the laboratory on the third day."

Answer: C

Rationale: A stool specimen for culture must be free of urine, water, and toilet paper. Therefore, the parent needs to understand how to collect the specimen so that it does not come into contact with any of these. In addition, the specimen should not be retrieved out of toilet water. Mineral oil, barium, and bismuth interfere with the detection of parasites. In such cases, specimen collection should be delayed for 7 to 10 days. Once the specimen is collected, it should be brought to the laboratory immediately.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Teaching/Learning

Reference: p. 1293

15. The nurse is preparing to obtain a blood specimen via capillary heel puncture. Which action would be **most** appropriate for the nurse to do?

- A. Apply a cool compress for several minutes before collection.
- B. Elevate the extremity used after puncturing it.
- C. Squeeze the area to facilitate specimen collection.
- D. Wipe away the first drop of blood with dry gauze.

Answer: D

Rationale: When obtaining a blood specimen by capillary puncture, the nurse should wipe away the first drop of blood with a cotton ball or dry gauze pad and then collect the sample without squeezing the foot to prevent possible hemolysis. Prior to the puncture, the nurse can apply a commercial heel warmer or warm compress for several minutes to promote vasodilation. The extremity being used should be placed in the dependent position after puncturing the heel.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1292

16. The nurse is assessing the tympanic temperature of several children. The nurse documents that the child with which temperature reading has a fever?

- A. 98.2° F (36.8° C)
- B. 99.2° F (37.3° C)
- C. 100° F (37.8° C)
- D. 100.8° F (38.2° C)

Answer: D

Rationale: A tympanic temperature greater than 100.4° F (greater than 38° C) is defined as fever. An oral temperature of 100° F (greater than 37.8° C) would identify a fever. An axillary temperature of 99° F (greater than 37.2° C) would identify a fever.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1285

17. A school-aged child with an infectious disease is placed on transmission-based precautions. If the child is not dehydrated or otherwise in distress, which nursing diagnosis would be the **priority**?

- A. Impaired skin integrity related to trauma secondary to pruritus and scratching
- B. Fluid volume deficit related to increased metabolic demands and insensible losses
- C. Social isolation related to infectivity and inability to go to the playroom
- D. Deficient knowledge related to how infection is transmitted

Answer: C

Rationale: Children who are placed on transmission-based precautions are not allowed to leave their rooms and are not allowed to go to common areas such as the playroom or schoolroom. Thus, they are at risk for social isolation. Impaired skin integrity, fluid volume deficit, and deficient knowledge may be appropriate but would depend on the infectious disease diagnosed.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Integrated Process: Nursing Process

Reference: p. 1288

18. When reviewing infectious diseases in the pediatric population, nursing students identify which disease as a common childhood exanthema?

- A. Mumps
- B. Rabies
- C. Rubella
- D. West Nile virus

Answer: C

Rationale: Rubella is a common childhood exanthema. Mumps is a viral infection. Rabies is a zoonotic infection. West Nile virus is a vector-borne disease.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1306

19. The parents of a 5-year-old have just found out that their child has head lice. Which statement by the parents would support the nursing diagnosis of deficient knowledge?

- A. "I can't believe it. We're not unclean, poor people."
- B. "We'll have to get that special shampoo."
- C. "Everybody in the house will need to be checked."
- D. "That explains his complaints of itching on his neck."

Answer: A

Rationale: Head lice is not an indication of poor hygiene or poverty. It occurs in all socioeconomic groups. Thus, the parents' statement about being unclean and poor reflects a lack of knowledge about the infection. A pediculicide is used to wash the hair to treat the infestation. Household contacts need to be examined and treated if affected. Extreme pruritus is the most common symptom, with nits or lice especially behind the ears or at the nape of the neck.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Teaching/Learning

Reference: p. 1318

20. A nurse suspects that an adolescent may have community-acquired methicillin-resistant *Staphylococcus aureus* (CAMRSA). What would the nurse expect to assess? Select all that apply.

- A. Participation in contact sport
- B. Recent cut on the lower leg
- C. History of a recent sore throat
- D. Raised fluctuant lesions
- E. Erythematous rash over the trunk and face

Answer: A, B, D

Rationale: With CAMRSA, skin and tissue infections are common, often appearing as a bump or skin area that is red, swollen, painful, and warm to the touch. There also may be fluctuance and purulent drainage. Participation in contact sports, openings in the skin such as abrasions and cuts, contact with contaminated items and surfaces, poor hygiene, and crowded living conditions are risk factors for CAMRSA. Recent sore throat and an erythematous rash on the trunk, face, and possibly the extremities are associated with scarlet fever.

Question format: Multiple Select

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1300

21. A child is diagnosed with a helminthic infection. Which treatments would the nurse expect to be prescribed? Select all that apply.

- A. Erythromycin
- B. Albendazole
- C. Pyrantel pamoate
- D. Acyclovir
- E. Metronidazole
- F. Permethrin

Answer: B, C

Rationale: Drugs used to treat helminthic infections include albendazole and pyrantel pamoate.

Erythromycin is used to treat bacterial infections. Acyclovir is used to treat viral infections.

Metronidazole is used to treat trichomoniasis. Permethrin is used to treat pediculosis.

Question format: Multiple Select

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Nursing Process

Reference: p. 1320

22. The client has a heavily draining wound for which there is an order to change the dressing every 4 hours. The nurse becomes busy and does not change the dressing as ordered. Which link in the chain of infection has the nurse allowed to flourish?

- A. Susceptible host
- B. Portal of exit
- C. Reservoir
- D. Mode of transmission

Answer: C

Rationale: The reservoir is the area where a pathogen grows and reproduces. Leaving the dressing unchanged allows for a dark, warm, nutrient rich, and moist environment where many organisms will thrive. A susceptible host is a person who cannot fight off an infection. The portal of exit is the way a pathogen exits the host. The mode of transmission is the way the pathogen travels.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Integrated Process: Nursing Process

Reference: p. 1288

23. The parents of a 7-month-old child with an infection ask the nurse about how to treat their child's fever. After providing teaching, the parents voice understanding with which statements? Select all that apply.

- A. "If my child's fever is under 102°F , I don't need to make an appointment with the physician."
- B. "Having a temperature over 38°C puts my child at risk for the infection spreading to the bloodstream."
- C. "I can use acetaminophen to help with the symptoms of the infection but it won't get rid of the infection."
- D. "Even though people get frightened, fevers are not a bad thing during an infection unless it gets too high."
- E. "Any fever is dangerous and can cause serious damage to brain cells if it goes on too long."

Answer: A, C, D

Rationale: In infants older than 3 months of age, fever less than 38.9°C (102°F) usually does not require treatment by a physician. Antipyretics, such as acetaminophen, provide symptomatic relief but do not change the course of the infection. A fever can actually enhance various components of the immune response. Infants younger than 3 months of age with a rectal temperature greater than 38°C should be seen by a physician or nurse practitioner because of increased risk of sepsis.

Question format: Multiple Select

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1285-1287

24. The mother of a 4-year-old boy has contacted the physician's office. She reports her son was exposed to someone with chickenpox. She has inquired about when her son may show if he has gotten the disease. What information should be provided?

- A. The illness should be seen in a week if he has been exposed.
- B. Symptoms of the disease should show up within 24 to 48 hours of exposure.
- C. The incubation period for the disease is between 10 and 21 days.
- D. Younger children will have longer periods of incubation.

Answer: C

Rationale: Chickenpox is the common name for varicella. This condition has an incubation period of 10 to 21 days.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1308

25. The nurse is providing education to the parents of a child diagnosed with pinworms. Which statement is **most** important for the nurse to include in the teaching?

- A. "Seal the child's clothing in a plastic bag for at least 10 days."

- B. "Be sure your child wears shoes at all times."
- C. "Make sure your child washes hands before eating."
- D. "After applying this special cream, leave it on for about 8 to 10 hours."

Answer: C

Rationale: The most effective measure to prevent pinworms or a recurrence is good hand hygiene, especially after using the bathroom and before eating. Sealing the child's clothing in a plastic bag is appropriate for pediculosis capitis. Having the child wear shoes at all times is helpful in preventing hookworm. Use of a cream that remains on for a specified time is associated with scabies.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1320

26. A nurse is conducting a health history for a 1-month-old with an infectious disorder. Which segment of the maternal health history would be **most** helpful for the nurse when determining if the infant developed the infection from the mother?

- A. Family history
- B. Past medical history
- C. Home treatments
- D. Present illness history

Answer: B

Rationale: Past medical history will provide information about the mother's pregnancy and birth, giving insight into the possibility of maternal transmission of the infection. Family history would provide information about lack of immunizations or recent infectious or communicable diseases. Home treatments and present illness history would provide no information about the possibility of maternal transmission of infection.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 1290

27. The nurse is caring for a hospitalized, 1-week-old infant who appears very ill. Which assessment finding(s) will the nurse report to the health care provider? Select all that apply.

- A. Petechiae
- B. Heart rate 100 beats/min
- C. Respiratory rate 60 breaths/min
- D. Axillary temperature 97.6°F (36.5°C)

E. Characteristic of cry

Answer: A, B, C, D, E

Rationale: Sepsis is suspected in any infant under 3 months of age until laboratory findings return. In an infant, the most important findings are hypothermia, bradycardia, and apnea. Tachypnea can be present in both infants and children. The nurse would be concerned with the infant's weak cry, lethargy, and an increased work of breathing such as rate, nasal flaring, grunting, and retractions. The child with sepsis generally has an elevated temperature, but hypothermia is seen in infants. The nurse should perform a good skin assessment. If petechiae are present, it is indicative of a very serious infection caused by *Neisseria meningitidis*.

Question format: Multiple Select

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1294-1296

28. While hospitalized, a child develops scarlet fever. Isolation has been prescribed by the health care provider. The nurse would place this child in what type of isolation?

- A. Airborne
- B. Droplet
- C. Contact
- D. Reverse

Answer: B

Rationale: Scarlet fever is produced by group A streptococcus. It is most seen in children ages 5 years to 15 years. It is spread by droplets from respiratory secretions by talking, coughing, or sneezing. These droplets can travel 3 feet (1 meter). Isolation recommendations require the use of a mask for care of the child. Airborne isolation is required for illness that also produce droplets but these are smaller, can travel further and stay suspended in air. An N95 mask and negative pressure room is required for this type of isolation. Contact isolation requires the use of gowns, masks and gloves for direct contact with an infected person. Reverse isolation occurs if the client is neutropenic.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Integrated Process: Nursing Process

Reference: p. 1289

29. The nurse is assessing a 8-month-old infant who has symptoms of poor feeding, a poor gag reflex, listlessness and a weak cry. What is the **most** important question the nurse should ask the parent about these symptoms?

- A. "Have you given your infant any honey?"

- B. "When did these symptoms begin?"
- C. "Has your infant had any unpasteurized milk to drink?"
- D. "What is the source of your family's water supply?"

Answer: A

Rationale: Infant botulism occurs when the infant ingests the spores of *Clostridium botulinum*. These multiply in the intestinal track and produce toxins. The disease is caused by the ingestion of spores from dust, improperly preserved home-canned foods and feeding an infant under 1 year of age raw honey. The infant has poor feeding, is listless, has a weak cry, and a has poor gag reflex--a distinguishing symptom. The nurse would ask about the water supply and unpasteurized milk if food poisonings or parasites were suspected. Asking about the date of the infant's illness is important, but this information does not take priority over the question about honey.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1304

30. A child is being treated for pertussis and is prescribed azithromycin by the health care provider. Which finding is **most** important for the nurse to report to the health care provider before administering this drug?

- A. Child has had previous episodes of supraventricular tachycardia (SVT).
- B. Child has a potassium level of 3.7 mEq/l (3.7 mmol/l).
- C. Child is also prescribed a proton pump inhibitor (PPI).
- D. Child experienced a rash on the back taking this drug previously.

Answer: A

Rationale: Azithromycin is recommended for use to treat pertussis in infants older than 1 month of age and children. It should, however, not be used in children at risk for cardiovascular events. It may cause a potentially fatal heart rhythm, because it can lead in changes in the electrical activity of the heart. It is especially important in children with prolonged QT intervals. The finding of SVT should be reported to the health care provider before the administration of the drug. The potassium level is within a normal range and it has no effect on the drug.

Azithromycin should not be given with any aluminum or magnesium antacids. The PPI should be safe. A rash may indicate an allergy to the drug and should be reported, but it is not the most important finding. The health care provider would make a determination for the drug administration based on risks versus benefits.

Question format: Multiple Choice

Chapter 37: Nursing Care of the Child With an Infectious or Communicable Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Nursing Process

Reference: p. 1303

Chapter 38

1. When providing care to a newborn infant who was born at 29 weeks' gestation, the nurse integrates knowledge of potential complications, being alert for signs and symptoms of what condition?
- A. Neonatal conjunctivitis
 - B. Facial deformities
 - C. Intracranial hemorrhage
 - D. Incomplete myelination

Answer: C

Rationale: Premature infants have more fragile capillaries in the periventricular area than term infants, which puts them at greater risk for intracranial hemorrhage. Neonatal conjunctivitis can occur in any newborn during birth and is caused by viruses, bacteria, or chemicals. Facial deformities are typical of babies of alcoholic mothers. Incomplete myelination is present in all newborns.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1355

2. The nurse knows that children have larger heads in relation to the body and a higher center of gravity. When developing a teaching plan for parents, the nurse includes information about an increased risk for which problem?

- A. Febrile seizures
- B. Head trauma
- C. Caput succedaneum
- D. Posterior plagiocephaly

Answer: B

Rationale: The larger head size in relation to the body, coupled with a higher center of gravity, causes children to hit their head more readily when involved in motor vehicle accidents, bicycle accidents, and falls. Febrile seizures are not related to anatomy or physiology. Caput succedaneum is an edematous area on the scalp caused by pressure of the uterus or vagina during head-first delivery. Posterior plagiocephaly is caused by early closure of the lamboid suture.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1327-1328

3. The nurse is caring for a child hospitalized with Reye syndrome who is in the acute stage of the illness. The nurse would assess the child most carefully for what finding?

- A. Indications of increased intracranial pressure
- B. An increase in the blood glucose level
- C. A decrease in the liver enzymes
- D. A presence of protein in the urine

Answer: A

Rationale: Reye syndrome is characterized by brain swelling, liver failure, and death in hours if treatment is not initiated. Therefore, increased intracranial pressure could occur. Liver enzyme levels typically increase. Blood glucose levels and protein in the urine are not characteristic of this illness.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1363

4. The physician has ordered rectal diazepam for a 2-year-old boy with status epilepticus. Which instruction is essential for the nurse to teach the parents?

- A. Monitor their child's level of sedation.
- B. Watch for fever indicating infection.
- C. Gradually reduce the dosage as seizures stop.
- D. Monitor for an allergic reaction to the medication.

Answer: A

Rationale: Diazepam is useful for home management of prolonged seizures and requires that the parents be educated on its proper administration. Monitoring the child's level of sedation is key when giving diazepam because it slows the central nervous system. Parents need to monitor the overall health of the child, including temperature when needed, but that has nothing to do with the diazepam. When the use of an anticonvulsant is stopped, gradual reduction of the dosage is necessary to prevent seizures or status epilepticus. This is not done without a physician's order. Monitoring for allergic reactions is necessary when any medications have been prescribed, but is not specific to diazepam.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies
Integrated Process: Teaching/Learning
Reference: p. 1342

5. As a result of seizure activity, a computed tomography (CT) scan was performed and showed that an 18-month-old child has intracranial arteriovenous malformation. When developing the child's plan of care, what would the nurse expect to implement actions to prevent?
- A. Drug interactions
 - B. Developmental disabilities
 - C. Hemorrhagic stroke
 - D. Respiratory paralysis

Answer: C

Rationale: Intracranial hemorrhage or hemorrhagic stroke is a risk for children with intracranial arteriovenous malformation. Drug interactions are a risk for children who are treated with combinations of anticonvulsants for epilepsy. Children with hydrocephalus are at an increased risk for developmental disabilities. Respiratory paralysis is a risk of botulism that typically affects infants younger than 6 months of age.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1355

6. A 16-year-old boy reports to the school nurse with headaches and a stiff neck. Which sign or symptom would alert the nurse that the child may have bacterial meningitis?
- A. Fixed and dilated pupils
 - B. Frequent urination
 - C. Sunset eyes
 - D. Sunlight is "too bright"

Answer: D

Rationale: Photophobia, or intolerance of light, is another symptom of bacterial meningitis. Fixed and dilated pupils are a symptom of head trauma and warrant prompt intervention. Frequent urination is a symptom of a type I Arnold-Chiari malformation. Sunset eyes indicate increased intracranial pressure typical of hydrocephalus.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1359

7. A 4-year-old boy has a febrile seizure during a well-child visit. What action would be a **priority**?

- A. Hyperextending the child's head while placing him on his side
- B. Using a tongue blade to pry open the child's jaw
- C. Loosening the child's clothing to ensure a patent airway
- D. Protecting the child from harm during the seizure

Answer: D

Rationale: During a seizure, the child should not be held down in a specific position. Protecting the child's head and body during the seizure is the priority. Ensuring a patent airway is an important intervention but is not accomplished by loosening the child's clothing or hyperextending his head. The child should be placed on his side and nothing should be inserted into his mouth to forcibly open the jaw.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1348-1349

8. The nurse has developed a teaching plan for the family of a 2-year-old boy who holds his breath when he gets frustrated. What will be **most** important to include in this plan?

- A. Provide cuddle time whenever the child begins to act out.
- B. Explain the child's behavior to the parents.
- C. Encourage the parents to interact more with the child.
- D. Stay close to prevent injury when he gets frustrated.

Answer: D

Rationale: Encourage the parents to maintain a safe environment when an episode is occurring, but to avoid giving extra attention to the child after the event since this could encourage repetition of the behavior. It is important for the parents to understand what is happening, but rewarding the child with cuddle time when he is misbehaving provides incorrect reinforcement of behaviors. Encouraging the parents to interact more with the child may be helpful, but the priority is safety for the child.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1371

9. The nurse is caring for an 8-year-old boy who has chronic epilepsy. What would be **most** important to address when teaching the child and parents about living with this condition?
- A. Multiple corrective surgeries to slowly remove diseased parts of his brain
 - B. Physical, occupational, and speech therapy to maximize his potential
 - C. Support for maintaining self-esteem because of his altered lifestyle
 - D. Hyperventilation therapy to counteract the periods of decreased oxygenation

Answer: C

Rationale: The effects of living with a seizure disorder can be devastating, and it is essential for the child to receive support to maintain self-esteem. While corrective surgery is possible, it would only be performed once. Physical, occupational, speech, and hyperventilation therapy are not indicated for treatment of epilepsy.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Integrated Process: Teaching/Learning

Reference: p. 1348

10. A 4-year-old boy has a history of seizures and has been started on a ketogenic diet. Which food selection would be **most** appropriate for his lunch?

- A. Fried eggs, bacon, and iced tea
- B. A hamburger on a bun, French fries, and milk
- C. Spaghetti with meatballs, garlic bread, and a cola drink
- D. A grilled cheese sandwich, potato chips, and a milkshake

Answer: A

Rationale: The ketogenic diet involves a high intake of fats, adequate protein intake, and a very low intake of carbohydrates, resulting in a state of ketosis. The child is kept in a mild state of dehydration. Eggs and bacon are high in fat; the tea does not contain any carbohydrates.

Therefore, this is the best choice. The hamburger is fat and protein, the bun is a carbohydrate, and the French fries and the milk both contain fat and protein, but both contain a lot of carbohydrates. The pasta and the sauce for the spaghetti are carbohydrates, the meatballs are protein, and the garlic bread is a carbohydrate, as is the cola drink. The grilled cheese sandwich has the fat and protein from the cheese, but the bread and chips are primarily carbohydrates, and the milkshake has fat, protein, and carbohydrates. Only the selection in A contains a ketogenic meal.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Basic Care and Comfort

Integrated Process: Teaching/Learning

Reference: p. 1341

11. A child with increased intracranial pressure is being treated with hyperventilation. The nurse understands that after this treatment:

- A. PaCO₂ levels decrease, causing vasoconstriction.
- B. drainage of cerebrospinal fluid occurs.
- C. activity is controlled via a stimulator.
- D. hyperexcitability of the nerves is reduced.

Answer: A

Rationale: Hyperventilation decreases PaCO₂, which results in vasoconstriction and therefore decreases intracranial pressure. A shunt would allow for drainage of cerebrospinal fluid. A vagal nerve stimulator is used to provide an appropriate dose of stimulation to manage seizure activity. Anticonvulsants decrease the hyperexcitability of nerves.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1340

12. The nurse assesses a child's level of consciousness, noting that the child falls asleep unless he is stimulated. What is the child's level of consciousness?

- A. Confusion
- B. Obtunded
- C. Stupor
- D. Coma

Answer: B

Rationale: Obtunded is a state in which the child has limited responses to the environment and falls asleep unless stimulation is provided. Confusion involves disorientation; the child may be alert but responds inappropriately to questions. Stupor exists when the child responds only to vigorous stimulation. Coma is a state in which the child cannot be aroused even with painful stimuli.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1330

13. During a well-child visit, the nurse assesses an infant's ability to suck on a pacifier. The nurse is assessing which cranial nerve?

- A. Olfactory
- B. Trigeminal
- C. Facial
- D. Accessory

Answer: B

Rationale: To test the trigeminal nerve, the nurse would note the strength of the infant's suck on a pacifier, thumb, or bottle. The olfactory nerve is not assessed in infants and young children. The facial nerve is assessed by noting the symmetry of facial expressions. For the infant, this would be assessed during spontaneous crying or smiling. The accessory nerve is assessed when the infant is in the sitting position and symmetry of the head position is noted.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 1331

14. The nurse inspects the eyes of a child and observes that the sclera is showing over the top of the iris. The nurse documents this finding as:

- A. Decorticate posturing
- B. Nystagmus
- C. Doll's eye
- D. Sunsetting

Answer: D

Rationale: Sunsetting is when the sclera of the eyes is showing over the top of the iris.

Decorticate posturing includes adduction of the arms, flexion at the elbows with the arms held over the chest, and flexion of the wrists with both hands fisted and the lower extremities adducted and extended. Nystagmus is manifested by involuntary rapid rhythmic eye movements. Doll's eye is a maneuver that tests for symmetric eye movement to the opposite side when the head is turned in the other direction.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Communication and Documentation

Reference: p. 1331

15. What finding would lead the nurse to suspect that a child is beginning to develop increased intracranial pressure?

- A. Bradycardia
- B. Cheyne-Stokes respirations
- C. Fixed, dilated pupils
- D. Projectile vomiting

Answer: D

Rationale: Projectile vomiting is an early sign of increased intracranial pressure. Bradycardia, Cheyne-Stokes respirations, and fixed dilated pupils are late signs of increased intracranial pressure.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1333

16. A nurse is talking with the parents of a child who has had a febrile seizure. The nurse would integrate an understanding of what information into the discussion?

- A. The child's risk for cognitive problems is greatly increased.
- B. Structural damage occurs with febrile seizure.
- C. The child's risk for epilepsy is now increased.
- D. Febrile seizures are benign in nature.

Answer: D

Rationale: Parents need reassurance that febrile seizures, although frightening, are benign in nature. Children who experience one or more febrile seizures are at no greater risk of developing epilepsy than the general population. No evidence exists that febrile seizures cause structural damage or cognitive declines.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Teaching/Learning

Reference: p. 1349

17. A nurse is preparing a school-aged child for a lumbar puncture. The nurse would expect to position the child in which manner?

- A. On her side with the head flexed forward and knees flexed to the abdomen
- B. Sitting upright with the head flexed forward to the chest
- C. Supine with arms and legs pronated and extended

D. Prone with the arms flexed under the chest

Answer: A

Rationale: When a lumbar puncture is performed on a child, the child is placed on his or her side with the head flexed forward and knees flexed to the abdomen. An infant would be positioned sitting upright with the head flexed forward. A supine position with the arms and legs pronated and extended suggests decerebrate posturing. A prone position is not used for a lumbar puncture.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1334

18. A group of nursing students are reviewing information related to seizures that occur in infants and children. The students demonstrate a need for additional review when they identify which type as common in neonates?

- A. Tonic
- B. Focal clonic
- C. Multifocal clonic
- D. Myoclonic

Answer: D

Rationale: Five major types of seizures have been recognized in the neonatal period: subtle, tonic, focal clonic, multifocal clonic, and myoclonic. Of these, myoclonic seizures rarely occur during the neonatal period. Subtle seizures affect preterm and full-term neonates. Tonic seizures primarily occur in preterm neonates. Focal clonic and multifocal clonic are more common in full-term neonates.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1349

19. Hydrocephalus is suspected in a 4-month-old infant. Which would the nurse expect to assess?

- A. Sunken fontanel
- B. Diminished reflexes
- C. Lower extremity spasticity
- D. Skull symmetry

Answer: C

Rationale: Hydrocephalus is manifested by spasticity of lower extremities, bulging fontanelles, brisk reflexes, and skull asymmetry.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1352

20. A nurse is providing teaching to the parents of a child who has had a shunt inserted as treatment for hydrocephalus. The parents demonstrate understanding of the teaching when they make what statement?

- A. "Having the shunt put in decreases his risk for developmental problems."
- B. "If he doesn't get an infection in the first week, the risk is greatly reduced."
- C. "He will need more surgeries to replace the shunt as he grows."
- D. "The shunt will help to prevent any further complications from his disease."

Answer: C

Rationale: Parents need to know that hydrocephalus is a chronic illness that requires lifelong follow-up and regular evaluations, including future surgeries as the child grows. The risk for infection is ever present, but is most common 1 to 2 months after shunt placement. The child with a shunt and hydrocephalus is at risk for potential growth and developmental disabilities as well as complications such as infection and malfunction of the shunt.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Teaching/Learning

Reference: p. 1355

21. A 15-year-old adolescent is brought to the emergency department by his parents. The adolescent is febrile with chills that started suddenly. He states, "I had a sinus infection and sore throat a couple of days ago." The nurse suspects bacterial meningitis based on which findings? Select all that apply.

- A. Complaints of stiff neck
- B. Photophobia
- C. Absent headache
- D. Negative Brudzinski sign
- E. Vomiting

Answer: A, B, E

Rationale: In addition to the adolescent's complaints and history, other findings suggesting bacterial meningitis include complaints of a stiff neck, photophobia, headache, positive Brudzinski sign, and vomiting.

Question format: Multiple Select

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1359

22. A child is brought to the emergency department after sustaining a concussion. The child is to be discharged home with his parents. What would the nurse include in the child's discharge instructions?

- A. "Expect his headache to get worse initially and then disappear."
- B. "Wake him every 2 hours to check his movement and responses."
- C. "Call your medical provider if he vomits more than five times."
- D. "Any watery fluid draining from his ears is normal."

Answer: B

Rationale: The nurse should instruct the parents to wake the child every 2 hours to ensure that he moves normally and wakes enough to recognize and respond appropriately to them. The parents should be instructed to call the physician or nurse practitioner or bring the child back to the emergency department if he experiences a constant headache that gets worse, vomits more than two times, or has oozing of blood or watery fluid from his ears or nose.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Teaching/Learning

Reference: p. 1365

23. A nurse is preparing a presentation for a local health fair about meningitis and has developed a display that lists the following causes:

Streptococcus group B

Haemophilus influenzae type B

Streptococcus pneumoniae

Neisseria meningitidis

What would the nurse highlight as the **most** common cause of meningitis in newborns?

- A. *Streptococcus* group B
- B. *Haemophilus influenzae* type B
- C. *Streptococcus pneumoniae*
- D. *Neisseria meningitidis*

Answer: A

Rationale: Meningitis due to *Streptococcus* group B along with *Escherichia coli* is most common in newborns and infants. *H. influenzae* type B is a common cause in infants between the ages of 6 and 9 months. *S. pneumoniae* and *N. meningitidis* are common causes in children older than 3 months and in adults.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1359

24. A group of students are reviewing information about head injuries in children. The students demonstrate understanding of this information when they identify what as the **most** common type of skull fracture in children?

- A. Linear
- B. Depressed
- C. Diastatic
- D. Basilar

Answer: A

Rationale: The most common type of skull fracture in children is a linear skull fracture, which can result from minor head injuries. Other, less common types of skull fractures in children include depressed, diastatic, and basilar.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1364

25. During class, a student states, "I didn't think children could have strokes. I thought this only occurred in older adults." When responding to the student, what would be **most** important for the instructor to integrate into the response?

- A. Strokes in children often have an identifiable cause.
- B. The signs and symptoms in children are different from an adult.
- C. Research has identified specific treatments for children.
- D. Ischemic strokes are more common than hemorrhagic strokes.

Answer: D

Rationale: In children, ischemic strokes are more common than hemorrhagic strokes. However, the cause of the stroke in many children remains unidentified. Signs and symptoms are similar to those in adults and will vary based on age; underlying cause, if known; and location of the stroke. Historically, children have been excluded from adult stroke studies and thus, many treatments used have had to be adapted from adult studies.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1369

26. A 10-month-old infant is brought to the emergency department by the parents after they found the infant face down in the bathtub. The parent states, "I just left the bathroom to answer the phone. When I came back, I found my infant." Which nursing action is **priority**?

- A. Assess the client's respiratory rate
- B. Start cardiopulmonary resuscitative measures
- C. Determine how long the client was face down in the water
- D. Apply a heart monitor to the client

Answer: A

Rationale: With a submersion injury, hypoxia is the primary problem. Therefore, assessment of airway and breathing are priority. Based on this assessment, the nurse would determine if resuscitative measures were needed. Other actions such as applying a heart monitor and obtaining additional information about the event would be done once the infant's airway and breathing are assessed and emergency interventions are instituted.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1368

27. A hospitalized child is scheduled for magnetic resonance imaging (MRI) with contrast. What nursing intervention(s) will the nurse complete to ensure safety during the examination? Select all that apply.

- A. Place child in clothing with no metal
- B. Connect the child to a heart monitor
- C. Assess the IV site for patency
- D. Review any prescriptions for sedation
- E. Assess for a latex allergy

Answer: A, C, D

Rationale: When preparing a child for an MRI procedure, it is important the child and parent are aware of the test procedure. No metal can be used in the MRI scanner room so all clothing, jewelry, etc. need to be removed before testing. IV contrast may be used so the IV needs to be patent and in good working order. If the child is to be sedated the nurse should review the sedation prescription and identify any discrepancies before the child goes for the examination. If the child is to be sedated a heart monitor will be used, but it is not necessary for the nurse on the unit to connect the child. A special monitor compatible with the MRI scanner will be used. If sedated the child may also receive oxygen just as a prevention because the exam take a long time in a confined space. Having a latex allergy is not a contraindication for receiving gadolinium, the MRI contrast used during testing.

Question format: Multiple Select

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1335

28. A child is in the emergency department with a head injury obtained in a motor vehicle crash. The glascow coma scale assessment is rated at 10 (3 eye opening, 3 motor, 4 verbal). How should the nurse interpret these findings?

- A. The child's eyes open to verbal stimuli, is confused and flexes with painful stimuli
- B. The child's eyes open spontaneously, able to localize pain and uses inappropriate words
- C. The child's eyes open to speech, is able to obey commands but is confused
- D. The child's eyes open to pain, opens to extension and says incomprehensible words

Answer: A

Rationale: The glascow coma scale is a widely used tool for assessing the extent of brain injury and prognosis. The scores are based on eye opening, motor response and verbal response. The perfect score is 15. The lower the score the more severe the injury and prognosis. Scores for a severe head injury are 8 or less. A moderate head injury scores between 9-12 points and a mild head injury scores between 13 and 15. With a score of 10 this child would be classified as having a moderate head injury. For answer B the eyes open spontaneously (4), localizes pain (5) and uses imcomprehensive words(2) for a total score of 11. For answer C the eyes open to speech (3), uses inappropriate words (2) and has flexion withdrawal (4) for a total score of 9. For answer D the eyes open to pain (2) extremities open to expension (2) and uses incomprehensible words (2) for a score of 6.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1330

29. Phenytoin IV has been prescribed by health care provider for a child who has experienced a seizure. Before administering the drug what should the nurse do?

- A. Determine the IV fluid infusing is normal saline
- B. Assess the child's vital signs
- C. Monitor the electrolyte levels
- D. Start another IV with a large bore needle

Answer: A

Rationale: The drug phenytoin can be administered PO or IV. If it is to be administered IV, the fluids needs to be normal saline solution. Any other type of fluid will cause the drug to precipitate in the IV tubing. There is no need to start an additional peripheral IV. The drug can be administered via a secondary set through the IV pump. The vital signs can be monitored after the drug is infusing. The electrolyte levels can be monitored, but treatment of the seizure is the priority. Fosphenytoin is another form of phenytoin and may be tolerated better. It can be administered through all IV fluids without precipitation.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Nursing Process

Reference: p. 1346

30. A child with a seizure disorder will be discharged home from the hospital on the drug levetiracetam. What discharge instruction is the **most** important for the nurse to provide the parent?

- A. Notify the health care provider if child experiences poor coordination
- B. Notify the health care provider if the number of seizures increases after 4 weeks
- C. Return to the clinic in 3 weeks for laboratory test to determine therapeutic level of the drug
- D. Do not take two doses together if one dose is missed

Answer: A

Rationale: Levetiracetam is used in children to help control seizures. One major side effect of the drug is that it can cause difficulty with gait or coordination. Another major side effect is the development of psychiatric symptoms. The parent should be instructed to call the health care provider immediately if either of these side effects occur. This drug does not have a therapeutic level so there is no need for routine laboratory tests. The parent should be instructed not to give the child two doses together if one has been missed, but this is not the most important instruction. The drug takes about 4 weeks to stabilize in the blood stream, so additional seizures may be seen during this time.

Question format: Multiple Choice

Chapter 38: Nursing Care of the Child With an Alteration in Intracranial Regulation/Neurologic Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Teaching/Learning

Reference: p. 1346

Chapter 39

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1379, Health History

1.The nurse is developing a plan of care for a 5-year-old child with a severe hearing impairment focusing on psychosocial interventions based on assessment findings. Which behavior would the nurse have **most** likely assessed?

- A) Immature emotional behavior
- B) Self-stimulatory actions
- C) Inattention and vacant stare
- D) Head tilt or forward thrust

Ans: A

Feedback:

Immature emotional behavior would be seen most frequently. The inability to hear impacts the socialization process and causes social problems for the child because the hearing impairment has inhibited normal development. Self-stimulatory actions, inattention, vacant stare, head tilt, or forward thrust may also cause problems with socialization, but they are typical of visually impaired children.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1384, Nursing Management

2.The nurse is caring for a 3-month-old with nasolacrimal duct obstruction. Which intervention would be **most** appropriate for the nurse to implement?

- A) Being careful to prevent spread of infection
- B) Teaching the parents how to gently massage the duct
- C) Applying hot, moist compresses to the affected eye
- D) Referring the child to an ophthalmologist

Ans: B

Feedback:

Massaging the nasolacrimal duct can cause it to open and drain. Teaching the parents how to do this would be part of the nurse's plan of care. Nasolacrimal duct obstruction is not infectious. Applying hot, moist compresses to the eye is an intervention for conjunctivitis. Nasolacrimal duct obstruction is often self-resolving, so there would be no need for a specialist's care.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1387, Health History

3.The nurse is caring for a 10-year-old with allergic conjunctivitis. The nurse would be alert to the child's increased risk for what issue?

- A) Atopic dermatitis
- B) Insect bite sensitivity
- C) Acute otitis media
- D) Frequent sore throats

Ans: A

Feedback:

Atopic dermatitis is a risk factor specifically for allergic conjunctivitis because of repeated exposure to the particular allergens. Acute otitis media, insect bite sensitivity, and frequent sore throats can occur but are not related to the allergic conjunctivitis.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Caring

Page and Header: 1394, Nursing Management, Box 39.1

4.The nurse is caring for a 6-year-old visually impaired boy and is about to begin the physical examination. Which intervention would be **most** appropriate to promote effective communication with the child?

- A) Show him the stethoscope.
- B) Describe the examination room.
- C) Use his name before touching him.
- D) Allow him to explore the exam room.

Ans: C

Feedback:

When interacting with a visually impaired child, it is a good communication technique to use his name to gain his attention before touching him. Letting him listen to his heart with the stethoscope, describing the examination room, and promoting exploration by touch are sound ways to interact, but are not specific to communicating with the child at the beginning of the assessment.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1386, Eyelid Disorders

5.The nurse is instructing the parents of a school-age child with an eye disorder how to care for her eye. Which condition would the nurse explain as resolving by itself without the use of antibiotics?

- A) Blepharitis
- B) Hordeolum
- C) Corneal abrasion

D) Chalazion

Ans: D

Feedback:

Chalazion usually resolves spontaneously but may require surgical drainage. Therapeutic management of blepharitis, hordeolum, and corneal abrasion may require antibiotic ointment.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1400, Nursing Management

6.The nurse is caring for a 3-year-old boy with amblyopia. Which intervention would be **most** appropriate to include in the child's plan of care?

- A) Rinsing the eye with cool water
- B) Educating the family about the disease
- C) Encouraging frequent hand washing
- D) Promoting eye safety

Ans: D

Feedback:

Promoting eye safety is extremely important for the child with amblyopia; if the better eye suffers a serious injury, both eyes may become blind. Rinsing the eye with cool water, educating the family about the disorder, and encouraging frequent hand washing are interventions for infectious conjunctivitis.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1386, Nursing Assessment

7.The nurse is examining a 7-year-old boy with blepharitis. What would the nurse least likely expect to assess?

- A) Redness
- B) Scaling
- C) Pain
- D) Edema

Ans: C

Feedback:

Blepharitis has symptoms of redness, scaling, and edema, but not pain. Pain is typically associated with hordeolum.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1378, Eyes

8.The nurse is caring for a newborn and knows that his vision, unlike his hearing, is not fully developed. Which aspect of the child's vision would the nurse expect to be similar to his father's vision?

- A) Adequate color detection
- B) Visual acuity of 20/100
- C) Nearsightedness
- D) Monocular vision

Ans: B

Feedback:

If the child's father has lost visual acuity, he and his new son could possibly have the same 20/100 vision. Poor color detection, nearsightedness, and monocular vision are characteristic of newborns and are the result of their lack of development.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1393, Visual Impairment

9.The nurse is taking a health history for a 9-year-old girl. Which finding would alert the nurse to a possible risk factor specifically associated with visual impairment?

- A) Being born at 39 weeks' gestation
- B) Having several hours of homework daily
- C) Being of African American heritage
- D) Being active in sports

Ans: C

Feedback:

African American heritage is a risk factor specifically for visual impairment. Although family history of the disorder, genetic syndrome, and previous medication use are risk factors for visual impairment, they are also risk factors for hearing impairment.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1395, 1396, Therapeutic Management, Table 39.3

10.The nurse is examining a 3-year-old boy with acute otitis media who has a mild earache and a temperature of 38.5°C. Which action will be taken?

- A) Obtain a culture of the middle ear fluid.
- B) Instruct the parents to watch for worsening symptoms.
- C) Administer antibiotics.
- D) Administer antivirals.

Ans: B

Feedback:

In this case, the child will be continually observed. If the symptoms persist or become worse, antibiotics will be prescribed. This clinical practice guideline was developed by the American Academy of Pediatrics and the American Academy of Family Physicians in order to avoid overusing antibiotics or obtaining a middle ear fluid culture with every occurrence of acute otitis media. Administering antiviral agents would not be appropriate for this child.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1386, Nursing Assessment

11.A nurse is examining a 7-year-old boy with hordeolum. Which would the nurse expect to find?

- A) Redness
- B) Scaling
- C) Pain
- D) Edema

Ans: C

Feedback:

Pain is typical of hordeolum or stye. Blepharitis has symptoms of redness, scaling, and edema but not pain.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1378, Ears

12. After teaching a group of parents about ear infections in children, which statement indicates that the teaching was successful?

- A) Infants with congenital deformities have an increased risk for ear infections.
- B) Ear infections typically increase as the child gets older.
- C) The shorter and wider eustachian tubes of an infant increase the risk.
- D) Adenoids shrink as the child grows, allowing more bacteria to enter.

Ans: C

Feedback:

The infant has relatively short, wide, horizontally placed eustachian tubes, allowing bacteria and viruses to gain access to the middle ear and resulting in an increased number of infections as compared to adults. Congenital deformities of the ear are associated with other body system anomalies, but not necessarily an increase in ear infections. As the child matures, the eustachian tubes assume a more slanted position, so older children and adults have fewer infections. A child's adenoids are often enlarged, leading to obstruction of the eustachian tubes and infection.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1391, Amblyopia

13. A nurse develops a plan of care for a child that includes patching the eye. This plan of care would be **most** appropriate for which condition?

- A) Astigmatism
- B) Hyperopia
- C) Myopia
- D) Amblyopia

Ans: D

Feedback:

Eye patching is used for amblyopia or any condition that results in one eye being weaker than the other. Corrective lenses would be appropriate for astigmatism, hyperopia, and myopia.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1378, Eyes

14. After teaching a group of new parents about their newborns' eyes and vision, which statement by the group indicates effective teaching?

- A) "Our newborn can see at distances of about 1 to 2 feet."
- B) "We won't know the baby's eye color until he's at least 6 months old."
- C) "A baby can easily distinguish colors, but they must be bright colors."
- D) "A newborn can focus with both eyes at the same time shortly after birth."

Ans: B

Feedback:

The eye color of an infant is determined by 6 to 12 months of age. A newborn sees best at distances of about 8 to 10 inches. The optic nerve is not completely myelinated, so color discrimination is incomplete. The rectus muscles are uncoordinated at birth and mature over time, so binocular vision may be achieved by 4 months of age.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1383, 1384, Therapeutic Management, Table 39.1

15. Assessment of a child leads the nurse to suspect viral conjunctivitis based on what finding?

- A) Mild pain
- B) Photophobia
- C) Itching
- D) Watery discharge

Ans: B

Feedback:

Viral conjunctivitis is characterized by lymphadenopathy, photophobia, and tearing. Mild pain is associated with bacterial conjunctivitis. Itching and watery discharge are associated with allergic conjunctivitis.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1400, Preventing Reinfection, Teaching Guidelines 39.2

16.What would the nurse include when teaching parents how to prevent otitis externa?

- A) Daily ear cleaning with cotton swabs
- B) Wearing earplugs when swimming
- C) Using a hair dryer on high to dry the ear canals
- D) Using hydrogen peroxide to dry the canal skin

Ans: B

Feedback:

To prevent otitis externa, the nurse would teach parents and children to wear earplugs when swimming and to avoid use of cotton swabs, headphones, and earphones. A hair dryer on a low setting can be used to dry the ear canals. A mixture of half rubbing alcohol and half vinegar can be used to dry the canal and alter the pH to discourage organism growth.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1400, Hearing Loss and Deafness

17. A nurse is reviewing the medical record of a child with hearing loss and notes that the child's hearing loss is in the range 40 to 60 decibels (dB). The nurse interprets this as indicating what level of hearing loss?

- A) Mild loss
- B) Moderate loss
- C) Severe loss
- D) Profound loss

Ans: B

Feedback:

A hearing loss of 40 to 60 dB indicates a moderate loss; 20 to 40 dB indicates a mild loss; 60 to 80 dB indicates a severe loss; and greater than 80 dB indicates a profound loss.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1387, 1388, Physical Examination, Table 39.2

18. A nurse is examining a child who has sustained blunt trauma to the eye area. The nurse suspects a simple contusion based on what finding?

- A) Pain in the eye
- B) Impaired visual acuity
- C) Blurred vision
- D) Intact extraocular movements

Ans: D

Feedback:

A simple contusion of the eye area is manifested by bruising and edema of the lids or surrounding eye area, intact extraocular eye movement, intact visual acuity, absence of diplopia or blurred vision, pain surrounding the eye but not within the eye, and pupils that are equal, are round, and react to light and accommodation.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1389, Refractive Errors

19. The parents of a 10-year-old girl with a refractive error ask the nurse about the possibility of laser surgery to correct the vision. Which statement by the nurse would be **most** appropriate?

- A) "As she gets older, her vision will begin to correct itself."
- B) "Laser surgery typically is not done until she's 18 years old."
- C) "She looks so cute in her glasses; why put her through surgery?"
- D) "She can use contact lenses soon, so surgery isn't necessary."

Ans: B

Feedback:

Because of the continuing refractive development in the child's vision through adolescence, laser surgery for vision correction is not recommended by the American Academy of Ophthalmology until 18 years of age. The refractive error will continue to change as the child's vision continues to develop, making the refraction unstable. Thus, corrective lens prescription may change but the refraction error will not correct itself. Glasses still carry a stigma and the child may be teased or bullied. The statement about the child looking cute in her glasses ignores the parents' question and concerns and questions the parents' desire for information. The use of contact lenses does not negate the possibility of surgery. However, laser surgery would have to wait until the child is 18 years of age.

Format: Multiple Select

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1394, Nursing Management, Box 39.1

20.A nurse is developing a plan of care for a child who is admitted to the hospital for surgery. The child is visually impaired. What would be **most** appropriate for the nurse to include in the child's plan of care? Select all that apply.

- A) Explaining instructions using simple and specific terms the child understands
- B) Allowing the child to explore the postoperative equipment with his hands
- C) Touching the child on his shoulder before letting the child know someone is there
- D) Using the child's body parts to refer to the area where he may have postoperative pain
- E) Speaking to the child in a voice that is slightly louder than the usual tone of voice

Ans: A, B, D

Feedback:

When interacting with a visually impaired child, the nurse would make directions and instructions simple and specific, encourage exploration of objects such as postoperative equipment through touch, and use the parts of the child's body as reference points for the location of items or for this child, his or her postoperative pain. The nurse should identify him- or herself first before touching the child and speak in a tone of voice that is appropriate to the situation.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1399, Providing Postoperative Care for the Child with Pressure-Equalizing Tubes

21.A child with persistent otitis media with effusion is to undergo insertion of pressure-equalizing tubes via a myringotomy. The child is to be discharged later that day. After teaching the parents about caring for their child after discharge, which statement indicates that the teaching was successful?

- A) "The tubes will stay in place for about a month and then fall out on their own."
- B) "His chances for ear infections now have dramatically decreased."
- C) "He should wear earplugs when swimming in a pool or a lake."
- D) "We should keep the ears protected with cotton balls for the first 24 hours."

Ans: C

Feedback:

When pressure-equalizing tubes are inserted, the surgeon may recommend avoiding water entry into the ears. Therefore, earplugs are suggested when the child is in the bathtub or swimming. When swimming in a lake, earplugs are especially important because lake water is contaminated with bacteria and entry of that water into the middle ear must be avoided. Typically, the tubes remain in place for at least several months and generally fall out on their own. Placement of pressure-equalizing tubes does not prevent middle ear infection. Other than earplugs for bathing and swimming, nothing else is placed in the child's ear.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1391, Nursing Assessment

22.An infant is diagnosed with a congenital cataract. What would the nurse expect to assess?

- A) Absent red reflex
- B) Rapid irregular eye movement
- C) Misalignment of the eyes
- D) Enlarged eye appearance

Ans: A

Feedback:

Assessment findings associated with congenital cataract include a history of lack of visual awareness; clouding of the cornea, which may or may not be visible; and no red reflex. Rapid irregular eye movement would suggest nystagmus. Misalignment of the eyes would suggest strabismus. Enlarged appearance of the eye is associated with infantile glaucoma.

Format: Multiple Select

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1383, 1384, Therapeutic Management, Table 39.1

23. A mother brings her child to the healthcare clinic because she thinks that the child has conjunctivitis. Which assessment findings would lead the nurse to suspect bacterial conjunctivitis? Select all that apply.

- A) Itching of the eyes
- B) Inflamed conjunctiva
- C) Stringy discharge
- D) Photophobia
- E) Mild pain
- F) Tearing

Ans: B, E

Feedback:

Bacterial conjunctivitis is manifested by inflamed conjunctiva, a purulent or mucoid discharge, mild pain, and occasional eyelid edema. Itching and a stringy discharge suggest allergic conjunctivitis. Photophobia and tearing suggest viral conjunctivitis.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1390, Educating about Eyeglass Use

24.The nurse is instructing a 7-year-old child and his parents about using his prescribed corrective lenses. What would the nurse include in these instructions?

- A) "Make sure to take your glasses off from time to time to allow your eyes to rest."
- B) "Remove your glasses with both hands and lay them with the lens upright on the surface."
- C) "Clean the glasses every day with a mild soap and water or commercial cleaning agent."
- D) "Use paper towels or tissues to dry and periodically clean the lenses."

Ans: C

Feedback:

Eyeglasses should be cleaned daily with mild soap and water or a commercial cleaning agent. The glasses should be worn at all times, but when removed, they should be removed with both hands and placed on their side (not directly on the lens on any surface). A soft cloth, not paper towels, tissues, or toilet paper, should be used to clean the lenses.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1378, Eyes

25.A group of students are reviewing information about the differences in the hearing and vision capabilities of a child when compared to an adult. The students demonstrate a need for additional study when they identify what as one of the differences?

- A) Hearing is completely developed at the time of birth.
- B) Visual acuity develops from birth throughout childhood.
- C) Binocular vision is usually achieved by 2 months of age.
- D) The ability to discriminate colors is completed by birth.

Ans: D

Feedback:

The optic nerve is not completely myelinated at birth, so color discrimination is incomplete. Hearing is intact at birth and visual acuity develops from birth throughout childhood. Binocular vision is achieved by 4 months of age.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacology and Parenteral Therapies

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1385, Preventing Infectious Spread

26. A child is diagnosed with bacterial conjunctivitis and is prescribed topical antibiotic therapy. The child's mother asks when he can return to school. Which response by the nurse would be **most** appropriate?

- A) "You need to wait until you finish the entire prescription of antibiotic."
- B) "Once the drainage is gone, he can go back to school."
- C) "You can send him to school this afternoon after his first dose of antibiotic."
- D) "He needs to be symptom-free for at least 72 hours."

Ans: B

Feedback:

For the child with bacterial conjunctivitis, the child may safely return to school or day care when the mucopurulent drainage is no longer present, usually after 24 to 48 hours of treatment with the topical antibiotic. There is no need to wait until the prescription is finished. The antibiotic is being given topically, not systemically. One dose of antibiotic is not sufficient to eradicate the infection. Typically, 24 to 48 hours of treatment is needed to stop the drainage, which, when no longer present, indicates that the child can return to school.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1394, Infectious and Inflammatory Disorders of the Eyes

27. The parents of a 5-year-old bring their son to the emergency department because of significant eyelid edema. The mother states, "He scratched himself near his eye a couple of days ago while playing outside in the yard." The nurse suspects periorbital cellulitis based on which finding?

- A) Evidence of discharge
- B) Reddened conjunctiva
- C) Purplish discoloration of eyelid
- D) Altered visual acuity

Ans: C

Feedback:

Periorbital cellulitis is a bacterial infection of the eyelids and tissue surrounding the eye. The bacteria may gain entry into the skin via an abrasion, laceration, insect bite, foreign body, or impetiginous lesion. It may also result from a nearby bacterial infection such as sinusitis. Findings include marked eyelid edema, purplish or red color of the eyelid, clear conjunctivae, absence of discharge, and normal visual acuity.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1389, Visual Disorders

28. After teaching a group of students about visual disorders, the instructor determines that the teaching was successful when the students identify what as the **most** common cause of visual difficulties in children?

- A) Astigmatism
- B) Strabismus
- C) Refractive errors

D) Nystagmus

Ans: C

Feedback:

The most common cause of visual difficulties in children is refractive errors. Astigmatism, strabismus, and nystagmus are other common visual disorders in children but are less common than refractive errors.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1391, 1392, Infantile Glaucoma

29. An infant is diagnosed with infantile glaucoma. When developing the plan of care for the infant, for what would the nurse expect to prepare the infant and family?

- A) Goniotomy
- B) Antibiotic therapy
- C) Contact lenses
- D) Patching of affected eye

Ans: A

Feedback:

Therapeutic management of infantile glaucoma is focused on surgical intervention via a goniotomy. Antibiotic therapy would be used to treat an infection. Contact lenses would be indicated for refractive errors and following removal of congenital cataracts. Patching of the affected eye is used for treating amblyopia and after surgery for congenital cataract.

Chapter 40

1. The nurse is examining an 8-year-old boy with tachycardia and tachypnea. The nurse anticipates which test as **most** helpful in determining the extent of the child's hypoxia?
- A. Pulmonary function test
 - B. Pulse oximetry
 - C. Peak expiratory flow
 - D. Chest radiograph

Answer: B

Rationale: Pulse oximetry is a useful tool for determining the extent of hypoxia. It can be used by the nurse for continuous or intermittent monitoring. Pulmonary function testing measures respiratory flow and lung volumes and is indicated for asthma, cystic fibrosis, and chronic lung disease. Peak expiratory flow testing is used to monitor the adequacy of asthma control. Chest radiographs can show hyperinflation, atelectasis, pneumonia, foreign bodies, pleural effusion, and abnormal heart or lung size.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Remember

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1413

2. The nurse is discussing discharge instructions with the parents of a 6-year-old who had a tonsillectomy. What is the **most** important thing to stress?
- A. Administer analgesics.
 - B. Encourage the child to drink liquids.
 - C. Inspect the throat for bleeding.
 - D. Apply an ice collar.

Answer: C

Rationale: Inspecting the throat for bleeding is the most important discharge information to give the parents. Hemorrhage is unusual postoperatively but may occur any time from the immediate postoperative period to as late as 10 days after surgery. The nurse should inspect the throat for bleeding. Mucus tinged with blood may be expected, but fresh blood in the secretions indicates bleeding. Administering analgesics, encouraging fluids and applying an ice collar are important but not as important as assessing for bleeding.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Teaching/Learning

Reference: p. 1426

3. A nurse is administering 100% oxygen to a child with a pneumothorax based on the understanding that this treatment is used primarily for which reason?

- A. Improve gas exchange
- B. Bypass the obstruction
- C. Hasten air reabsorption
- D. Prevent hypoxemia

Answer: C

Rationale: Administration of 100% oxygen is used to treat pneumothorax primarily because it hastens the reabsorption of air. Generally this is used only for a few hours. Although the oxygen also improves gas exchange and prevents hypoxemia, these are not the reasons for its use in this situation. There is no obstruction with a pneumothorax.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1435

4. Bacterial pneumonia is suspected in a 4-year-old boy with fever, headache, and chest pain. Which assessment finding would **most** likely indicate the need for this child to be hospitalized?

- A. Fever
- B. Oxygen saturation level of 96%
- C. Tachypnea with retractions
- D. Pale skin color

Answer: C

Rationale: Pneumonia is usually a self-limiting disease. Children with bacterial pneumonia can be successfully managed at home if the work of breathing is not severe and oxygen saturation is within normal limits. Hospitalization would most likely be required for the child with tachypnea, significant retractions, poor oral intake, or lethargy for the administration of supplemental oxygen, intravenous hydration, and antibiotics. Fever, although common in children with pneumonia, would not necessitate hospitalization. An oxygen saturation level of 96% would be within normal limits. Pallor (pale skin color) occurs as a result of peripheral vasoconstriction in an effort to conserve oxygen for vital functions; this finding also would not necessitate hospitalization.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1431

5. The nurse is assessing a 5-year-old girl who is anxious, has a high fever, speaks in a whisper, and sits up with her neck thrust forward. Based on these findings, what would be **least** appropriate for the nurse to perform?

- A. Providing 100% oxygen
- B. Visualizing the throat
- C. Having the child sit forward
- D. Auscultating for lung sounds

Answer: B

Rationale: The child is exhibiting signs and symptoms of epiglottitis, which can be life-threatening. Under no circumstances should the nurse attempt to visualize the throat. Reflex laryngospasm may occur, precipitating immediate airway occlusion. Providing 100% oxygen in the least invasive manner that is most acceptable to the child is a sound intervention, as is allowing the child to assume a position of sitting forward with the neck extended. Auscultation would reveal breath sounds consistent with an obstructed airway.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1428

6. The nurse is educating the parents of a 7-year-old boy with asthma about the medications that have been prescribed. Which drug would the nurse identify as an adjunct to a β_2 -adrenergic agonist for treatment of bronchospasm?

- A. Ipratropium
- B. Montelukast
- C. Cromolyn
- D. Theophylline

Answer: A

Rationale: Ipratropium is an anticholinergic administered via inhalation to produce bronchodilation without systemic effects. It is generally used as an adjunct to a β_2 -adrenergic agonist. Montelukast decreases the inflammatory response by antagonizing the effects of leukotrienes. Cromolyn prevents release of histamine from sensitized mast cells. Theophylline provides for continuous airway relaxation.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Teaching/Learning

Reference: p. 1439

7. The nurse is caring for a 3-year-old girl with a respiratory disorder. The nurse anticipates the need for providing supplemental oxygen to the child when performing which action?

- A. Suctioning a tracheostomy tube
- B. Administering drugs with a nebulizer
- C. Providing tracheostomy care
- D. Suctioning with a bulb syringe

Answer: A

Rationale: Supplemental oxygenation may be necessary before, and is always performed after, suctioning a child with a tracheostomy tube. Providing tracheostomy care, administering drugs with a nebulizer, and suctioning with a bulb syringe do not require supplemental oxygen.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1454

8. The nurse is examining a 5-year-old. Which sign or symptom is a reliable **first** indication of respiratory illness in children?

- A. Slow, irregular breathing
- B. A bluish tinge to the lips
- C. Increasing lethargy
- D. Rapid, shallow breathing

Answer: D

Rationale: Tachypnea, or increased respiratory rate, is often the first sign of respiratory illness in infants and children. Slow, irregular breathing and increasing listlessness are signs that the child's condition is worsening. Cyanosis (a bluish tinge to the lips) or the degree of cyanosis present is not always an accurate indication of the severity of respiratory involvement.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1410

9. A child requires supplemental oxygen therapy at 8 liters per minute. Which delivery device would the nurse **most** likely expect to be used?

- A. Simple mask
- B. Venturi mask
- C. Nasal cannula
- D. Oxygen hood

Answer: A

Rationale: A simple mask would be used to deliver a flow rate of 8 liters per minute. A Venturi mask would be used to deliver a specific percentage of oxygen, from 24% to 50%. A nasal cannula would be used to deliver no more than 4 liters per minute. An oxygen hood requires a liter flow of 10 to 15 liters per minute.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1420

10. A group of nursing students are reviewing information about the variations in respiratory anatomy and physiology in children in comparison to adults. The students demonstrate understanding of the information when they identify which finding?

- A. Children's demand for oxygen is lower than that of adults.
- B. Children develop hypoxemia more rapidly than adults do.
- C. An increase in oxygen saturation leads to a much larger decrease in pO₂.
- D. Children's bronchi are wider in diameter than those of an adult.

Answer: B

Rationale: Children develop hypoxemia more rapidly than adults do because they have a significantly higher metabolic rate and faster resting respiratory rates than adults do, which leads to a higher demand for oxygen. A smaller decrease in oxygen saturation reflects a disproportionately much larger decrease in pO₂. The bronchi in children are narrower than in adults, placing them at higher risk for lower airway obstruction.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Understand

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Teaching/Learning

Reference: p. 1408

11. The nurse is providing care to several children who have been brought to the clinic by the parents reporting cold-like symptoms. The nurse would **most** likely suspect sinusitis in which child?

- A. A 2-year-old with thin watery nasal discharge
- B. A 3-year-old with sneezing and coughing
- C. A 5-year-old with nasal congestion and sore throat
- D. A 7-year-old with halitosis and thick, yellow nasal discharge

Answer: D

Rationale: The frontal sinuses, those most commonly associated with sinus infection, develop by age 6 to 8 years. Therefore, the 7-year-old would most likely experience sinusitis. In addition, this child also exhibits halitosis and a thick, yellow nasal discharge, other findings associated with sinusitis. Thin watery discharge in a 2-year-old is more likely to indicate allergic rhinitis. A 3-year-old with coughing and sneezing or a 5-year-old with nasal congestion and sore throat suggests the common cold.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1422

12. A parent asks the nurse about immunizing her 7-month-old daughter against the flu. Which response by the nurse would be **most** appropriate?

- A. "She really doesn't need the vaccine until she reaches 1 year of age."
- B. "She will probably receive it the next time she is to get her routine shots."
- C. "Since your daughter is older than 6 months, she should get the vaccine every year."
- D. "The vaccine has many side effects, so she wouldn't get it until she's ready to go to school."

Answer: C

Rationale: The current recommendations are for all children older than 6 months of age to be immunized yearly against influenza.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1424

13. A child with a pneumothorax has a chest tube attached to a water seal system. When assessing the child, the nurse notices that the chest tube has become disconnected from the drainage system. What would the nurse do **first**?

- A. Notify the physician.
- B. Apply an occlusive dressing.
- C. Clamp the chest tube.
- D. Perform a respiratory assessment.

Answer: C

Rationale: If a chest tube becomes disconnected from the water seal drainage system, the nurse would first clamp the chest tube to prevent air from entering the child's chest cavity. Then the nurse would perform a respiratory assessment and notify the physician. An occlusive dressing would be applied first if the chest tube became dislodged from the child's chest.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1435

14. A nurse is preparing a teaching plan for the family of a child with allergic rhinitis. When describing the immune reaction that occurs, the nurse would identify the role of which immunoglobulin?

- A. IgA
- B. IgE
- C. IgG
- D. IgM

Answer: B

Rationale: The immunoglobulin involved in the immune response associated with allergic rhinitis is IgE. IgA, IgG, and IgM are not involved in this response.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Teaching/Learning

Reference: p. 1436

15. A group of nursing students are reviewing the medications used to treat asthma. The students demonstrate understanding of the information when they identify which agent as appropriate for an acute episode of bronchospasm?

- A. Salmeterol
- B. Albuterol
- C. Ipratropium
- D. Cromolyn

Answer: B

Rationale: Albuterol is a short-acting β_2 -adrenergic agonist that is used for treatment of acute bronchospasm. Salmeterol is a long-acting β_2 -adrenergic agonist used for long-term control or exercise-induced asthma. Ipratropium is an anticholinergic agent used as an adjunct to β_2 -adrenergic agonists for treatment of bronchospasm. Cromolyn is a mast cell stabilizer used prophylactically but not to relieve bronchospasm during an acute wheezing episode.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Teaching/Learning

Reference: p. 1439

16. The nurse is preparing to perform a physical examination of a child with asthma. Which technique would the nurse be **least** likely to perform?

- A. Inspection
- B. Palpation
- C. Percussion
- D. Auscultation

Answer: B

Rationale: When examining the child with asthma, the nurse would inspect, auscultate, and percuss. Palpation would not be used.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1440

17. A nursing instructor is preparing a class on chronic lung disease. What information would the instructor include when describing this disorder?

- A. It is a result of cystic fibrosis.
- B. It is seen most commonly in premature infants.
- C. It typically affects females more often than males.
- D. It is characterized by bradypnea.

Answer: B

Rationale: Chronic lung disease, formerly known as bronchopulmonary dysplasia, is often diagnosed in infants who have experienced respiratory distress syndrome, most commonly seen in premature infants. Male gender is a risk factor for development. Tachypnea and increased work of breathing are characteristic of chronic lung disease.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Teaching/Learning

Reference: p. 1446

18. A nurse is teaching the parents of a child diagnosed with cystic fibrosis about medication therapy. Which would the nurse instruct the parents to administer orally?

- A. Recombinant human DNase
- B. Bronchodilators
- C. Anti-inflammatory agents
- D. Pancreatic enzymes

Answer: D

Rationale: Pancreatic enzymes are administered orally to promote adequate digestion and absorption of nutrients. Recombinant human DNase, bronchodilators, and anti-inflammatory agents are typically administered by inhalation.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Teaching/Learning

Reference: p. 1447-1448

19. When performing the physical examination of a child with cystic fibrosis, what would the nurse expect to assess?

- A. Dullness over the lung fields
- B. Increased diaphragmatic excursion
- C. Decreased tactile fremitus
- D. Hyperresonance over the liver

Answer: C

Rationale: Examination of a child with cystic fibrosis typically reveals decreased tactile fremitus over areas of atelectasis, hyperresonance over the lung fields from air trapping, decreased diaphragmatic excursion, and dullness over the liver when enlarged.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1449

20. The nurse is preparing to provide tracheostomy care to an infant. After gathering the necessary equipment, what would the nurse do next?

- A. Position the infant supine with a towel roll under the neck.
- B. Cut the new tracheostomy ties to the appropriate length.
- C. Cut the tracheostomy ties from around the tracheostomy tube.
- D. Cleanse around the site of the tracheostomy with the prescribed solution.

Answer: A

Rationale: After gathering the necessary equipment, the nurse would position the infant supine with a blanket or towel roll to extend the neck. Then the nurse would open all the packaging and cut the new tracheostomy ties to the appropriate length. This would be followed by cleaning the site with the appropriate solution and then rinsing it. After placing the pre-cut sterile gauze under the tracheostomy tube, the nurse would cut the ties and remove them from the tube while an assistant holds the tube in place.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1455

21. A child is brought to the emergency department by his parents because he suddenly developed a barking cough. Further assessment leads the nurse to suspect that the child is experiencing croup. What would the nurse have **most** likely assessed?

- A. High fever
- B. Dysphagia
- C. Toxic appearance
- D. Inspiratory stridor

Answer: D

Rationale: A child with croup typically develops a bark-like cough often at night. This may be accompanied by inspiratory stridor and suprasternal retractions. Temperature may be normal or slightly elevated. A high fever, dysphagia, and toxic appearance are associated with epiglottitis.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1427

22. A child has been prescribed a nasal cannula for oxygen delivery. What should the nurse do **before** applying the cannula?

- A. Assess patency of the nares
- B. Test the oxygen saturation
- C. Add humidification to the delivery device
- D. Assess the lung sounds

Answer: A

Rationale: A nasal cannula is a good delivery device for children, because it allows them to eat and talk unobstructed. Because the device is designed for flow through the nares, the patency of the nares should be assessed prior to using the cannula. If the nares are blocked from secretions, suctioning may be required. If there is a defect in the upper airway causing blockage, the nasal cannula may not be an appropriate oxygen delivery device. The oxygen saturation should have been measured and used as a guide for the prescription of oxygen therapy. Adding humidification is a way to keep the upper airways from becoming too dry, but oxygen can be started before humidity is added. Anytime a child is sick enough to require oxygen all respiratory assessments, including lung sounds, should be done. It does not matter, however, what the lung

sounds are if the child is in enough distress to require oxygen. The lung sounds can be assessed after oxygen is started.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1420

23. The nurse is obtaining a health history of a child suspected of tuberculosis. What question would the nurse ask **first** about the child's cough?

- A. "How long has your child had a cough?"
- B. "Does your child cough only at night?"
- C. "Does your child cough up anything when coughing?"
- D. "Has your child been around anyone who is coughing?"

Answer: A

Rationale: Tuberculosis is a highly contagious disease. Most children contract it from an infected immediate household member. When taking the health history, the nurse should ask about symptoms such as malaise, weight loss, anorexia, chest tightness and a cough. The child's cough from tuberculosis is described as progressing slowly over several weeks and months rather than having an acute onset. Asking about the production from the cough is a way to determine if hemoptysis has occurred. Asking about being around anyone coughing is a way to determine if the child has been exposed to anyone with tuberculosis. Coughing only at night could be related to other respiratory disorders such as asthma.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1433

24. The nurse is teaching the parent of a child with cystic fibrosis about nutrition requirements for the child. What should be included in this teaching?

- A. "Give your child high-calorie foods and snacks."
- B. "Feed your child foods that are high in protein."
- C. "Administer water soluble vitamins."
- D. "Give pancreatic enzymes with meals."
- E. "Give your child foods high in fat."

Answer: A, B, D

Rationale: Children with cystic fibrosis (CF) have trouble digesting and absorbing nutrients. They tend to be underweight. For optimal health, their diets should be high in calories and high in protein, with the supplementation of fat soluble vitamins and pancreatic enzymes. This diet

helps with growth and the optimal nutrients. The fat soluble vitamins (vitamins A, D, E and K) are needed, because children with CF have trouble absorbing fat and need the vitamin supplementation to aid in fat absorption. Water soluble vitamins (the B vitamins and vitamin C) do not aid in fat absorption. The child should not have a high-fat diet, because the extra fat is difficult to digest and be absorbed. Pancreatic enzymes are necessary because they are missing due to the disease process. They are necessary to aid in digestion. They should be ingested with meals.

Question format: Multiple Select

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1447-1448

25. The nurse is preparing a room for a child being transferred out of the intensive care unit. The child has a tracheostomy. What item(s) are essential for the nurse to have available at the bedside in case of emergency? Select all that apply.

- A. A new tracheostomy tube of the same size
- B. A new tracheostomy tube of a smaller size
- C. A bag valve mask
- D. A sterile tracheostomy kit
- E. Cleaning supplies for the tracheostomy

Answer: A, B, C

Rationale: A child with a tracheostomy can have an emergent situation for any number of reasons. It is important to always have emergency equipment at the bedside to provide immediate care when these situations arrive. Two spare tracheostomy tubes should always be at the bedside, one the same size as in place and once a size smaller. These would be needed if the tube became dislodged. A bag valve mask needs to remain at the bedside at all times. Ideally it should be connected to oxygen, but that is an individual protocol for the health care organization. The bag can be used to hyperoxygenate the child prior to or following suctioning or it can be used in an emergent situation such as a respiratory arrest. Sterile tracheostomy kits and cleaning supplies can be available at the bedside, but they are used for routine cleaning and not for emergencies.

Question format: Multiple Select

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1454

26. A parent with a child who has cystic fibrosis asks the nurse how to determine if the child is receiving an adequate amount of pancreatic enzymes. How should the nurse respond? Select all that apply.

- A. "The dose is adequate when your child is only having 1 to 2 stools per day."

- B. "The dose is adequate when your child's weight is improving."
- C. "The dose prescribed is based on your child's pancreatic laboratory values so it should be correct."
- D. "When your child starts to eat more quantity of food you will need to adjust the amount of enzyme pills."
- E. "You will need to give your child less enzyme pills when high-fat foods are eaten."

Answer: A, B, D

Rationale: Pancreatic enzymes are required for the child with cystic fibrosis (CF) to help absorb nutrients from the diet and to aid in digestion. They are given with each meal and snack the child eats. The number of capsules required at each dose depends upon the diagnosis of how the pancreas is functioning and the amount of food needing to be digested. The pancreatic laboratory values may determine a baseline for the number of pills to start with, but the dosage is adjusted regularly. The dosage of pancreatic enzymes is adjusted until an adequate growth pattern is established and the child is having no more than 1 to 2 stools per day. The child should be given an increased number of enzyme pills when a meal with high-fat content is consumed, not fewer.

Question format: Multiple Select

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder
Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Teaching/Learning

Reference: p. 1449

27. A child is in the emergency department with an asthma exacerbation. Upon auscultation the nurse is unable to hear air movement in the lungs. What action should the nurse take **first**?

- A. Administer a beta-2 adrenergic agonist
- B. Administer oxygen
- C. Start a peripheral IV
- D. Administer corticosteroids

Answer: A

Rationale: When lungs sounds are unable to be heard in a child with asthma, the child is very ill. This means there is severe airway obstruction. The air movement is so severe wheezes cannot be heard. The priority treatment is to administer an inhaled short term bronchodilator (beta-2 adrenergic agonist). The child may require numerous inhalations until bronchodilation occurs and air can pass through the bronchi. Oxygen can be started but until the bronchi are dilated no oxygen can get through to the lung fields. In IV would need to be started and IV steroids administered to reduce the inflammation, but the priority is bronchodilation.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder
Cognitive Level: Analyze

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 1417

28. A hospitalized child suddenly begins reporting "my chest hurts," is tachypneic, and has tachycardia. The nurse auscultates the lung sounds and finds absent breath sounds on one side. After notifying the health care provider what action would the nurse take **first**?

- A. Prepare for chest tube insertion
- B. Administer oxygen
- C. Obtain oxygen saturation measurement
- D. Prepare for mechanical ventilation

Answer: A

Rationale: A pneumothorax is a collection of air in the pleural space. Trapped air consumes space in the pleural cavity causing a partial or complete collapse. The priority symptom a nurse would assess is the decreased or absent lung sounds on the affected side. A pneumothorax can occur spontaneously in a healthy child or it can occur in a child with chronic lung disease, has been on a ventilator or has had thoracic surgery. Additional symptoms the child would experience would be chest pain, tachypnea, retractions, grunting, cyanosis and tachycardia. Many of these symptoms could be present with any child with an acute or chronic lung disease or respiratory distress, but the defining symptom is the absent breath sounds. The treatment for a pneumothorax is with a chest tube so the priority action would be to gather supplies and prepare for the health care provider to insert a chest tube. Obtaining an oxygen saturation level measurement will only provide data, it will not help the child in distress. Oxygen may need to be administered, but with a pneumothorax it will be very ineffective. Mechanical ventilation would be a last resort and could actually make the situation worse if the lung was not reinflated.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1435

29. A child is hospitalized with pneumonia. The nurse assesses an increase in the work of breathing and in the respiratory rate. What intervention should the nurse do **first** to help this child?

- A. Elevate the head of the bed
- B. Administer oxygen
- C. Notify the health care provider
- D. Obtain oxygen saturation levels

Answer: A

Rationale: The child who is experiencing increased work of breathing should be placed in a position to better open the airway and provide more room for lung expansion. Generally this is accomplished by elevating the head of the bed. If this does not improve the work of breathing, then administering oxygen should be done. The oxygen saturation should be measured because it will provide information as to the severity of the respiratory problem, but this measurement will

not directly help the child. The health care provider should be notified if the child continues to deteriorate.

Question format: Multiple Choice

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1414

30. An infant with a high respiratory rate is NPO and is receiving IV fluids. What assessment(s) will the nurse make to assure this infant is hydrated? Select all that apply.

- A. Measure skin turgor
- B. Palpate anterior fontanel
- C. Determine urine output
- D. Review electrolyte laboratory results
- E. Assess the lung sounds

Answer: A, B, C

Rationale: IV fluids are necessary many times for infants and children who are experiencing high respiratory rates. The high respiratory rates make the child very tired from the increased work of breathing. In an infant there are very little reserves so the infant tires very quickly, especially when the work of sucking is added to the compromised respiratory state. To determine if the infant is hydrated the nurse should assess the skin turgor, palpate for a flat anterior fontanel, observe for moist mucus membranes and measure the urine output. The urine output should be 1 to 2ml/kg/hr. The electrolyte laboratory results will tell the nurse if the infant has an electrolyte imbalance, not a fluid imbalance. Assessing the lung sounds will not tell if the child is hydrated, only if the lungs are "wet" and fluid overloaded. The infant would also exhibit additional signs of respiratory distress if the lungs are fluid overloaded.

Question format: Multiple Select

Chapter 40: Nursing Care of the Child With an Alteration in Gas Exchange/Respiratory Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1415

Chapter 41

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1476, Health History and Physical Examination

1. The nurse is conducting a physical examination of a child with a ventricular septal defect. Which finding would the nurse expect to assess?

- A) Right ventricular heave
- B) Holosystolic harsh murmur along the left sternal border
- C) Fixed split-second heart sound
- D) Systolic ejection murmur

Ans: B

Feedback:

With ventricular septal defects, there is often a characteristic holosystolic harsh murmur along the left sternal border. Right ventricular heave, fixed split-second heart sound, and systolic ejection murmur are typically found with atrial septal defects.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1462, Take Note!

2.The nurse is administering digoxin as ordered and the child vomits the dose. What should the nurse do **next**?

- A) Contact the healthcare provider.
- B) Offer a snack and administer another dose.
- C) Immediately administer another dose.
- D) Administer next dose as ordered in 12 hours.

Ans: D

Feedback:

Digoxin should be administered at regular intervals, every 12 hours, 1 hour before or 2 hours after feeding. If the child vomits digoxin, the nurse should not give a second dose and should wait until the next scheduled dose. It is not necessary to contact the healthcare provider.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1476, Health History and Physical Examination

3.The nurse is caring for an infant with suspected patent ductus arteriosus. Which assessment finding would the nurse identify as helping to confirm this suspicion?

- A) Thrill at the base of the heart
- B) Harsh, continuous, machine-like murmur under the left clavicle
- C) Faint pulses
- D) Systolic murmur best heard along the left sternal border

Ans: B

Feedback:

With patent ductus arteriosus, a harsh, continuous, machine-like murmur (usually loudest under the left clavicle) is heard at the first and second intercostal spaces. A thrill at the base, faint pulses, and systolic murmur heard best along the left sternal border point to aortic stenosis.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1484, Nursing Assessment

4. The nurse is conducting a physical examination of a child with a suspected cardiovascular disorder. Which finding would the nurse **most** likely expect to assess if the child had transposition of the great vessels?

- A) Significant cyanosis without presence of a murmur
- B) Abrupt cessation of chest output with an increase in heart rate/filling pressure
- C) Soft systolic ejection
- D) Holosystolic murmur

Ans: A

Feedback:

Significant cyanosis without presence of a murmur is highly indicative of transposition. Abrupt cessation of chest output accompanied by an increase in heart

rate and filling pressure is indicative of cardiac tamponade. A soft systolic ejection or holosystolic murmur can be found with other disorders, such as hypoplastic left heart syndrome, but is not highly suspicious of transposition.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1494, Physical Examination

5.The nurse is assessing a child with suspected infective endocarditis. Which assessment finding would the nurse interpret as a sign of extracardiac emboli?

- A) Pruritus
- B) Roth spots
- C) Delayed capillary refill
- D) Erythema marginatum

Ans: B

Feedback:

Roth spots are splinter hemorrhages with pale centers on the sclerae, palate, buccal mucosa, chest, fingers, or toes, and are signs of extracardiac emboli. Delayed capillary refill time does not point to extracardiac emboli. Wheezing and pruritus are indicative of a hypersensitivity reaction. Erythema marginatum is a classic rash associated with acute rheumatic fever.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1498, Physical Examination

6. When conducting a physical examination of a child with suspected Kawasaki disease, which finding would the nurse expect to assess?

- A) Hirsutism or striae
- B) Strawberry tongue
- C) Malar rash
- D) Café au lait spots

Ans: B

Feedback:

Dry, fissured lips and a strawberry tongue are common findings with Kawasaki disease. Acne, hirsutism, and striae are associated with anabolic steroid use. Malar rash is associated with lupus. Café au lait spots are associated with neurofibromatosis.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1495, Nursing Assessment

7. After teaching a group of students about acute rheumatic fever, the instructor determines that the teaching was successful when the students identify which assessment finding?

- A) Janeway lesions
- B) Jerky movements of the face and upper extremities
- C) Black lines
- D) Osler nodes

Ans: B

Feedback:

Sydenham chorea is a movement disorder of the face and upper extremities associated with acute rheumatic fever. Janeway lesions, black lines, and Osler nodes are associated with infective endocarditis.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 1465, Auscultation

8. A nurse is reviewing the medical record of a child and finds that the child has a grade III murmur. After auscultating the child's heart sounds, how would the nurse document this murmur?

- A) Loud without a thrill
- B) Loud with a precordial thrill
- C) Soft and easily heard

D) Loud, audible with a stethoscope

Ans: A

Feedback:

A grade III murmur is loud without a thrill. Grade II is soft and easily heard. Grade IV is loud with a precordial thrill. Grade V is characterized as loud, audible with a stethoscope.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1493, Providing Adequate Nutrition

9. The nurse is caring for a 2-month-old infant who has been diagnosed with acute heart failure. The nurse is providing teaching about nutrition. Which statement by the mother indicates a need for further teaching?

A) "The baby may need as much as 150 calories/kg/day."

B) "Small, frequent feedings are best if tolerated."

C) "I need to feed him every hour to make sure he eats enough."

D) "Gavage feedings may be required for now."

Ans: C

Feedback:

Although offering small frequent feedings is appropriate if the infant tolerates them, feeding every hour is not necessary. During the acute phase, continuous or intermittent gavage feedings may be needed to help the infant maintain or gain

weight. Due to the increased metabolic demands, the infant may require as much as 150 calories/kg/day.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1491, 1492, Health History

10. The nurse is caring for an infant girl with a suspected cardiovascular disorder. Which statement by the mother would warrant further investigation?

- A) "My baby does not make any grunting noises."
- B) "The baby seems more comfortable over my shoulder."
- C) "The baby usually drinks all of her bottle."
- D) "I don't notice any rapid breathing patterns."

Ans: B

Feedback:

The nurse should be alert to statements indicating that the baby seems to be more comfortable when she is sitting up or over her mother's shoulder than when she is lying flat. Grunting or rapid breathing would be a cause for concern. Drinking all of the bottle would be considered normal.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Understand

Integrated Process: Communication and Documentation

Page and Header: 1465, Auscultation

11. Auscultation of a child's heart reveals a loud murmur with a precordial thrill. The nurse documents this as which grade?

A) Grade II

B) Grade III

C) Grade IV

D) Grade V

Ans: C

Feedback:

A grade IV murmur is loud with a precordial thrill. A grade II murmur is soft and easily heard. A grade III murmur is characterized as loud without a thrill. A grade V murmur is characterized as loud, audible without a stethoscope.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1465, Auscultation

12. After assessing a child's blood pressure, the nurse determines the pulse pressure and finds that it is narrowed. What would the nurse identify as associated with this finding?

A) Aortic stenosis

- B) Patent ductus arteriosus
- C) Aortic insufficiency
- D) Complete heart block

Ans: A

Feedback:

A narrowed pulse pressure is associated with aortic stenosis. A widened pulse pressure is associated with patent ductus arteriosus, aortic insufficiency, fever, anemia, or complete heart block.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1472, Educating about Home Care Following Cardiac Catheterization, Teaching Guidelines 41.1

13. A 9-year-old child has undergone a cardiac catheterization and is being prepared for discharge. The nurse is instructing the parents and child about postprocedure care. Which statement by the parents indicates that the teaching was successful?

- A) "This pressure dressing needs to stay on for 5 days from now."
- B) "He can't eat but he can drink fluids for the next 24 hours."
- C) "He should avoid taking a bath for about 3 days, but he can shower."
- D) "It's normal if he says he feels like his heart skipped a beat."

Ans: C

Feedback:

After a cardiac catheterization, the child should avoid tub baths for about 3 days, but he can shower or use sponge baths. The pressure dressing should be removed the day after the procedure and a dry sterile dressing or adhesive bandage is applied for the next several days. After the procedure, the child can resume his usual diet. Any reports of fluttering or the heart skipping a beat should be reported.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1462, 1469, Common Medical Treatments, Drug Guide 41.1

14. A newborn is diagnosed with patent ductus arteriosus. The nurse anticipates that the healthcare provider will **most** likely order which medication?

- A) Alprostadol
- B) Heparin
- C) Indomethacin
- D) Spironolactone

Ans: C

Feedback:

Indomethacin is the drug typically ordered to close a patent ductus arteriosus. Alprostadol would be indicated to maintain the ductus arteriosus temporarily in infants with ductal-dependent congenital heart defects. Heparin would be used for prophylaxis and treatment of thromboembolic disorders, especially after surgery. Spironolactone would be used to manage edema due to heart failure and to treat hypertension.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1491, Teaching Guidelines 41.2

15. The nurse is preparing a teaching plan for the parents of a child who has been diagnosed with a congenital heart defect. What would the nurse be least likely to include?

- A) Daily weight assessment
- B) Maintenance of strict bed rest
- C) Prevention of infection
- D) Signs of complications

Ans: B

Feedback:

A child with congenital heart disease should be allowed to engage in activity as tolerated, with rest periods frequently throughout the day to prevent overexertion. Daily weights, infection prevention measures, and signs of complications are all appropriate to include when teaching parents of a child with a congenital heart defect.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1478, Disorders With Increased Pulmonary Flow

16. After teaching a class about the hemodynamic characteristics of congenital heart disease, the instructor determines that the teaching has been successful when the class identifies which defect as an example of a disorder involving increased pulmonary blood flow?

- A) Tetralogy of Fallot
- B) Atrial septal defect
- C) Hypoplastic left heart syndrome
- D) Transposition of the great vessels

Ans: B

Feedback:

Atrial septal defect is an example of a disorder involving increased pulmonary blood flow. Tetralogy of Fallot is a defect involving decreased pulmonary blood flow. Transposition of the great vessels and hypoplastic left heart syndrome are examples of mixed disorders.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1499, 1500, Nursing Assessment, Table 41.3

17. A 7-year-old child with a family history of cardiovascular disease is being screened for hyperlipidemia. When reviewing the child's laboratory test results, which total cholesterol level would be of significant concern?

- A) 120 mg/dL (3.11 mmol/L)
- B) 150 mg/dL (3.88 mmol/L)
- C) 180 mg/dL (4.66 mmol/L)
- D) 210 mg/dL (5.44 mmol/L)

Ans: D

Feedback:

A total cholesterol level greater than 200 mg/dL (5.18 mmol/L) is considered high and would be of the greatest concern. Levels of 120 mg/dL (3.11 mmol/L) and 150 mg/dL (3.88 mmol/L) are considered within the normal range. A level of 180 mg/dL (4.66 mmol/L) would be considered borderline and significant. However, a level greater than 200 mg/dL (5.18 mmol/L) would be of greater concern.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1465, 1466, Laboratory and Diagnostic Testing, Common Laboratory and Diagnostic Tests 41.1

18. A child with a suspected cardiovascular disorder is to undergo diagnostic testing and is scheduled for an echocardiogram. When explaining this test to the child, what would the nurse **most** likely include?

- A) "This test will check the pattern of how your heart is beating."

- B) "They'll take a picture of your chest to look at the heart's size."
- C) "A special wand that picks up sound is used to check your heart."
- D) "Small patches are attached to your chest to check the heart rhythm."

Ans: C

Feedback:

An echocardiogram is a noninvasive ultrasound procedure using a gel-coated wand that assesses the heart wall thickness, the size of the chambers, valve and septal motion, and the relationship of the great vessels to other cardiac structures. An electrocardiogram reveals the pattern or rhythm of the heart's beating and involves small patches or electrodes attached to the chest. A chest radiograph involves a radiographic film of the chest to determine the size of the heart and its chambers.

Format: Multiple Select

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1494, Physical Examination

19. The nurse is reviewing the medical record of a child with infective endocarditis. What would the nurse expect to find? Select all that apply.

- A) White blood cell count revealing leukopenia
- B) Microscopic hematuria with urinalysis
- C) Electrocardiogram with prolonged PR interval
- D) Lungs clear on auscultation
- E) Petechiae on palpebral conjunctiva

Ans: B, C, E

Feedback:

With infective endocarditis, leukocytosis, microscopic hematuria, prolonged PR interval, adventitious lung sounds, and petechiae on the palpebral conjunctiva are noted.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1478, Disorders with Increased Pulmonary Flow

20. A child with heart failure is receiving supplemental oxygen. The nurse understands that in addition to improving oxygen saturation, this intervention also has what effect?

- A) Cause vasodilation
- B) Increase pulmonary vascular resistance
- C) Promote diuresis
- D) Mobilize secretions

Ans: A

Feedback:

Oxygen improves oxygen saturation and also functions as a vasodilator and decreases pulmonary vascular resistance. Diuretics promote diuresis. Chest physiotherapy helps to mobilize secretions.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1462, 1469, Common Medical Treatments, Drug Guide 41.1

21. The nurse is developing a plan of care for an infant with heart failure who is receiving digoxin. The nurse would hold the dose of digoxin and notify the healthcare provider if the infant's apical pulse rate was:

- A) 140 beats per minute
- B) 120 beats per minute
- C) 100 beats per minute
- D) 80 beats per minute

Ans: D

Feedback:

In an infant, if the apical pulse rate is less than 90 beats per minute, the dose is held and the healthcare provider should be notified.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1497, Nursing Management

22.A nurse is working with an adolescent who is slightly overweight and was recently diagnosed with hypertension. They are discussing nutritional management. Which statement by the adolescent demonstrates understanding of the information?

- A) "I have to make sure that I don't eat a lot of salty foods."
- B) "I can eat any amount at a meal as long as I don't eat between meals."
- C) "I should eat plenty of fresh fruits and vegetables."
- D) "If I skip breakfast, I can eat a much bigger lunch."

Ans: C

Feedback:

Nutritional management includes controlling portion sizes, decreasing the intake of sugary beverages and snacks, eating more fresh fruits and vegetables, and eating a healthy breakfast. Salt restriction and potassium or calcium supplements have not been shown to decrease blood pressure in children.

Format: Multiple Select

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1497, 1498, Kawasaki Disease

23.A child is diagnosed with Kawasaki disease and is in the acute phase of the disorder. What would the nurse expect the healthcare provider to prescribe? Select all that apply.

- A) Intravenous immunoglobulin
- B) Ibuprofen

C) Acetaminophen

D) Aspirin

E) Alprostadil

Ans: A, D

Feedback:

In the acute phase, high-dose aspirin in four divided doses daily and a single infusion of intravenous immunoglobulin are used. Acetaminophen is used to reduce fever. Nonsteroidal anti-inflammatory agents such as ibuprofen are avoided while the child is receiving aspirin therapy. Alprostadil is used to temporarily keep the ductus arteriosus patent in infants with ductal-dependent congenital heart defects.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1465, Take Note!

24. An infant with congenital heart disease is to undergo surgery to correct the defect. The mother states, "I guess I'm going to have to stop breastfeeding her." Which response by the nurse would be **most** appropriate?

A) "That's true, but we'll make sure she gets the best intravenous nutrition."

B) "Unfortunately, your baby needs more nutrients than what breast milk can provide."

C) "Breast milk may help to boost her immune system, so you can continue to use it."

D) "She won't be able to suck, so we have to give her fortified formula through a tube."

Ans: C

Feedback:

Breastfeeding a child before and after cardiac surgery may boost the infant's immune system, which can help fight postoperative infection. If breastfeeding is not possible, mothers can pump milk and the breast milk may be given via bottle, dropper, or gavage feeding. In addition, breastfeeding is associated with decreased energy expenditure during the act of feeding.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1465--1468, Nursing Diagnoses

25. During a follow-up visit, the parents of a 5-month-old infant diagnosed with congenital heart disease tell the nurse, "We're just so tired and emotionally spent. All these tests and examinations are overwhelming. We just want to have a normal life. We're so focused on the baby that it seems like our 3-year-old is lost in the shuffle." Which nursing diagnosis would the nurse identify as **most** appropriate?

- A) Risk for delayed growth and development related to necessary treatments
- B) Deficient knowledge related to the care of a child with congenital heart disease
- C) Interrupted family processes related to demands of caring for the ill child
- D) Fear related to infant's cardiac condition and need for ongoing care

Ans: C

Feedback:

The statements by the parents indicate that there is disruption in the family resulting from the demands of caring for the ill infant and they verbalized concern about their older child. The child may be at risk for delayed growth and development, but this is not indicated by the parents' statements. The parents may lack knowledge about their infant's condition and they may be experiencing fear about the infant's condition, but the statements reflect issues related to the family functioning.

Format: Multiple Select

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1499, 1500, Nursing Assessment, Table 41.3

26. A child with suspected dyslipidemia undergoes laboratory testing. The nurse is reviewing the results. Which finding would the nurse interpret as supporting the diagnosis? Select all that apply.

- A) Total cholesterol level of 150 mg/dL (3.88 mmol/L)
- B) Total cholesterol level of 180 mg/dL (4.66 mmol/L)
- C) Total cholesterol level of 220 mg/dL (5.70 mmol/L)
- D) LDL level of 90 mg/dL (2.33 mmol/L)
- E) LDL level of 120 mg/dL (3.11 mmol/L)
- F) LDL level of 140 mg/dL (3.63 mmol/L)

Ans: C, F

Feedback:

A total cholesterol level over 200 mg/dL (5.18 mmol/L) and LDL level above 130 mg/dL (3.37 mmol/L) are considered high and would support the diagnosis of dyslipidemia. Total cholesterol levels between 170 to 199 mg/dL (4.40 to 5.15 mmol/L) and LDL levels between 110 to 129 mg/dL (2.85 to 3.34 mmol/L) are considered borderline. Total cholesterol levels less than 170 mg/dL (4.40 mmol/L) and LDL levels less than 110 mg/dL (2.85 mmol/L) are acceptable in children.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1478, Atrial Septal Defect

27. The mother of a 4-week-old infant is tearful. She reports the healthcare provider has told her that her son has a small atrial septal defect. She reports she is worried and asks the nurse more about the condition. Which statement by the parents **best** indicates an understanding of the nurse's teaching?

- A) "This greatly places my son at risk for cardiac failure."
- B) "If this does not resolve by the time my child is 1 year old, he will likely need surgery."
- C) "Most of the time this condition spontaneously resolves."
- D) "Since the surgery to correct this condition can be risky my son will need to be at least 40 pounds."

Ans: C

Feedback:

Atrial septal defects in children most likely resolve without treatment. Those that are not corrected by the age of 18 months will likely require surgical intervention. When planned, surgery is not usually performed until the child is at least 3 years of age. There is no indication other problems are present, so the child is not at an increased risk for cardiac failure.

Format: Multiple Select

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1465, 1466, Laboratory and Diagnostic Testing, Common Laboratory and Diagnostic Tests 41.1

28.The nurse is caring for a child that just returned from a coronary arteriogram in which the catheter was placed through the left femoral artery. Which nursing actions demonstrate knowledge of the procedure? Select all that apply.

- A) The nurse allows the client up to the bathroom only.
- B) The nurse assesses the dorsalis pedis pulse in the left foot.
- C) The nurse assesses the puncture site frequently.
- D) The nurse tells the parents that the healthcare provider will discuss the results of the procedure with them.
- E) The nurse assesses the client's vital signs every 8 hours.

Ans: B, C, D

Feedback:

The nurse must assess the pulse distal to the puncture site to determine that circulation remains adequate to the extremity. Assessing the puncture site ensures

early recognition of bleeding from the site. The healthcare provider will be able to inform the parents regarding the results of the procedure after completion. The child should be kept on bed rest for a specified period of time, so they cannot be up to the bathroom. Vital signs will need to be taken more frequently than every 8 hours for early detection of complications.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Caring

Page and Header: 1478, Atrial Septal Defect

29. The nurse is caring for a newborn diagnosed with an atrial septal defect (ASD). The parents voice concern and state, "I can't believe this is happening. Will our child be okay?" What is the nurse's **best** response?

- A) "If the defect isn't treated it can cause problems such as pulmonary hypertension, heart failure, atrial arrhythmias, or stroke."
- B) "While each case is different, the majority of these defects correct on their own. Let's see what the tests show, then speak with the healthcare provider."
- C) "Since there are no symptoms being exhibited right now, your child will likely not require surgery until the age of 3 years."
- D) "Most children have no symptoms of this defect."

Ans: B

Feedback:

While all responses supply correct information about the disorder, the best response is, "While each case is different, the majority of these defects correct on their own.

Let's see what the tests show, then speak with the healthcare provider." This individualizes the response to this child, offers realistic hope, and verifies that the healthcare provider will need to be consulted to answer questions regarding prognosis.

Chapter 42

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1535, 1535, Educating the Family and Child, Nursing Procedure 42.2

1. The nurse is teaching the mother of a 5-year-old boy with a history of impaction how to administer enemas at home. Which response from the mother indicates a need for further teaching?

- A) "I should position him on his abdomen with knees bent."
- B) "He will require 250 to 500 mL of enema solution."
- C) "I should wash my hands and then wear gloves."
- D) "He should retain the solution for 5 to 10 minutes."

Ans: A

Feedback:

A 5-year-old child should lie on his left side with his right leg flexed toward the chest. An infant or toddler is positioned on his abdomen. Using 250 to 500 mL of solution, washing hands and wearing gloves, and retaining the solution for 5 to 10 minutes are appropriate responses.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1541, Functional Abdominal Pain, Box 42.5

2. The nurse is taking a health history of an 11-year-old girl with recurrent abdominal pain. Which response would lead the nurse to suspect irritable bowel syndrome?

- A) "I always feel better after I have a bowel movement."
- B) "I don't take any medicine right now."
- C) "The pain comes and goes."
- D) "The pain doesn't wake me up in the middle of the night."

Ans: A

Feedback:

In cases of irritable bowel syndrome, the pain may be relieved by defecation. Use of medications and pain that comes and goes or wakes the person up in the middle of the night are all relevant findings pertinent to recurrent abdominal pain.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Caring

Page and Header: 1537, Promoting Effective Family Coping

3. The nurse is caring for a 3-year-old girl with short bowel syndrome as a result of trauma to the small intestine. The girl's mother is extremely anxious and tells the nurse she is afraid she will never learn how to care for her daughter at home. How should the nurse respond?

- A) "I will help you become an expert on your daughter's care."
- B) "You must learn how to care for your daughter at home."
- C) "You really need the support of your husband."
- D) "There is a lot to learn and you need a positive attitude."

Ans: A

Feedback:

The nurse needs to empower families to become the experts on their children's needs and conditions via education and participation in care. The most positive approach in this case is to let the mother know the nurse will support her and help her become an expert on her daughter's care. Telling the mother that she must learn how to care for her daughter or that she must have a positive attitude is not helpful. Telling her that she needs the support of her husband is irrelevant and unhelpful.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1539, Physical Examination

4. The nurse is conducting a physical examination of a child with suspected Crohn disease. Which finding would be the most suspicious of Crohn disease?

- A) Normal growth patterns
- B) Perianal skin tags or fissures
- C) Poor growth patterns
- D) Abdominal tenderness

Ans: B

Feedback:

Perianal skin tags and/or fissures are highly suspicious of Crohn disease. Poor growth patterns and abdominal tenderness are common to Crohn disease but are also seen with many other conditions. Normal growth patterns would not point to Crohn disease because of problems with absorbing nutrients.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1515, 1516, Providing Ostomy Care, Nursing Procedure 42.1

5. The nurse is caring for an infant with a temporary ileostomy. As part of the plan of care, the nurse monitors for skin breakdown around the stoma. If redness occurs, what would be most appropriate to promote healing and prevent further skin breakdown?

- A) Clean the area well with a scented diaper wipe.
- B) Apply a barrier/healing cream or paste on the skin.
- C) Use a barrier wafer to attach the appliance.
- D) Sanitize the area with an alcohol wipe after each diaper change.

Ans: B

Feedback:

The nurse should use a barrier/healing cream or paste on the skin around the stoma to promote healing and prevent further skin breakdown. Diaper wipes that contain fragrance or alcohol can sting if used on nonintact skin and can worsen skin breakdown. The barrier wafer would be helpful but does not address the skin breakdown.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1512, Promoting Effective Breathing Patterns

6. The nurse is caring for a 4-year-old boy who has undergone an appendectomy. The child is unwilling to use the incentive spirometer. Which approach would be most appropriate to elicit the child's cooperation?

- A) "Can you cough for me please?"
- B) "You must blow in this or you might get pneumonia."
- C) "If you don't try, I will have to get the healthcare provider."
- D) "Can you blow this cotton ball across the tray?"

Ans: D

Feedback:

Children are more likely to cooperate with interventions if play is involved. Encourage deep breathing by playing games. Asking the boy to cough is less likely to engage him. Telling the child he might get pneumonia is not age appropriate and is unhelpful. Threatening to call the healthcare provider is unhelpful and inappropriate. Remember, however, that the incentive spirometer works on the principle of the amount of air inhaled, not exhaled. Having the child take a deep breath prior to blowing the cotton ball is a beginning step.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1508--1511, Laboratory and Diagnostic Testing, Common Laboratory and Diagnostic Tests 42.1

7. A nurse is caring for a 14-year-old girl scheduled for a barium swallow/upper gastrointestinal (GI) series. Before providing instructions, what would be the priority?

- A) Screening the girl for pregnancy
- B) Reminding her to drink plenty of fluids after the procedure
- C) Ordering a bowel preparation

- D) Reminding the girl about potential light-colored stools

Ans: A

Feedback:

Females of reproductive age must be screened for pregnancy prior to the test because radiography is used. A bowel preparation is not necessary for a barium swallow/upper GI series. The reminders about fluids and light-colored stools are appropriate but are not the first priority.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1524, Nursing Management

8. The nurse has developed a plan of care for a 12-month-old hospitalized with dehydration as a result of rotavirus. Which intervention would the nurse include in the plan of care?

- A) Encouraging consumption of fruit juice
- B) Offering Kool-Aid or popsicles as tolerated
- C) Encouraging milk products to boost caloric intake
- D) Maintaining the intravenous (IV) fluid rate as ordered

Ans: D

Feedback:

The nurse should maintain an IV line and administer the IV fluid as ordered to maintain fluid volume. High-carbohydrate fluids like fruit juice, Kool-Aid, and popsicles should be avoided as they are low in electrolytes, increase simple carbohydrate consumption, and can decrease stool transit time. Milk products should be avoided during the acute phase of illness as they may worsen diarrhea.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 1518, Promoting Adequate Nutrition

9. The nurse is caring for a 2-month-old with a cleft palate. The child will undergo corrective surgery at age 3 months. The mother would like to continue breastfeeding the baby after surgery and wonders if it is possible. How should the nurse respond?

- A) "There is a good chance that you will be able to breastfeed almost immediately."
- B) "Breastfeeding is likely to be possible but check with the surgeon."
- C) "After the suture line heals, breastfeeding can resume."
- D) "We will have to wait and see what happens after the surgery."

Ans: B

Feedback:

Postoperatively, some surgeons allow breastfeeding to be resumed almost immediately. However, the nurse needs to advise the mother to check with the surgeon to determine when breastfeeding can resume. Telling the mother that she has to wait until the suture line heals may be inaccurate. Telling her to wait and see does not answer her question.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1520, Nursing Management

10. The school nurse is working with a 10-year-old girl with recurrent abdominal pain. The girl's teacher has been less than understanding about the frequent absences and trips to the nurse's office. How should the nurse respond?

- A) "Be patient; she is trying some new medication."
- B) "The pain she is having is real."
- C) "The family is working toward improvement."
- D) "Please do not add to this family's stress."

Ans: B

Feedback:

It is important to educate the teacher that this recurrent abdominal pain is a true pain that the child feels and it is not "in her mind." Telling the teacher not to add to the family's stress or that the family is working toward improvement does not teach. The nurse must have the permission of the family to discuss the girl's medication.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1508, Palpation

11. When examining the abdomen of a child, which technique would the nurse use last?

- A) Auscultation
- B) Percussion
- C) Palpation
- D) Inspection

Ans: C

Feedback:

Palpation should be the last part of the abdominal examination. Inspection, auscultation, and percussion should be done before palpation.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1520, 1521, Health History, Comparison Chart 42.1

12. Which finding would lead the nurse to suspect that a child is experiencing moderate dehydration?

- A) Dusky extremities
- B) Tenting of skin
- C) Sunken fontanel
- D) Hypotension

Ans: C

Feedback:

A child with moderate dehydration would exhibit sunken fontanel. Severe dehydration would be characterized by dusky extremities, skin tenting, and hypotension.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

13. The nurse is determining maintenance fluid requirements for a child who weighs 25 kg. How much fluid would the child need per day?

- A) 1,560 mL
- B) 1,600 mL
- C) 1,650 mL
- D) 1,700 mL

Ans: B

Feedback:

Using the following formula of 100 mL/kg for the first 10 kg, plus 50 mL/kg for the next 10 kg, and then 20 mL/kg for the remaining kg, the child would require $(100 \times 10) + (50 \times 10) + (20 \times 5) = 1,000 + 500 + 100 = 1,600$ mL in 24 hours.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Teaching/Learning

14. The parents of a child diagnosed with celiac disease ask the nurse what types of food they can offer their child. What recommendation would the nurse include in the teaching plan?

- A) Frozen yogurt
- B) Rye bread
- C) Creamed spinach
- D) Fruit juice

Ans: D

Feedback:

For the child with celiac disease, foods containing gluten such as frozen yogurt, rye bread, and creamed vegetables should be avoided. Fruit juice would be an appropriate suggestion in a gluten-free diet.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 1527, Nursing Assessment

15. The nurse is providing care to a child with an intussusception. The child has a bowel movement and the nurse inspects the stool. The nurse would most likely document the stool's appearance as having what quality?

- A) Greasy
- B) Clay-colored
- C) Currant jelly-like
- D) Bloody

Ans: C

Feedback:

The child with intussusception often exhibits currant jelly-like stools that may or may not be positive for blood. Greasy stools are associated with celiac disease. Clay-colored stools are observed with biliary atresia. Bloody stools can be seen with several gastrointestinal disorders, such as inflammatory bowel disease.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 1506, Esophagus

16. The mother of a 3-week-old infant old brings her daughter in for an evaluation. During the visit, the mother tells the nurse that her baby is spitting up after feedings. Which response by the nurse would be most appropriate?

- A) "We need to tell the healthcare provider about this."
- B) "Infants this age commonly spit up."
- C) "Your daughter might have an allergy."
- D) "Don't worry; you're just feeding her too much."

Ans: B

Feedback:

In infants younger than 1 month of age, the lower esophageal sphincter is not fully developed, so infants younger than 1 month of age frequently regurgitate after feedings. Many children younger than 1 year of age continue to regurgitate for several months, but this usually disappears with age. The mother's report is not a cause for concern, so the healthcare provider does not need to be notified.

Additional information would be needed to determine if the infant had an allergy. Although the infant's stomach capacity is small, telling the mother not to worry does not address the mother's concern, and telling her that she is feeding the daughter too much implies that she is doing something wrong.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1507, Insensible Fluid Losses

17. A group of students are reviewing information about fluid balance and losses in children in comparison to adults. The students demonstrate a need for additional review when they state that:

- A) children have a proportionately greater amount of body water than do adults.
- B) fever plays a greater role in insensible fluid losses in infants and children.
- C) a higher metabolic rate plays a major role in increased insensible fluid losses.
- D) the infant's immature kidneys have a tendency to overconcentrate urine.

Ans: D

Feedback:

The young infant's renal immaturity does not allow the kidneys to concentrate urine as well as in older children and adults, placing them at risk for dehydration or overhydration. Children do have a proportionately greater amount of body water than adults, and fever is important in promoting insensible fluid losses in infants and children because children become febrile more readily and their fevers are higher than those in adults. Children also experience a higher metabolic rate, which accounts for increased insensible fluid losses and increased need for water for excretory function.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1525, Educating the Family

18. An 8-month-old infant is brought to the clinic for evaluation. The mother tells the nurse that she has noticed some white patches on the infant's tongue that look like curdled milk after breastfeeding. The nurse suspects oral candidiasis (thrush). Which question would the nurse use to help confirm this suspicion?

- A) "Are you having breast pain when you nurse the baby?"
- B) "Has he had any dairy problems recently?"
- C) "Is he experiencing any vomiting lately?"
- D) "How have his stools been this past week?"

Ans: A

Feedback:

The infant may develop thrush from the mother if the mother has a fungal infection of the breast. Asking the mother about breast pain would be important because this type of infection can cause the mother a great deal of pain with nursing. Dairy products are not associated with oral candidiasis but are associated with the development of infectious diarrhea in infants. Vomiting is unrelated to thrush. The infant also may have candidal diaper rash, but this would be manifested on the skin as a beefy-red rash with satellite lesions, not in his stools.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1522, Nursing Assessment

19. The parents of a 6-week-old boy come to the clinic for evaluation because the infant has been vomiting. The parents report that the vomiting has been increasing in frequency and forcefulness over the last week. The mother says, "Sometimes, it seems like it just bursts out of his mouth." A diagnosis of hypertrophic pyloric stenosis is suspected. When performing the physical examination, what would the nurse most likely find?

- A) Sausage-shaped mass in the upper midabdomen
- B) Hard, moveable, olive-shaped mass in the right upper quadrant
- C) Tenderness over the McBurney point in the right lower quadrant
- D) Abdominal pain in the epigastric or umbilical region

Ans: B

Feedback:

With hypertrophic pyloric stenosis, a hard, moveable, olive-shaped mass would be palpated in the right upper quadrant. A sausage-shaped mass in the upper midabdomen would suggest intussusception. Tenderness over the McBurney point would be associated with appendicitis. Epigastric or umbilical pain would be associated with peptic ulcer disease.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1507, 1514, Common Medical Treatments, Drug Guide 42.1

20. A nursing instructor is developing a class presentation about the medications used to treat peptic ulcer disease. Which drug class would the instructor be least likely to include in the presentation?

- A) Antibiotics
- B) Proton pump inhibitors
- C) Histamine antagonists
- D) Prokinetics

Ans: D

Feedback:

Treatment for peptic ulcer disease includes antibiotics if Helicobacter pylori are verified, histamine antagonists, and/or proton pump inhibitors. Prokinetics are used to stimulate the gastrointestinal tract to help empty the stomach faster and promote intestinal motility. They are not used for peptic ulcer disease.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Caring

Page and Header: 1538, Providing Child and Family Education

21. The parents of a boy diagnosed with Hirschsprung disease are anxious and fearful of the upcoming surgery. The mother states, "I'm worried about having to care for our son's ostomy." Which intervention would be most helpful for the parents?

- A) Explaining to them about the diagnosis and surgery
- B) Having a wound, ostomy, and continence nurse meet with them
- C) Reinforcing that the ostomy will be temporary
- D) Teaching them about the medications used to slow stool output

Ans: B

Feedback:

Although explaining about the diagnosis and surgery, reinforcing that the ostomy will be temporary, and teaching them about medications would be appropriate, the parents are voicing concerns about caring for the ostomy. Therefore, having a wound, ostomy, and continence nurse meet with them would address these concerns and help them deal with the anxieties and care of a newly placed stoma.

Format: Multiple Select

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1543, Laboratory and Diagnostic Tests

22. The nurse is providing care to a child with pancreatitis. When reviewing the child's laboratory test results, what would the nurse expect to find? Select all that apply.

- A) Leukocytosis
- B) Decreased C-reactive protein
- C) Elevated serum amylase levels
- D) Positive stool culture
- E) Decreased serum lipase levels

Ans: A, C

Feedback:

With pancreatitis, serum amylase and lipase levels are elevated and levels three times the normal values are extremely indicative of pancreatitis. Leukocytosis is common with acute pancreatitis. C-reactive protein levels may be elevated. Stool cultures are not used to evaluate this disorder. Positive stool cultures would indicate a bacterial cause of diarrhea.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1507, 1508, 1509, Laboratory and Diagnostic Testing, Common Laboratory and Diagnostic Tests 42.1

23. A child is scheduled for a lower endoscopy. What would the nurse include in the child's plan of care in preparation for this test?

- A) Explaining about the need to ingest barium
- B) Establishing an intravenous access for radionuclide administration
- C) Administering the prescribed bowel cleansing regimen
- D) Withholding prescribed proton pump inhibitors for 5 days before

Ans: C

Feedback:

Prior to a lower endoscopy, the child must undergo bowel cleansing to allow visualization of the lower gastrointestinal tract via a fiberoptic instrument. Barium is ingested for an upper gastrointestinal and/or small bowel series. Radionuclides are used with a hepatobiliary scan. Proton pump inhibitors are withheld for 5 days before a urea breath test.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Remember

Integrated Process: Teaching/Learning

Page and Header: 1543, Gallbladder Disease

24. A group of students are reviewing information about gallbladder disease in children. The students demonstrate a need for additional review when they state:

- A) cholesterol gallstones are more frequently found in males.
- B) pigment stones are found primarily in the common bile duct.
- C) pancreatitis is a common complication of cholecystitis in children.
- D) cholecystitis is due to chemical irritation from obstructed bile flow.

Ans: A

Feedback:

Cholesterol gallstones are seen more often in females than males and increased risk occurs with age and onset of puberty. Pigment stones are usually found in the common bile duct. Pancreatitis is a common complication in children with gallstone disease. Cholecystitis is an inflammation of the gallbladder that is caused by chemical irritation due to the obstruction of bile flow from the gallbladder into the cystic ducts.

Format: Multiple Select

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1540, 1541, Nursing Management, Teaching Guidelines 42.2

25. After teaching the parents of a child diagnosed with celiac disease about nutrition, the nurse determines that the teaching was effective when the parents identify which foods as appropriate for their child? Select all that apply.

- A) Wheat germ
- B) Peanut butter
- C) Carbonated drinks
- D) Shellfish
- E) Jelly
- F) Flavored yogurt

Ans: B, C, D, E

Feedback:

Foods allowed in a gluten-free diet include peanut butter, carbonated drinks, shellfish, and jelly. Wheat germ and flavored yogurt should be avoided.

Format: Multiple Select

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1537, 1538, Physical Examination, Comparison Chart 42.2

26. A group of nursing students are reviewing information about inflammatory bowel disease in preparation for a class discussion on the topic. The students demonstrate understanding of the material when they identify which characteristics of Crohn disease? Select all that apply.

- A) Distributed in a continuous fashion
- B) Most common between the ages of 10 and 20 years
- C) Elevated erythrocyte sedimentation rate
- D) Low serum iron levels
- E) Tenesmus
- F) Loss of haustra within bowel

Ans: B, C, D

Feedback:

Crohn disease is most common between the ages of 10 and 20 years. Erythrocyte sedimentation rate is elevated, and serum iron levels are low. Ulcerative colitis is distributed continuously distal to proximal, with tenesmus and loss of haustra within the bowel. Crohn disease is segmental, with disease-free skip areas common, and the bowel wall has a cobblestone appearance.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Remember

Integrated Process: Teaching/Learning

Page and Header: 1535, 1536, Educating the Family and Child, Nursing Procedure 42.2

27. After teaching the parents of a 6-year-old how to administer an enema, the nurse determines that the teaching was successful when they state that they will give how much solution to their child?

- A) 100 to 200 mL

- B) 200 to 300 mL
- C) 250 to 500 mL
- D) 500 to 1,000 mL

Ans: D

Feedback:

For a school-age child, typically 500 to 1,000 mL of enema solution is given. For an infant, 250 mL or less is used; for a toddler or preschooler, 250 to 500 mL is used.

Format: Multiple Select

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1517, Health History

28. The nurse is caring for a 6-month-old with a cleft lip and palate. The mother of the child demonstrates understanding of the disorder with which statements? Select all that apply.

- A) "My smoking during pregnancy didn't have anything to do with this disorder. Smoking primarily causes low birth weight."
- B) "I know my baby takes a lot longer to feed than most children this age."
- C) "It really worries me that my baby may have some other disorders that haven't been detected yet."
- D) "I wonder if my baby will develop speech problems when language development begins?"
- E) "Thankfully there are healthcare providers that specialize in correcting this type of disorder."

Ans: B, C, D, E

Feedback:

Feeding and speech are especially difficult for the child with cleft lip and palate until the defect is repaired. Cleft lip and palate occurs frequently in association with other anomalies and has been identified in more than 350 syndromes. Plastic surgeons or craniofacial specialists, oral surgeons, dentists or orthodontists, and prosthodontists are some of the healthcare providers that specialize in repair of this disorder. The mother is incorrect in stating that smoking is not associated with cleft lip or palate. Maternal smoking during pregnancy is a major risk factor for the disorder.

Format: Multiple Select

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1533, Constipation and Encopresis

29. The nurse is performing a gastrointestinal assessment on a 7-year-old boy. The parents are assisting with the history. Which assessment findings are indicative of constipation? Select all that apply.

- A) "Our child only has 3 to 4 bowel movements per week."
- B) "Our child complains of pain because his bowel movements are so hard."
- C) "Our child tells us that his belly hurts a lot of the time."
- D) "I can tell he holds his bowel movement much of the time because of the way he stands."
- E) "I find smears of stool in his underwear almost every day."

Ans: B, C, D, E

Feedback:

Pain, stool withholding behavior (retentive posturing), and encopresis (soiling of fecal contents into the underwear beyond the age of expected toilet training) are all signs of chronic functional constipation. Less than 3 bowel movements is considered constipation.

Format: Short Answer

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1521, 1522, Nursing Management, Box 42.2

30. The nurse is preparing to administer intravenous fluids to manage a child with dehydration. The medical record indicates the child weighs 60 lb (27.2 kg). How many milliliters will initially be administered? Record your answer using two decimal places.

Ans: 545.45

Feedback:

Nursing goals for the infant or child with dehydration are aimed at restoring fluid volume and preventing progression to hypovolemia. Provide oral rehydration to children for mild to moderate states of dehydration. Children with severe dehydration should receive intravenous fluids. Initially, administer 20 mL/kg of normal saline or lactated Ringer, and then reassess the hydration status.

Chapter 43

1. The nurse is caring for a child who is experiencing an acute renal transplant rejection and is to receive muromonab-CD3. What would the nurse **most** likely expect to assess after the first dose is administered?
 - A. Fever with chills, chest tightness
 - B. Cough, hyperkalemia
 - C. Photosensitivity, gastrointestinal (GI) upset
 - D. Urinary retention, decreased appetite

Answer: A

Rationale: The first dose of muromonab-CD3 can cause fever, chills, chest tightness, wheezing, nausea, and vomiting. Cough and hyperkalemia are associated with angiotensin-converting enzyme inhibitors. Photosensitivity and GI upset are often associated with diuretics. Urinary retention and decreased appetite are associated with imipramine.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Nursing Process

Reference: p. 1559

2. The nurse is visually inspecting a urine specimen from a 12-year-old boy. The nurse documents gross hematuria with a specimen of which color?
 - A. Cloudy yellow
 - B. Cola colored
 - C. Pale to almost clear urine
 - D. Light orange to moderately yellow colored

Answer: B

Rationale: Gross hematuria causes the urine to appear tea, cola, or even dirty green colored. Cloudy urine is typically a sign of infection. Normal urine ranges from moderately yellow to pale or almost clear. Orange-colored urine can occur because of medication.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1572

3. The nurse is caring for a 4-year-old with a suspected urinary tract infection. What would be **most** appropriate to say to the child when obtaining a urine specimen from him?

- A. "I will need a urine sample."
- B. "Let your mom help you tinkle in this cup."
- C. "Please tinkle in this cup right now."
- D. "Please void in this cup instead of the toilet."

Answer: B

Rationale: The nurse needs to use familiar terms to explain to the child what is needed and to gain cooperation. The most positive approach would be to let the child's mother help rather than demanding that he tinkle right now. Using the terms "urine sample" or "void" is not appropriate for a 4-year-old.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1561

4. The nurse is providing postsurgical care for an infant who has undergone a hypospadias repair. Which action by the nurse would be **most** important to help keep the area clean while maintaining proper position of the drainage tubing?

- A. Keeping the drainage tube taped in an upright position
- B. Administering antibiotics as ordered
- C. Administering analgesics as prescribed
- D. Using a double-diapering technique

Answer: D

Rationale: Double diapering is a method used to protect a child's urethra and stent or catheter after surgery and additionally helps to keep the area clean and free from infection. Keeping the drainage tube taped in an upright position, administering antibiotics, and administering analgesics are also important, but double diapering keeps the area clean and helps prevent infection.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1561

5. The nurse is caring for a 4-year-old girl with vulvovaginitis. After instructing the girl's mother on how to help prevent subsequent episodes, which statement by the mother indicates a need for additional teaching?

- A. "She tells me she wipes from front to back."
- B. "I will make sure she changes her underwear every day."
- C. "She should avoid bubble baths."
- D. "I will help supervise her wiping after bowel movements."

Answer: A

Rationale: At the age of 4, the mother should not **assume** that the girl will wipe properly. The mother will need to supervise her wiping in order to train her properly. Making sure the child changes her underwear daily, avoiding bubble baths, and supervising her wiping after bowel movements indicate that the mother has understood the instructions.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1580

6. A nurse is caring for a 7-year-old girl scheduled for an intravenous pyelogram (IVP). Which action would be the **priority** before the test?

- A. Checking with the parents for any allergies
- B. Ensuring adequate hydration
- C. Giving the girl an enema
- D. Screening her for pregnancy

Answer: A

Rationale: It is important to double-check whether the girl has any allergies. The test is contraindicated in children allergic to shellfish or iodine. Adequate hydration is also important, but the check for allergies is a priority. Only females of reproductive age must be screened for pregnancy. An enema is not necessary at all institutions.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Integrated Process: Nursing Process

Reference: p. 1555

7. A 6-year-old child has undergone a renal transplant and is receiving cyclosporine. The nurse instructs the parents to be especially alert for which complication?

- A. Weight loss

- B. Hypotension
- C. Signs of infection
- D. Hair loss

Answer: C

Rationale: The parents should be especially alert for signs of infection as cyclosporine is an immunosuppressant drug. Weight gain instead of weight loss, hypertension instead of hypotension, and increased facial hair instead of hair loss are some other potential side effects.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Nursing Process

Reference: p. 1559

8. The nurse is caring for a 12-year-old girl with nephrotic syndrome. The girl confides that she feels like a "freak" compared to her peers because of her weight, edema, and moon face. Which response by the nurse would be **most** appropriate?

- A. "Let's put you in touch with some other girls who are also having the same body changes."
- B. "Luckily, this is just a temporary, unfortunate part of your condition; you need to accept it."
- C. "Your real friends do not care about your appearance and just want you to get well."
- D. "You are beautiful in your own way; what matters is what is on the inside."

Answer: A

Rationale: It is important to introduce the girl to other youngsters with chronic renal conditions so she does not feel so isolated. Adolescents need interaction with peers. Telling the girl that this is a temporary condition, her real friends don't care about her appearance, and she is beautiful in her own way dismisses the girl's concerns and does not offer solutions. Nephrotic syndrome is a chronic condition, so telling her the condition is temporary also is inaccurate.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Reference: p. 1571

9. An 8-year-old girl is scheduled for a renal ultrasound. What would the nurse include in the plan of care when preparing the child for this test?

- A. Withholding food and fluids after midnight
- B. Checking the child for allergies to shellfish
- C. Ensuring the child has a full bladder
- D. Informing the child she should feel no discomfort

Answer: D

Rationale: The nurse should inform the child that she should feel no discomfort during the test. No fasting is required and no dye is used, so allergies are not a concern. A full bladder is needed for urodynamic studies.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Reference: p. 1555

10. The nurse is preparing a teaching plan for the parents of a child with a urinary tract infection (UTI). In educating the parents, the nurse would recommend that the child avoid:

- A. a liberal fluid intake.
- B. caffeine.
- C. cranberry juice.
- D. cotton underwear.

Answer: B

Rationale: Caffeine is an irritant to the bladder and should be avoided. Liberal fluid intake and cranberry juice should be encouraged. The child should wear cotton underwear to avoid perineal irritation.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Teaching/Learning

Reference: p. 1567

11. The mother of a child with end-stage renal disease asks the nurse why her son is getting an injection of erythropoietin. When responding to the mother, the nurse explains that the rationale is:

- A. to treat low calcium levels.
- B. to stimulate growth in stature.
- C. to stimulate red blood cell growth.
- D. to correct acidosis.

Answer: C

Rationale: Erythropoietin is given to stimulate red blood cell growth. Vitamin D and calcium are used to correct hypocalcemia. Growth hormone is used to stimulate growth in stature. Citric acid and sodium citrate (or sodium bicarbonate tablets) are used to correct acidosis.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Teaching/Learning

Reference: p. 1576

12. A child is diagnosed with hemolytic-uremic syndrome (HUS). Review of the child's laboratory test results would reveal which finding?

- A. Decreased blood urea nitrogen (BUN) and creatinine
- B. Decreased platelets and leukocytosis
- C. Hypernatremia and hypokalemia
- D. Respiratory acidosis and proteinuria

Answer: B

Rationale: The child with HUS typically exhibits severe thrombocytopenia (decreased platelets) and leukocytosis. BUN and creatinine are elevated. Hyponatremia, hyperkalemia, metabolic acidosis, and proteinuria also may be noted.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1573

13. After teaching the parents of a child with a hydrocele about this condition, which statement indicates that the teaching was successful?

- A. "If this gets worse and we don't treat it, our son could become infertile."
- B. "This condition should gradually go away on its own."
- C. "The surgeon is going to operate on him immediately."
- D. "It's going to be difficult putting ice packs on his scrotum."

Answer: B

Rationale: Hydrocele requires watchful waiting because it will usually resolve spontaneously on its own. Hydrocele is not associated with the development of infertility; a varicocele, if left untreated, can lead to infertility. Immediate surgery is warranted for testicular torsion. Ice packs to the scrotum are helpful in relieving pain associated with epididymitis.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Teaching/Learning

Reference: p. 1583

14. The nurse is reviewing the laboratory test results of a child with nephrotic syndrome. What would the nurse **least** likely expect to find?

- A. Hyperlipidemia
- B. Hypoalbuminemia
- C. Decreased blood urea nitrogen (BUN)
- D. Hypoproteinemia

Answer: C

Rationale: With nephrotic syndrome, proteinuria, hyperlipidemia, decreased serum protein levels (hypoproteinemia), and decreased serum albumin levels (hypoalbuminemia) are present. BUN typically becomes elevated.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Remember

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1554

15. The nurse is applying a urine bag to a 15-month-old boy to collect a urine specimen. Which action would the nurse take **first**?

- A. Apply benzoin to the scrotal area.
- B. Tuck the bag downward inside the diaper.
- C. Pat the perineal area dry after cleaning.
- D. Apply the narrow portion of the bag on the perineal space.

Answer: C

Rationale: When applying a urine bag, the nurse would first cleanse the perineal area well and pat it dry. If a culture was to be obtained, the nurse would cleanse the genital area with povidone-iodine or according to institutional protocol. Next the nurse would apply benzoin around the scrotum and allow it to dry. Then the nurse would apply the urine bag, making sure that the penis is fully inside the bag, tucking it downward inside the diaper to discourage leaking.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1580

16. A group of students are reviewing information about renal failure in children. The students demonstrate a need for additional teaching when they identify which agent as a potential contributor to renal failure?

- A. Vancomycin
- B. Gentamicin
- C. Co-trimoxazole
- D. Amoxicillin

Answer: D

Rationale: Amoxicillin is a penicillin and is not associated with nephrotoxicity leading to renal failure. Vancomycin, gentamicin (an aminoglycoside), and co-trimoxazole (a sulfonamide) are nephrotoxic.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Remember

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Teaching/Learning

Reference: p. 1574

17. A nurse is preparing a presentation for a local parent group about urinary tract infections (UTIs) in children. Which organism would the nurse incorporate into the presentation as the **most** common cause?

- A. *Klebsiella*
- B. *Escherichia coli*
- C. *Staphylococcus aureus*
- D. *Pseudomonas*

Answer: B

Rationale: *E. coli* most commonly causes UTI. Other less common causative organisms include *Klebsiella*, *S. aureus*, and *Pseudomonas*.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1566

18. A nurse is interviewing the parents of a child diagnosed with obstructive uropathy. Which statement by the parents would the nurse identify as significant?

- A. "She's been constipated quite a few times."
- B. "We've noticed that her bed is wet in the morning."
- C. "She had surgery to repair a problem with her anus."

D. "She had a bacterial skin infection about a week ago."

Answer: C

Rationale: Risk factors associated with obstructive uropathy include prune belly syndrome, chromosome abnormalities, anorectal malformations, and ear defects. The statement about surgery to repair an anal problem suggests an anorectal malformation. Constipation is a risk factor for urinary tract infections. Bedwetting suggests enuresis. A bacterial skin infection is associated with acute glomerulonephritis.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 1562

19. A nurse identifies a nursing diagnosis of

Impaired urinary elimination related to infection in the urinary tract as manifested by dysuria for a preschooler. When developing the plan of care, what would be **most** important for the nurse to do first?

- A. Develop a schedule for bladder emptying.
- B. Encourage fluid intake.
- C. Assess usual voiding patterns.
- D. Monitor intake and output.

Answer: C

Rationale: The first action would be to assess the child's usual voiding patterns to establish a baseline to develop an appropriate schedule for bladder emptying. Encouraging fluid intake and monitoring intake and output would be appropriate, but these would not be the first action.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Analyze

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 1557

20. While presenting a panel discussion to a group of parents about urinary tract infections (UTIs) in children, one of the parents asks the nurse, "Why would my daughter be more at risk than my son?" Which response by the nurse would be **most** accurate?

- A. "Girls have a smaller bladder size than boys do."
- B. "A girl's urethra is closer to the rectal opening."
- C. "A girl's urethra is longer than a boy's urethra."
- D. "Her kidneys are less well protected."

Answer: B

Rationale: In females, the urethra is shorter, which allows bacteria to enter the bladder. It also is closer in physical proximity to the rectum, leading to possible contamination. Bladder size does not differ between boys and girls. The kidneys are less well protected in the abdomen, increasing the risk for injury but not UTIs.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1566

21. A child returns from surgery in which a stoma was created in the abdominal wall to the bladder. The nurse identifies this as a:

- A. vesicostomy.
- B. ureteral stent.
- C. continent urinary diversion.
- D. bladder augmentation.

Answer: A

Rationale: A vesicostomy refers to a stoma created in the abdominal wall to the bladder. A ureteral stent is a thin catheter temporarily placed in the ureter to drain urine. A continent urinary diversion uses a piece of the intestine to create a bladder that can be catheterized. Bladder augmentation involves the use of a piece of the stomach or intestine to enlarge bladder capacity.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1558

22. The nurse is preparing an 8-year-old girl for a cystoscopy. Which instruction would be **most** appropriate to give to the child?

- A. "You need to make sure that you don't go to the bathroom before the test."
- B. "You might feel some burning when you go to the bathroom afterward."
- C. "I'm going to have to put a tube into your bladder to empty it."
- D. "I have to put a thick tight rubber band around your arm to get a blood specimen."

Answer: B

Rationale: Cystoscopy is an endoscopic visualization of the urethra and bladder. The nurse would instruct the child that she might experience some burning when she voids after the procedure. A full bladder is needed for urodynamic studies. Putting a tube into the bladder describes a catheterization. Putting a thick tight rubber band suggests a tourniquet, which is used to obtain blood specimens.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Teaching/Learning

Reference: p. 1555

23. The nurse is assessing a 5-year-old child's genitourinary system. Which findings would the nurse document as normal? Select all that apply.

- A. Labial fusion
- B. Round abdomen
- C. Positive bowel sounds
- D. Dullness over the spleen
- E. Undescended testicles

Answer: B, C, D

Rationale: Normal findings include a round abdomen, positive bowel sounds, dullness over the spleen, and descended testicles. Labial fusion, a distended abdomen, and undescended testicles are abnormal findings.

Question format: Multiple Select

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 1553

24. The nurse is providing instruction to the parents of a newborn boy. The parents have decided not to circumcise the child. What information should be included in the discussion? Select all answers that apply.

- A. The foreskin should be pulled back for cleaning at least once per day.
- B. The foreskin should be pulled back gently with each diaper change.
- C. Clean the penis gently with soap and water.
- D. If the foreskin is not retractable do not force it.
- E. When the foreskin is retracted, gently replace it prior to completing diapering.

Answer: C, D, E

Rationale: The newborn's foreskin does not normally retract. This may not be possible until later in infancy. If the foreskin does not retract do not force it. If the foreskin is able to be retracted, do so gently. Return the foreskin to place prior to applying the diaper. Soap and water should be used several times per day to clean the penis and perineal area.

Question format: Multiple Select

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1581

25. The nurse is caring for a client with hemolytic-uremic syndrome (HUS). The client is demonstrating oliguria. What does the nurse expect to find when reviewing the client's records?

- A. A pattern of below-normal blood pressure
- B. Higher fluid output than fluid intake
- C. Elevated BUN and creatinine levels
- D. Increased glomerular filtration rate (GFR)

Answer: C

Rationale: Oliguria is the result of acute renal failure associated with HUS. The BUN and creatinine level are indications of kidney function and are elevated with acute renal failure.

Hypertension is associated with HUS. Output is decreased with renal failure, as is GFR.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1573

26. A 15-year-old client presents to the emergency room reporting an abrupt onset of severe, sudden pain on the right side of the scrotum while playing football. The nurse notes a blue-black swelling of the affected scrotum. Which action will the nurse complete **next**?

- A. Complete a head-to-toe assessment
- B. Have the client rate the pain
- C. Notify the primary health care provider
- D. Monitor the client's urine output

Answer: C

Rationale: The nurse would suspect testicular torsion, which is a surgical emergency that necessitates immediate surgical correction to prevent testicular necrosis and possible gangrene. Therefore, the nurse would notify the health care provider immediately. The nurse would then have the client rate the pain, complete a head-to-toe assessment, and monitor urine output.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1583

27. The nurse is taking a health history of a child with suspected acute poststreptococcal glomerulonephritis. Which response by the client's parent will the nurse highlight for the primary health care provider as an indicator for this condition?

- A. "My child's has recently reported urinary frequency."
- B. "My child just got over a head cold with laryngitis."
- C. "My child's urine is pale yellow in color."
- D. "My child's eyes appear sunken to me."

Answer: B

Rationale: Known risk factors include a recent episode of pharyngitis or other streptococcal infection, decreased urine output, rust or cola colored urine, and swelling around the eyes.

Edema may occur in the abdomen, face, eyes, feet, ankles, hands, or generally.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1572

28. The nurse is administering an IV infusion of albumin to a child with nephrotic syndrome. What is the **primary** concern for the nurse when administering this medication to the child?

- A. Fluid overload
- B. Electrolyte imbalance
- C. Increased blood pressure
- D. Urine output

Answer: A

Rationale: Many children with nephrotic syndrome develop hypoalbuminemia and require the administration of albumin. Albumin increases the intravascular pressure, causing the movement of fluid from the interstitial space to the intravascular space. As a result, fluid overload can occur. The treatment is to administer furosemide after the albumin infusion is complete. Furosemide is a diuretic that will help excrete the extra fluid from the vascular space, thus preventing fluid overload. Electrolyte imbalances would occur if the low albumin was not treated. The blood pressure and urine output should be assessed during the medication administration to determine renal function.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Nursing Process

Reference: p. 1559

29. A child is hospitalized with acute poststreptococcal glomerulonephritis. What assessments should the nurse include in the plan of care for this child?? Select all that apply.

- A. Assess level of consciousness
- B. Assess pain
- C. Monitor blood pressure
- D. Auscultate lung sounds
- E. Inspect the urine

Answer: B, C, D, E

Rationale: Acute poststreptococcal glomerulonephritis (APSGN) is an immune process that injures the renal glomeruli. Children come to the healthcare provider with fever, anorexia, headaches and abdominal pain. The focus of care is primarily on fluid volume and managing hypertension. The child would have edema so the nurse should assess thoroughly the lung sounds for crackles, and the work of breathing. Hypertension occurs from the damaged kidneys so the blood pressure should be assessed often and hypertension treated. Assessment of pain is necessary. The pain is abdominal in nature and should be treated appropriately. The urine will have proteinuria and hematuria. It is tea colored from the gross blood in the urine. The level of consciousness is not affected by APSGN.

Question format: Multiple Select

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1572

30. An infant has undergone a hypospadias repair. What intervention will the nurse teach the parents to keep the site clean and to reduce swelling?

- A. "It is important to use double diapering to keep stool off the site."
- B. "The compression dressing should be changed if it becomes soiled."
- C. "Keep the penis taped to the abdomen so stool cannot get to surgical site."
- D. "You can use a gauze dressing to cover the urethral stent."

Answer: A

Rationale: Hypospadias occurs when the urethral opening is on the ventral side of the penis. It needs to be repaired because the male cannot aim a urinary stream while standing and it causes

erectile dysfunction when the child is older. The penile dressing following surgery is usually a compression type to decrease edema and bruising. The easiest way to accomplish this type of dressing is through double diapering. Double diapering also prevents the stool from getting to the penis and surgical site causing an infection. The penis is generally taped to the abdomen to prevent the catheter or stent from causing stress on the urethral sutures, not to keep the site clean or prevent swelling. Gauze is not used over the surgical site. Double diapering provides a compression dressing and the soiled diaper should be changed with every bowel movement.

Question format: Multiple Choice

Chapter 43: Nursing Care of the Child With an Alteration in Urinary Elimination/Genitourinary Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Basic Care and Comfort

Integrated Process: Teaching/Learning

Reference: p. 1561

Chapter 44

1. The nurse is teaching the mother of a 5-year-old boy with a myelomeningocele who has developed a sensitivity to latex. Which response from his mother indicates a need for further teaching?
 - A. "He needs to get a medical alert identification."
 - B. "I will need to discuss this with his caregivers."
 - C. "A product's label indicates whether it is latex-free."
 - D. "He must avoid all contact with latex."

Answer: C

Rationale: The Food and Drug Administration (FDA) requires that all medical supplies be labeled if they contain latex, but this is not the case with consumer products. The mother must be familiar with products that contain latex. The Spina Bifida Association of America maintains an updated list of latex-containing products. Getting a medical alert identification, talking with his caregivers, and avoiding all contact with latex are correct.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Analyze

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Integrated Process: Teaching/Learning

Reference: p. 1610

2. The nurse is providing postoperative care for a 14-month-old girl who has undergone a myelomeningocele repair. The girl's mother is extremely anxious and tells the nurse she is afraid she will never learn how to care for her daughter at home. Which response by the nurse would be **most** appropriate?

- A. "I will help you become comfortable in caring for your daughter."
- B. "You must learn how to care for your daughter at home."
- C. "You will need to learn to collaborate with all the caregivers."
- D. "There is a lot to learn, and you need a positive attitude."

Answer: A

Rationale: The nurse needs to empower families to become the experts on their child's needs and conditions via education and participation in care. The most positive approach is to let the mother know the nurse will support her and help her become an expert on her daughter's care. Telling the mother that she must learn how to care for her daughter or that she must have a positive attitude is not helpful. Telling her that she needs to collaborate with the caregivers is true, but does not address her fears.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Integrated Process: Teaching/Learning

Reference: p. 1611

3. The nurse is caring for a 10-year-old with Duchenne muscular dystrophy. As part of the plan of care, the nurse focuses on maintaining his cardiopulmonary function. Which intervention would the nurse implement to **best** promote maximum chest expansion?

- A. Deep-breathing exercises
- B. Upright positioning
- C. Coughing
- D. Chest percussion

Answer: B

Rationale: The nurse should emphasize that the child's position should be arranged to promote maximum chest expansion. This is usually in the upright position. Deep-breathing exercises are for strengthening/maintaining respiratory muscles. Coughing helps clear the airways. Chest percussion helps loosen secretions in lungs.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1623

4. A 6-year-old child with cerebral palsy has been admitted to the hospital for some tests. The child's condition is stable. A parent remains with the child, but the parent is obviously exhausted and stressed. Which response by the nurse would be **most** appropriate?

- A. "Would you like me to bring you a blanket and pillow?"
- B. "You are doing such a wonderful job with your child."
- C. "Your child is in good hands; consider going home to get some sleep."
- D. "Are you planning to spend the night or to go home?"

Answer: C

Rationale: Providing daily, intense care can be quite demanding and tiring. When a child with cerebral palsy is admitted to the hospital, this may serve as a time of respite for family and primary caregivers. The nurse should remind the parent that the child is in good hands and urge the parent to go home. Asking whether the parent is planning to stay might make the parent feel obligated to stay. Asking if the parent wants a blanket or pillow does not encourage the parent to leave the hospital. Telling the parent he or she is doing a good job is nice, but does not encourage the parent to take a break.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Integrated Process: Caring

Reference: p. 1630

5. A nurse is caring for a 14-year-old girl following myelography. What is the **priority** nursing action?

- A. Monitoring for a decrease in spasticity
- B. Observing for signs of meningeal irritation
- C. Assessing motor function
- D. Observing for mental confusion or hallucinations

Answer: B

Rationale: Following myelography, the nurse should carefully observe for signs of meningeal irritation because of what is involved in this procedure. Monitoring for a decrease in muscle spasticity, assessing motor function, and observing for mental confusion or hallucinations is appropriate following an intrathecal test dose of baclofen.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1594

6. The nurse has developed a plan of care for a 6-year-old with muscular dystrophy. He was recently injured when he fell out of bed at home. Which intervention would the nurse suggest to prevent further injury?

- A. Recommend the bed's side rails be raised throughout the day and night.
- B. Suggest a caregiver be present continuously to prevent falls from bed.
- C. Encourage a loose restraint to be used when he is in bed.
- D. Recommend raising the bed's side rails when a caregiver is not present.

Answer: D

Rationale: The nurse should recommend that side rails on the bed be elevated when a caregiver is not present. The use of restraints should be avoided if at all possible. Suggesting that a caregiver be present at all times places undue stress on the family. Close observation is more appropriate. Recommending side rails be elevated at all times may be upsetting to the child and make him feel like a "baby."

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Integrated Process: Nursing Process

Reference: p. 1623

7. The nurse is caring for a 2-month-old with cerebral palsy. The infant is limp and flaccid with uncontrolled, slow, worm-like, writhing, and twisting movements. What word would the nurse use when documenting these observations?

- A. Spastic
- B. Athetoid
- C. Ataxic
- D. Mixed

Answer: B

Rationale: Athetoid cerebral palsy is characterized by abnormal, involuntary movement. It affects all four extremities with possible involvement of the face, neck, and tongue. The movements increase in periods of stress. Dysarthria and drooling may be present as well. Spastic cerebral palsy is characterized by poor control of posture, balance, and movement; exaggeration of deep tendon reflexes; and hypertonicity of affected extremities. Ataxic is characterized by poor coordination, unsteady gait, and wide-based gait.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Communication and Documentation

Reference: p. 1627

8. The nurse is teaching a group of students about myelinization in a child. Which statement by the students indicates that the teaching was successful?

- A. Myelinization is completed by 4 years of age.
- B. The process occurs in a head-to-toe fashion.
- C. The speed of nerve impulses slows as myelinization occurs.
- D. Nerve impulses become less specific in focus with myelinization.

Answer: B

Rationale: Myelinization occurs in a cephalocaudal, proximodistal manner and is completed by 2 years of age. As myelinization proceeds, nerve impulses become faster and more accurate.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation
Integrated Process: Teaching/Learning
Reference: p. 1588

9. When developing the plan of care for a child with cerebral palsy, which treatment would the nurse expect as least likely?
- A. Skeletal traction
 - B. Physical therapy
 - C. Orthotics
 - D. Occupational therapy

Answer: A

Rationale: Skeletal traction would be the least likely treatment for a child with cerebral palsy. Physical therapy, orthotics and braces, and occupational therapy are all common treatments used for cerebral palsy.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Teaching/Learning

Reference: p. 1626-1627

10. A nurse is preparing a program for a group of parents about injury prevention. What would the nurse include as an important contributing factor for cervical spine injury in a child?
- A. Exposure to teratogens while in utero
 - B. Immaturity of the central nervous system
 - C. Increased mobility of the spine
 - D. Incomplete myelinization

Answer: C

Rationale: Compared to the adult, a child's spine is very mobile, especially in the cervical spine region, resulting in a higher risk for cervical spine injury. Exposure to teratogens in utero may lead to altered growth and development of the brain or spinal cord. Immaturity of the central nervous system places the infant at risk for insults that may result in delayed motor skill attainment or cerebral palsy. Incomplete myelinization reflects the lack of motor control.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1588

11. A child with Duchenne muscular dystrophy is to receive prednisone as part of his treatment plan. After teaching the child's parents about this drug, which statement by the parents indicates the need for additional teaching?

- A. "We should give this drug before he eats anything."
- B. "We need to watch carefully for possible infection."
- C. "The drug should not be stopped suddenly."
- D. "He might gain some weight with this drug."

Answer: A

Rationale: Corticosteroids such as prednisone can cause gastric upset, so the medication should be given with food to reduce this risk. The drug may mask the signs of infection, so the parents need to monitor the child closely for any changes. Treatment with this drug should not be stopped abruptly due to the risk for acute adrenal insufficiency. Common side effects of this drug include weight gain, osteoporosis, and mood changes.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Teaching/Learning

Reference: p. 1600

12. What information would the nurse include in the preoperative plan of care for an infant with myelomeningocele?

- A. Positioning supine with a pillow under the buttocks
- B. Covering the sac with saline-soaked nonadhesive gauze
- C. Wrapping the infant snugly in a blanket
- D. Applying a diaper to prevent fecal soiling of the sac

Answer: B

Rationale: For the infant with a myelomeningocele, saline-soaked nonadhesive gauze or antibiotic-soaked gauze is used to keep the sac moist. The infant is positioned prone, with a folded towel under the abdomen, so that the urine and feces flow away from the sac. A warmer or isolette is used to keep the infant warm. Blankets are avoided because they could place excess pressure on the sac. Diapering may be contraindicated to avoid placing pressure on the sac.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1608

13. The nurse is assessing a newborn who was delivered after a prolonged labor due to an abnormal presentation. The newborn sustained a cranial nerve injury. The nurse would **most** likely expect to assess deficits related to which cranial nerve?

- A. Optic
- B. Facial
- C. Acoustic
- D. Trigeminal

Answer: B

Rationale: The most common cranial nerve injury occurring during birth trauma involves facial nerve palsy. The optic, acoustic, and trigeminal nerves are not typically injured during birth trauma.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 1592

14. A child with spastic cerebral palsy is to receive botulin toxin. The nurse prepares the child for administration of this drug by which route?

- A. Oral
- B. Subcutaneous injection
- C. Intramuscular injection
- D. Intravenous infusion

Answer: C

Rationale: Botulin toxin is administered by injection into the muscle. It may cause dry mouth. It is not administered orally, by subcutaneous injection, or by intravenous infusion.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Nursing Process

Reference: p. 1600

15. The nurse is assessing the neuromusculoskeletal system of a newborn. What is an abnormal assessment finding?

- A. Sluggish deep tendon reflexes
- B. Full range of motion in extremities
- C. Absence of hypotonia
- D. Lack of purposeful muscular control

Answer: A

Rationale: Deep tendon reflexes are present at birth and are initially brisk in the newborn and progress to average over the first few months. Sluggish deep tendon reflexes indicate an abnormality. The newborn is capable of spontaneous movement but lacks purposeful control. Full range of motion is present at birth. Healthy infants and children demonstrate normal muscle tone; hypertonia or hypotonia is an abnormal finding.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Analyze

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 1588

16. A child with cerebral palsy has undergone surgery for placement of a baclofen pump. Which instruction would the nurse include when teaching the parents about caring for their child?

- A. Wait 48 hours before allowing the child to take a tub bath.
- B. Do not allow the child to sleep on the left side for about 4 weeks.
- C. Call the health care provider if the child's temperature is over 100.5°F (38°C).
- D. Discourage the child from stretching or bending forward for 4 weeks.

Answer: D

Rationale: After insertion of a baclofen pump, the parents should discourage any twisting at the waist, reaching high overhead, stretching, or bending forward or backward for 4 weeks. The child would avoid tub baths for about 2 weeks and avoid sleeping on the stomach for 4 weeks. The parents should notify the health care provider if the child's temperature is greater than 101.5°F (38.6°C).

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Teaching/Learning

Reference: p. 1630

17. A nursing instructor is preparing for a class discussion on spinal muscular atrophy (SMA). When describing type 2 SMA, which information would the instructor include? Select all that apply.

- A. Onset before 6 months of age
- B. Weakness most severe in shoulders and hips
- C. Difficulty with swallowing
- D. Slowly progressing condition
- E. Genetic disease with autosomal recessive inheritance

Answer: B, D, E

Rationale: Any type of spinal muscular atrophy is a genetic motor neuron disease due to autosomal recessive inheritance. Type 2 SMA usually occurs between 6 and 18 months of age, with weakness that is most severe in the shoulders, hips, thighs, and upper back. It is slower in progression than type 1. Survival into adulthood is common if respiratory status is maintained appropriately. Type 1 SMA occurs before birth to 6 months of age and the child usually has difficulty swallowing, sucking, and breathing.

Question format: Multiple Select

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Understand

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Teaching/Learning

Reference: p. 1624

18. An 8-year-old girl was diagnosed with a closed fracture of the radius at approximately 2 p.m. The fracture was reduced in the emergency department and her arm placed in a cast. At 11 p.m. her mother brings her back to the emergency department due to unrelenting pain that has not been relieved by the prescribed narcotics. Which action would be the **priority**?

- A. Notifying the doctor immediately
- B. Applying ice
- C. Elevating the arm
- D. Giving additional pain medication as ordered

Answer: A

Rationale: The nurse should notify the doctor immediately because the girl's symptoms are the classic sign of compartment syndrome. Immediate treatment is required to prevent excessive swelling and to detect neurovascular compromise as quickly as possible. The ice should be removed and the arm brought below the level of the heart to facilitate whatever circulation is present. Giving additional pain medication will not help in this situation.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Reference: p. 1640

19. The nurse is caring for an active 14-year-old boy who has recently been diagnosed with scoliosis. He is dismayed that a "jock" like himself could have this condition, and is afraid it will impact his spot on the water polo team. Which response by the nurse would **best** address the boy's concerns?

- A. "If you wear your brace properly, you may not need surgery."
- B. "The good news is that you have very minimal curvature of your spine."
- C. "Let's talk to another boy with scoliosis, who is winning trophies for his swim team."

D. "Let's talk to the doctor about your treatment options."

Answer: C

Rationale: Because this boy is concerned about limiting his participation in water polo and perceives scoliosis as a disease that does not affect "jocks," putting the child in contact with someone with the same problem would be helpful. Telling the adolescent about not needing surgery if he wears his brace or that his curvature is minimal may or may not be true in his case and thus would be false reassurance. Although these suggestions and also the suggestion about talking to the doctor about treatment options could be helpful by engaging his input in the treatment, these do not address his specific concerns about his body image.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Caring

Reference: p. 1635-1636

20. The nurse is caring for a female infant with torticollis and is providing instructions to the parents about how to help their daughter. Which statement by the parents indicates a need for further teaching?

- A. "We must encourage our daughter to turn her head both ways."
- B. "Flatness on one side of the head is a common side effect."
- C. "We must apply firm pressure and stretching every other day."
- D. "We will do a daily stretching regimen with multiple sessions."

Answer: C

Rationale: The nurse needs to remind the parents that the stretching exercises should be done several times a day. The stretching is applied with gentle, not firm, pressure and should be done every day for multiple sessions. The statements about turning the head both ways, flatness on one side as common, and daily stretching with multiple sessions are correct.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Teaching/Learning

Reference: p. 1618

21. The nurse is caring for a 10-year-old in traction. While performing a skin assessment, the nurse notices that the skin over the calcaneus appears slightly red and irritated. Which action would the nurse take **first**?

- A. Reposition the child's foot on a pressure-reducing device.
- B. Apply lotion to his foot to maintain skin integrity.

- C. Make sure the skin is clean and dry.
- D. Gently massage his foot to promote circulation.

Answer: A

Rationale: The nurse's first action is to remove continuous pressure from this area. The other actions can help decrease the potential for skin breakdown, but the pressure must be relieved first.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Basic Care and Comfort

Integrated Process: Nursing Process

Reference: p. 1590

22. The nurse is caring for a 14-month-old boy with rickets who was recently adopted from overseas. His condition was likely a result of a diet very low in milk products. The nurse is providing teaching regarding treatment. Which response by the parents indicates a need for further teaching?

- A. "We must give him calcium and phosphorus with food every morning."
- B. "He must take vitamin D as prescribed and spend some time in the sunlight."
- C. "He must take calcium at breakfast and phosphorus at bedtime."
- D. "We should encourage him to have fish, dairy, and liver if he will eat it."

Answer: A

Rationale: The nurse should emphasize that the calcium and phosphorus supplements should be administered at alternate times to promote proper absorption of both of these supplements. Taking vitamin D, spending time in the sun, and encouraging intake of fish, dairy, and liver are appropriate responses.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Teaching/Learning

Reference: p. 1631

23. The nurse is caring for a 14-year-old client in traction prior to surgery. The client has been in the hospital for 2 weeks and will require an additional 10 days in the hospital following surgery. The client states, "I feel isolated and I am refusing any more treatment." Which response by the nurse is **most** appropriate?

- A. "I know it is boring here, but the best place for you to remain immobile is the hospital."
- B. "I will see if you can have friends come spend a few nights with you."
- C. "Let's come up with things for you to do and see if your friends can come visit."

D. "If you refuse further treatment, your condition will only get worse."

Answer: C

Rationale: After 2 weeks in traction, an adolescent can become easily bored and isolated from usual peer interaction. The most helpful intervention would be to engage the help of the client to develop a list of books, games, movies, and other activities the client would enjoy. The nurse should also encourage visitation and phone calls from friends. Telling the client friends can come spend the night in the hospital is not most appropriate as minors are not typically encouraged to stay overnight. Telling the adolescent the condition will worsen if the client resists treatment is threatening and inappropriate.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Integrated Process: Caring

Reference: p. 1590-1591

24. The nurse is caring for a 2-year-old girl in a bilateral brace with tibia vara. Her parents are upset by their toddler's limited mobility. Which response by the nurse would be **most** appropriate?

- A. "If you don't follow the therapy, your daughter could develop severe bowing of her legs."
- B. "It's important to use the brace or your daughter may need surgery."
- C. "You are doing a great job. Let's put our heads together on how to keep her busy."
- D. "You'll need to accept this since treatment may be required for several years."

Answer: C

Rationale: The nurse should support the parents by encouraging and praising their compliance with bracing. It is also important to work with the parents to help develop age-appropriate diversions to promote normal growth and development. Telling the parents that they must be compliant or their daughter could develop severe bowing does not teach, does not offer solutions, and does not address the parents' concerns. Telling the parents that they must simply accept this and that the treatment could take years is likely to upset them and does not teach. It also does not address their concerns.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Integrated Process: Caring

Reference: p. 1619

25. The nurse is conducting a physical examination of a child with suspected developmental dysplasia of the hip. Which finding would help confirm this diagnosis?

- A. Abduction occurs to 75 degrees and adduction to within 30 degrees (with stable pelvis).
- B. A distinct "clunk" is heard with Barlow and Ortolani maneuvers.
- C. A high-pitched "click" is heard with hip flexion or extension.
- D. The thigh and gluteal folds are symmetric.

Answer: B

Rationale: A distinct "clunk" while performing Barlow and Ortolani maneuvers is caused as the femoral head dislocates or reduces back in to the acetabulum. A higher-pitched "click" may occur with flexion or extension of the hip. This is a benign, adventitious sound that should not be confused with a true "clunk" when assessing for developmental dysplasia of the hip. Abduction to 75 degrees, adduction within 30 degrees, and symmetric thigh and gluteal folds are normal findings.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1616

26. The nurse is caring for an infant with osteogenesis imperfecta and is providing instruction on how to reduce the risk of injury. Which response from the mother indicates a need for further teaching?

- A. "I need to avoid pushing or pulling on an arm or leg."
- B. "I must carefully lift the baby from under the armpits."
- C. "I should not bend an arm or leg into an awkward position."
- D. "We must avoid lifting the legs by the ankles to change diapers."

Answer: B

Rationale: The nurse needs to emphasize that the mother must not lift a baby or young child with osteogenesis imperfecta from under the armpits as it may cause harm. Avoiding pushing or pulling, not bending an arm or leg into an awkward position, and avoiding lifting the legs by the ankles are appropriate responses.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Teaching/Learning

Reference: p. 1615

27. The nurse is developing a teaching plan for a child who is to have his cast removed. What instruction would the nurse **most** likely include?

- A. Applying petroleum jelly to the dry skin

- B. Rubbing the skin vigorously to remove the dead skin
- C. Soaking the area in warm water every day
- D. Washing the skin with dilute peroxide and water

Answer: C

Rationale: After a cast is removed, the child and family should be instructed to soak the area in warm water every day to help soften and remove the dry flaky skin. Moisturizing lotion, not petroleum jelly, should be applied to the skin. Vigorous rubbing would traumatize the skin and should be avoided. Warm soapy water, not dilute peroxide and water, should be used to wash the area.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Basic Care and Comfort

Integrated Process: Teaching/Learning

Reference: p. 1602-1603

28. When teaching a group of parents about the skeletal development in children, what information is most helpful?

- A. The growth plate is made up of the epiphysis.
- B. A young child's bones commonly bend instead of break with an injury.
- C. The infant's skeleton has undergone complete ossification by birth.
- D. Children's bones have a thin periosteum and limited blood supply.

Answer: B

Rationale: A young child's bones are more flexible and more porous with a lower mineral count than adults. Thus, bones will often bend rather than break when an injury occurs. The growth plate is composed of the epiphysis and physis. The infant's skeleton is not fully ossified at birth. Children's bones have a thick periosteum and an abundant blood supply.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1589

29. The school nurse is presenting a class to a group of students about common overuse disorders. Which disorder would the school nurse include?

- A. Dislocated radial head
- B. Transient synovitis of the hip
- C. Osgood-Schlatter disease
- D. Scoliosis

Answer: C

Rationale: Overuse syndromes refer to a group of disorders that result from repeated force applied to normal tissue. An example is Osgood-Schlatter disease. Dislocated radial head, transient synovitis of the hip, and scoliosis are not considered overuse syndromes.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1642

30. The nurse is assessing a child with a possible fracture. What would the nurse identify as the **most** reliable indicator?

- A. Lack of spontaneous movement
- B. Point tenderness
- C. Bruising
- D. Inability to bear weight

Answer: B

Rationale: Point tenderness is one of the most reliable indicators of a fracture in a child. Neglect of an extremity, inability to bear weight, bruising, erythema, and pain may be present, but these findings can also suggest other conditions.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Analyze

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1593

31. An 8-year-old boy with a fractured forearm is to have a fiberglass cast applied. What information would the nurse include when teaching the child about the cast?

- A. The cast will take a day or two to dry completely.
- B. The edges will be covered with a soft material to prevent irritation.
- C. The child initially may experience a very warm feeling inside the cast.
- D. The child will need to keep his arm down at his side for 48 hours.

Answer: C

Rationale: A fiberglass cast usually takes only a few minutes to dry and will cause a very warm feeling inside the cast. Therefore, the nurse needs to warn the child that this will occur.

Fiberglass casts usually have a soft fabric edge so they usually do not cause skin rubbing at the

edges and don't require petaling. The child should be instructed to elevate his arm above the level of the heart for the first 48 hours.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Basic Care and Comfort

Integrated Process: Teaching/Learning

Reference: p. 1599

32. A child has undergone surgery using steel bar placement to correct pectus excavatum. What position would the nurse instruct the parents to avoid?

- A. Semi-Fowler
- B. Supine
- C. High Fowler
- D. Side-lying

Answer: D

Rationale: After surgery to correct pectus excavatum, the nurse would instruct the parents to avoid positioning the child on either side because this could disrupt the bar's position. Semi- or high Fowler's position and the supine position would be appropriate.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Teaching/Learning

Reference: p. 1612

33. A newborn is diagnosed with metatarsus adductus. The parents ask the nurse how this occurred. Which response by the nurse would be **most** appropriate?

- A. "This condition is due to a genetic defect in the bones."
- B. "It's most likely from how the baby was positioned in utero."
- C. "They really don't know what causes this condition."
- D. "There is probably an underlying deformity of the baby's hip."

Answer: B

Rationale: Metatarsus adductus is a medial deviation of the forefoot that occurs as a result of in utero positioning. Osteogenesis imperfecta is a genetic bone disorder. The underlying cause of congenital clubfoot is not known. Developmental dysplasia of the hip involves a deformity of the newborn's hip.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Teaching/Learning

Reference: p. 1613

34. A nurse is preparing a presentation for a parent group about musculoskeletal injuries. When describing a child's risk for this type of injury, the nurse integrates knowledge that bone growth occurs primarily in which area?

- A. Growth plate
- B. Epiphysis
- C. Physis
- D. Metaphysis

Answer: B

Rationale: Growth of the bones occurs primarily in the epiphyseal region. This area is vulnerable and structurally weak. Traumatic force applied to the epiphysis during injury may result in fracture in that area of the bone. The growth plate refers to the combination of the epiphysis, the end of a long bone, and the physis, a cartilaginous area between the epiphysis and the metaphysis.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1589

35. A group of nursing students are reviewing information about types of skin traction and skeletal traction. The students demonstrate understanding of this information when they identify which of these as a type of skeletal traction?

- A. Russell traction
- B. Bryant traction
- C. Buck traction
- D. Side arm 90-90 traction

Answer: D

Rationale: Side arm 90-90 traction is a type of skeletal traction with force applied through a pin in the distal femur. Russell traction, Bryant traction, and Buck traction are types of skin traction.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1604

36. The nurse is providing care to a child with a long-leg hip spica cast. What is the **priority** nursing diagnosis?

- A. Risk for impaired skin integrity due to cast and location
- B. Deficient knowledge related to cast care
- C. Risk for delayed development related to immobility
- D. Self-care deficit related to immobility

Answer: A

Rationale: Although deficient knowledge, risk for delayed development, and self-care deficit may be applicable, the child is at increased risk for skin breakdown due to the size of the cast and its location. In addition, the cast has an opening, which allows for elimination. Soiling of cast edges or leakage of urine or stool can lead to skin breakdown.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Analyze

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 1597-1598

37. A nurse is providing instructions to the parents of a 3-month-old infant with developmental dysplasia of the hip who is being treated with a Pavlik harness. Which statement(s) by the parents demonstrates understanding of the instructions? Select all that apply.

- A. "We need to adjust the straps so that they are snug but not too tight."
- B. "We should change the diaper without taking our infant out of the harness."
- C. "We need to check the area behind our infant's knees for redness and irritation."
- D. "We need to send the harness to the dry cleaners to have it cleaned."
- E. "We need to call the health care provider if our infant is not able to actively kick the legs."

Answer: B, C, E

Rationale: Instructions related to use of a Pavlik harness include changing the child's diaper while in the harness; checking the areas behind the knees and diaper area for redness, irritation, or breakdown; and calling the health care provider if the child is unable to actively kick the legs. The straps are not to be adjusted without checking with the health care provider first. The harness can be washed with mild detergent by hand and air dried. A hair dryer can be used to dry the harness but only if the air fluffing setting (no heat) is used.

Question format: Multiple Select

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Teaching/Learning

Reference: p. 1617

38. When assessing a child for slipped capital femoral epiphysis, what would the nurse identify as possible risk factors? Select all that apply.

- A. Age younger than 8 years
- B. Black race
- C. History of cystic fibrosis
- D. Excessive activity
- E. Obesity

Answer: B, E

Rationale: Risk factors associated with slipped capital femoral epiphysis include age between 9 and 16 years, black race, sedentary lifestyle, and being overweight or obese. A history of cystic fibrosis may contribute to rickets.

Question format: Multiple Select

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 1631

39. An 18-month-old was brought to the emergency department by her mother, who states, "I think she broke her arm." The child is sent for a radiograph to confirm the fracture. Additional assessment of the child leads the nurse to suspect possible child abuse. Which type of fracture would the radiograph **most** likely reveal?

- A. Plastic deformity
- B. Buckle fracture
- C. Spiral fracture
- D. Greenstick fracture

Answer: C

Rationale: A spiral fracture is very rare in children. A spiral femoral or humeral fracture, particularly in a child younger than 2 years of age, should always be thoroughly investigated to rule out the possibility of child abuse. Plastic, buckle, and greenstick fractures are common in children and do not usually suggest child abuse.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1640

40. A pediatric client diagnosed with Duchenne muscular dystrophy is prescribed a corticosteroid. Which statement by the caregiver indicates additional education by the nurse is needed?

- A. "I will monitor my child for signs of infection."
- B. "My child should take this medicine with food."
- C. "I will call the primary health care provider if my child develops a moon-face."
- D. "If I notice my child gain weight, I will stop the medication."

Answer: D

Rationale: Corticosteroids may be prescribed to treat Duchenne muscular dystrophy for their anti-inflammatory and immunosuppressive actions. The nurse would provide additional education if the caregiver stated the medication would be stopped. The nurse would educate to not stop treatment abruptly or acute adrenal insufficiency may occur. Corticosteroids may mask signs of infection; therefore, the child should be monitored for infection and the health care provider notified if any signs noted. The medication should be administered with food to decrease gastrointestinal upset. The caregiver should be taught to monitor for signs of Cushing syndrome (moon-face).

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Integrated Process: Teaching/Learning

Reference: p. 1621

41. The school nurse has performed scoliosis screening. Based on this assessment, which children require the nurse to implement a referral to the healthcare provider? Select all that apply.

- A. The child with asymmetric shoulder elevation
- B. The child with a limb length discrepancy
- C. The child with a lateral curve of the spine
- D. The child with a one-sided hump upon bending over
- E. The child who's sibling had scoliosis surgically corrected
- F. The child who has uneven balance

Answer: A, B, C, D

Rationale: Scoliosis is defined by a lateral curve of the spine greater than 10 degrees. This curve causes displacement of the ribs. The nurse would first inspect the back in a standing position and note any asymmetric shoulder elevation, the prominence of one scapula, an uneven curve at the waistline, or a rib hump on one side. While standing the nurse could also assess for leg length discrepancy and this could be measured. The nurse would then have the child bend over and observe for a pronounced hump on one side. The nurse should notify the parents and refer the child to the healthcare provider for evaluation if any of these symptoms are found. The sibling with a scoliosis repair would not be a concern unless it was known the family had a genetic

diagnosis. Most scoliosis is idiopathic. Uneven balance is not a sign of scoliosis. The nurse would have to complete further assessments for this child.

Question format: Multiple Select

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Analyze

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 1635

42. A child is brought to the clinic after tripping over a rock. The child states "I twisted my ankle" and is given a diagnosis of a sprain. What intervention is most important for the nurse to include in the discharge instructions for this child?

- A. For the first 24 hours apply ice for 20 minutes and remove for 60 minutes
- B. Bedrest with leg elevated for 36 hours
- C. May take an NSAID for pain as prescribed
- D. Use compression dressing for 72 hours

Answer: A

Rationale: A sprain results from twisting or a turning motion of the affected body part. Usually that is an ankle or a knee. The tendons and ligaments stretch excessively and may tear slightly. Edema, bruising and the inability to bear weight are the most common symptoms. Interventions for care include RICE (rest, ice, compression, elevation), activity restrictions and/or splints or crutches. The most important intervention is the use of RICE. In this process the ice is applied for 20-30 minutes and then removed for 60 minutes. This can be done for up to 48 hours. This causes vasoconstriction to decrease the pain and swelling. Bedrest is not required, only limiting activities. Compression dressings, such as an elastic wrap are used, but there is no time limit as to how long they are needed. It depends upon the amount of swelling decreases. NSAIDs may be taken for pain if needed but the ice will produce a better pain relief.

Question format: Multiple Choice

Chapter 44: Nursing Care of the Child With an Alteration in Mobility/Neuromuscular or Musculoskeletal Disorder

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Teaching/Learning

Reference: p. 1641

Chapter 45

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1675, Preventing Burns and Carbon Monoxide Poisoning

1. The nurse is teaching the mother of a toddler about burn prevention. Which response by the mother indicates a need for further teaching?

- A) "We will leave fireworks displays to the professionals."
- B) "I will set our water heater at 130 degrees."
- C) "All sleepwear should be flame retardant."
- D) "The handles of pots on the stove should face inward."

Ans: B

Feedback:

If the temperature of the water heater is set at 130°F, a child can be burned significantly in only 30 seconds. The recommended maximal home hot water heater temperature is 120°F. Leaving fireworks to the professionals, using flame-retardant sleepwear, and turning the handles of pots on the stove inward are correct.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1677, Nursing Management

2. The nurse is providing parental teaching about home care for an 8-year-old boy with widespread sunburn on his back and shoulders. Which response indicates a need for further teaching?

- A) "Cool compresses may help cool the burn."
- B) "He should manually peel off any flaking skin."
- C) "Nonsteroidal anti-inflammatory drugs like ibuprofen are helpful."
- D) "He should avoid hot showers or baths for a couple of days."

Ans: B

Feedback:

If skin flaking occurs, the child should be discouraged from manually "peeling" the flaked skin as it can cause further injury. Using cool compresses, taking nonsteroidal anti-inflammatory drugs, and avoiding hot showers or baths are appropriate measures.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Caring

Page and Header: 1666, Nursing Management

3. The nurse is providing care for a 14-year-old girl with severe acne. The girl expresses sadness and distress about her appearance. Which response by the nurse would be most appropriate?

- A) "Are you using your medicine every day?"
- B) "Your condition will most likely improve in a year or two."
- C) "Many people feel this way; I know someone who can help."
- D) "If you have any scarring you can undergo dermabrasion."

Ans: C

Feedback:

Depression can occur as a result of body image disturbances with severe acne. The nurse should provide emotional support to adolescents undergoing acne therapy and refer teens for counseling if necessary. Telling the girl that her condition is likely to improve in a year or two is not helpful. Asking the girl whether she uses her medicine every day or reminding her that her scars can be addressed with dermabrasion does not address her feelings of sadness and distress.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Communication and Documentation

Page and Header: 1664, Nursing Assessment

4. The nurse is conducting a physical examination of a 9-month-old baby with a flat, discolored area on the skin. The nurse documents this as a:

- A) papule.
- B) macule.
- C) vesicle.
- D) scale.

Ans: B

Feedback:

A macule is a flat, discolored area on the skin. A papule is a small, raised bump on the skin. A vesicle is a fluid-filled bump on the skin. Scaling is flaking of the skin.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1668, Pressure Ulcers

5. A nurse is caring for a 5-year-old in Bucks traction. When conducting a skin examination for signs of pressure ulcers, the nurse pays particular attention to which area?

- A) Sacral area
- B) Hip area
- C) Occiput
- D) Upper arm

Ans: C

Feedback:

Common sites of pressure ulcers in hospitalized children include the occiput and toes, while children who require wheelchairs for mobility demonstrate pressure ulcers in the sacral or hip areas more frequently. The upper arm is not a common site for pressure ulcers.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1670, 1671, Physical Examination, Box 45.4

6. A 6-year-old boy has been admitted to the hospital with burns. The nurse notes carbonaceous sputum. What action would be the priority?

- A) Determining the burn depth
- B) Eliciting a description of the burn
- C) Estimating burn extent
- D) Ensuring a patent airway

Ans: D

Feedback:

Carbonaceous sputum is a sign of potential airway injury due to smoke inhalation. Therefore, the nurse should ensure a patent airway while obtaining a brief history and simultaneously evaluating the child and providing emergency care. If the burn does not pose an immediate, life-threatening risk, the nurse would obtain an in-depth history and elicit a description of the burn. Determining the burn depth and extent are part of the secondary survey.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1671, Laboratory and Diagnostic Tests

7. A nurse is caring for a 14-year-old girl who received an electrical burn. The nurse would anticipate preparing the girl for which diagnostic tests as ordered?

- A) Pulse oximetry
- B) Fiberoptic bronchoscopy
- C) Xenon ventilation-perfusion scanning
- D) Electrocardiographic monitoring

Ans: D

Feedback:

Electrocardiographic monitoring is important for the child who has suffered an electrical burn to identify possible cardiac arrhythmias, which can be noted for up to 72 hours after a burn injury. Fiberoptic bronchoscopy and xenon ventilation-perfusion scanning may be ordered to evaluate an inhalation injury, not an electrical burn. Pulse oximetry is used to evaluate pulmonary function and would not be indicated in the case of an electrical burn.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1651, 1654, Common Medical Treatments, Drug Guide 45.1

8. The nurse is caring for an infant with candidal diaper rash. Which topical agent would the nurse expect the healthcare provider to order?

- A) Corticosteroids
- B) Antifungals
- C) Antibiotics
- D) Retinoids

Ans: B

Feedback:

Candidal diaper rash would require a fungicide. The nurse would expect to administer topical antifungals as ordered. Corticosteroids are not typically recommended for young infants and are used for atopic dermatitis and certain types of contact dermatitis. Antibiotics would be ineffective against fungal infections. Retinoids are indicated for moderate to severe acne.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1674, Treating Infected Burns

9. The nurse is caring for a 15-year-old boy who has sustained burn injuries. The nurse observes the burn developing a purplish color with discharge and a foul odor. The nurse suspects which infection?

- A) Burn wound cellulitis
- B) Invasive burn cellulitis
- C) Burn impetigo
- D) Staphylococcal scalded skin syndrome

Ans: B

Feedback:

Invasive burn cellulitis results in the burn developing a dark brown, black, or purplish color with a discharge and foul odor. In burn wound cellulitis, the area around the burn becomes increasingly red, swollen, and painful early in the course of burn management. Burn impetigo is characterized by multifocal, small, superficial abscesses. Staphylococcal scalded skin syndrome is not a burn infection; however, it is managed similarly to burns.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1661, Promoting Skin Hydration

10. The nurse is caring for a child with widespread itching and has recommended bathing as a relief measure. After teaching the mother about this, which statement from the mother indicates a need for further instruction?

- A) "After bathing, I need to rub his skin everywhere to make sure he is completely dry."
- B) "I must make sure I use lukewarm water instead of hot water."
- C) "Oatmeal baths are helpful; we can add Aveeno skin relief bath treatment."
- D) "We should leave his skin moist before applying medication or moisturizer."

Ans: A

Feedback:

The nurse needs to emphasize to the mother that she must only pat the child dry and not rub his skin. Rubbing can cause further itching. Additionally, the skin should be left moist prior to applying medication or moisturizer. Lukewarm water and oatmeal baths are appropriate.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Remember

Integrated Process: Teaching/Learning

Page and Header: 1650, Differences in the Skin Between Children and Adults

11. After teaching a class about the differences in the skin of infants and adults, the nurse determines that additional teaching is necessary when the class states:

- A) "An infant's skin is thinner than an adult's, so substances placed on the skin are absorbed more readily."
- B) "The infant's epidermis is loosely connected to the dermis, increasing the risk for breakdown."
- C) "The infant has a lower risk for damage from ultraviolet radiation because the skin is more pigmented."
- D) "An infant has less subcutaneous fat, which places the infant at a higher risk for heat loss."

Ans: C

Feedback:

Infants have less pigmentation in their skin, placing them at increased risk for skin damage from ultraviolet radiation. The infant's skin is thinner, the epidermis is loosely connected, and there is less subcutaneous fat.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1651, 1654, Common Medical Treatments, Common Medical Treatments 45.1

12. The nurse is preparing a class for a group of adolescents about reducing the risk of skin cancer. What information would the nurse include?

- A) Using a sunscreen with para-aminobenzoic acid (PABA) with an SPF of at least 10
- B) Applying sunscreen at least 1 hour before going outside in the sun
- C) Avoiding sun exposure between the hours of 10 AM and 2 PM
- D) Using artificial ultraviolet (UV) tanning beds instead of sun exposure

Ans: C

Feedback:

Avoiding sun exposure between the hours of 10 AM and 2 PM is one method of reducing the risk for skin cancer. Sunscreens with an SPF of 15 or greater that are fragrance- and PABA-free should be used. Sunscreen should be applied at least 30 minutes before exposure and then reapplied at least every 2 hours while exposed. Artificial UV light, including tanning beds, should be avoided.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1656, 1657, Nursing Assessment, Table 45.1

13. A nurse is assessing the skin of a child with cellulitis. What would the nurse expect to find?

- A) Red, raised hair follicles
- B) Warmth at skin disruption site
- C) Papules progressing to vesicles
- D) Honey-colored exudate

Ans: B

Feedback:

Cellulitis is manifested by erythema, pain, edema, and warmth at the site of skin disruption. Red and raised hair follicles would indicate folliculitis. Papules

progressing to vesicles and a honey-colored exudate would suggest nonbullous impetigo.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1672, Restoring and Maintaining Fluid Volume

14. When developing the plan of care for a child with burns requiring fluid replacement therapy, what information would the nurse expect to include?

- A) Administration of colloid initially followed by a crystalloid
- B) Determination of fluid replacement based on the type of burn
- C) Administration of most of the volume during the first 8 hours
- D) Monitoring of hourly urine output to achieve less than 1 mL/kg/hr

Ans: C

Feedback:

With fluid replacement therapy, most of the volume is administered during the first 8 hours. Crystalloids (such as Ringer lactate) are administered for the first 24 hours, and then colloids are used once capillary permeability is less of a concern. Fluid replacement is determined by the amount of body surface area burned. Hourly urine output is expected to be at least 1 mL/kg/hr.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1659, Nursing Management

15. What would the nurse include when teaching an adolescent about tinea pedis?

- A) "Keep your feet moist and open to the air as much as possible."
- B) "Dry the area between your toes really well."
- C) "Wear nylon or synthetic socks every day."
- D) "Go barefoot when you are in the locker room at school."

Ans: B

Feedback:

Keeping the feet clean and dry is key for the child with tinea pedis. This includes rinsing the feet with water or a water/vinegar mixture and drying them well, especially between the toes. The adolescent should wear cotton socks and shoes that allow the feet to breathe. Going barefoot at home is allowed, but the adolescent should wear flip-flops around swimming pools and locker rooms.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1661, Laboratory and Diagnostic Tests

16. A child is diagnosed with atopic dermatitis. Which laboratory test would the nurse expect the child to undergo to provide additional evidence for this condition?

- A) Erythrocyte sedimentation rate
- B) Potassium hydroxide prep
- C) Wound culture
- D) Serum immunoglobulin E (IgE) level

Ans: D

Feedback:

IgE levels are often used to evaluate for atopic dermatitis. IgE levels are elevated in this condition. Erythrocyte sedimentation rate may be used but this test is nonspecific and only indicates infection or inflammation. Potassium hydroxide prep is used to identify fungal infections. Wound culture would be done to identify a specific organism if an infection occurs with atopic dermatitis.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1655, 1657, Bacterial Infections, Table 45.1

17. The nurse is providing care to a child with folliculitis. What would the nurse expect to administer?

- A) Topical mupirocin
- B) Oral cephalosporin
- C) Intravenous oxacillin
- D) Topical Eucerin cream

Ans: A

Feedback:

For folliculitis, topical mupirocin is indicated in conjunction with aggressive hygiene and warm compresses. Oral cephalosporins are used for nonbullous impetigo if there are numerous lesions. Intravenous oxacillin is used for severe cases of staphylococcal scalded skin syndrome. Topical Eucerin cream is used for atopic dermatitis.

Format: Multiple Select

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1659, 1670, Nursing Management, Teaching Guidelines 45.1

18. A nurse is preparing a class for parents of infants about managing diaper dermatitis. What advice would the nurse include in the presentation? Select all that apply.

- A) Applying topical nystatin to the diaper area
- B) Using a blow dryer on warm to dry the diaper area
- C) Refraining from using rubber pants over diapers
- D) Using scented diaper wipes to clean the area
- E) Washing the diaper area with an antibacterial soap

Ans: B, C

Feedback:

For diaper dermatitis, topical products such as ointments or creams containing vitamins A, D, and E; zinc oxide; or petrolatum help to provide a barrier. Nystatin is an antifungal agent used for diaper candidiasis. Using a blow dryer on warm to dry the area, avoiding the use of rubber pants, and using unscented diaper wipes or ones free of preservatives are appropriate. The area should be washed with a soft cloth, without harsh soaps.

Format: Multiple Select

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1656, Nursing Assessment

19. A group of students are preparing for a class exam on skin disorders. As part of their preparation, they are reviewing information about acne vulgaris and its association with increased sebum production. The students demonstrate understanding of the information when they identify which areas as having the highest sebaceous gland activity? Select all that apply.

- A) Face
- B) Upper chest
- C) Neck
- D) Back
- E) Shoulders

Ans: A, B, D

Feedback:

The face, upper chest, and back are the areas of highest sebaceous activity and thus the most common areas for acne lesions to occur. The neck and shoulders are not typical areas involved with acne.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1664, Urticaria

20. An instructor is developing a plan for a class of nursing students on various skin disorders. When describing urticaria, what would the instructor include?

- A) It is a type IV hypersensitivity reaction.
- B) Histamine release leads to vasodilation.
- C) Wheals appear first followed by erythema.
- D) The nonpruritic rash blanches with pressure.

Ans: B

Feedback:

Urticaria is a type I hypersensitivity reaction caused by an immunologically mediated antigen-antibody response of histamine release from the mast cells.

Vasodilation and increased vascular permeability result, leading to erythema and then wheals. The rash is pruritic and blanches with pressure.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1661, Inspection and Observation

21. A nurse is inspecting the skin of a child with atopic dermatitis. What would the nurse expect to observe?

- A) Erythematous papulovesicular rash
- B) Dry, red, scaly rash with lichenification
- C) Pustular vesicles with honey-colored exudates
- D) Hypopigmented oval scaly lesions

Ans: B

Feedback:

Atopic dermatitis or eczema is characterized by a dry, red, scaly rash with lichenification and hypertrophy. An erythematous papulovesicular rash is associated with contact dermatitis. Pustules and vesicles with honey-colored exudates suggest nonbullous impetigo. Hypopigmented oval scaly lesions are associated with tinea versicolor.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1670, Physical Examination

22. A nurse is performing a primary survey on a child who has sustained partial thickness burns over his upper body areas. What action should the nurse take first?

- A) Inspect the child's skin color.
- B) Assess for a patent airway.
- C) Observe for symmetric breathing.
- D) Palpate the child's pulse.

Ans: B

Feedback:

When performing a primary survey, the nurse first assesses the child's airway for patency and then intervenes accordingly to ensure that the airway is patent. Next the nurse would evaluate the child's skin color, respiratory effort, and symmetry of breathing and breath sounds. Then the nurse would determine the pulse strength, perfusion status, and heart rate.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1672, Promoting Oxygenation and Ventilation

23. A 3-year-old child has sustained severe burns and is ordered to receive 100% oxygen. What would the nurse use to administer the oxygen?

- A) Nasal cannula
- B) Venturi mask
- C) Nonrebreather mask
- D) Oxygen hood

Ans: C

Feedback:

All children with severe burns should receive 100% oxygen via a nonrebreather mask or bag--valve--mask ventilation. A nasal cannula provides only low oxygen concentrations (22% to 44%); a Venturi mask provides only 24% to 50% oxygen concentrations. An oxygen hood is used for infants only.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1670, Physical Examination

24. As part of a clinical conference with a group of nursing students, the instructor is describing the burn classification. The instructor determines that the teaching has been successful when the group identifies what as characteristic of full-thickness burns?

- A) Skin that is reddened, dry, and slightly swollen
- B) Skin appearing wet with significant pain
- C) Skin with blistering and swelling
- D) Skin that is leathery and dry with some numbness

Ans: D

Feedback:

Full-thickness burns may be very painful, numb, or pain-free in some areas. They appear red, edematous, leathery, dry, or waxy and may display peeling or charred skin. Superficial burns are painful, red, dry, and possibly edematous. Partial-thickness and deep partial-thickness burns are very painful and edematous and have a wet appearance or blisters.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1670, Health History, Box 45.3

25. A 4-year-old is brought to the emergency department with a burn. What would alert the nurse to the possibility of child abuse?

- A) Burn assessment correlates with mother's report of contact with a portable heater.
- B) Parents state that the injury occurred approximately 15 to 20 minutes ago.
- C) Clear delineations are noted between burned and nonburned skin areas.
- D) The burn area appears asymmetric and nonuniform.

Ans: C

Feedback:

Suggested signs of a burn resulting from possible child abuse include a uniform appearance of the burn with clear delineations of burned and nonburned areas. Abuse would also be suspected if the report of the injury was inconsistent with burn injury or there was a delay in seeking treatment. An asymmetric nonuniform burn often correlates with a splatter-type burn resulting from the child pulling a source of hot fluid onto himself or herself.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1675, 1676, Providing Burn Care at Home, Teaching Guidelines 45.4

26. A nurse is preparing a presentation for a local parent group about burn prevention and care in children. What would the nurse be least likely to include in the presentation when describing how to care for a superficial burn?

- A) Using cool water over the burned area until the pain lessens
- B) Applying ice directly to the burned skin area
- C) Covering the burn with a clean, nonadhesive bandage
- D) Giving the child acetaminophen for pain relief

Ans: B

Feedback:

With a superficial burn, ice should not be applied to the skin. Using cool water over the burn area; covering with a clean, nonadhesive bandage; and using acetaminophen for pain relief are appropriate to include in the presentation.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1650, Differences in the Skin Between Children and Adults

27. The nurse is interviewing the mother of a 6-month-old being seen at a well-child visit. The mother reports she has used an over-the-counter topical ointment intended for adults on her child for a skin rash. What is the most appropriate response by the nurse?

- A) "This is dangerous so please do not do this again."
- B) "Why did you do that instead of contacting your healthcare provider?"
- C) "Children have thin skin and can absorb medications differently than adults."
- D) "How often do you use this medication?"

Ans: C

Feedback:

Children have thinner skin than adults. They will absorb topical medications more rapidly than adults. Medications concentrated for adults should not be used on children. It is important to explain this to the parent. It is confrontational to tell her this is dangerous or to tell her to contact the healthcare provider. The frequency of use is information that should be obtained but the education is most important in this scenario.

Format: Multiple Select

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1675, 1676, Providing Burn Care at Home, Teaching Guidelines 45.4

28. The mother of a 15-year-old girl has contacted the clinic to report that her daughter has burned the back of her hand with a curling iron. The child's mother reports the burn is mild but states her daughter is complaining of pain. After consulting with the healthcare provider, what instructions can the nurse anticipate will be recommended? Select all that apply.

- A) Apply a thin film of protective cocoa butter.
- B) Run cool water over the injured area.
- C) Apply ice for 15 to 20 minutes each hour until the pain subsides.
- D) Take acetaminophen using the manufacturer's guidelines.
- E) Apply a thin layer of petroleum jelly to the burned area.

Ans: B, D

Feedback:

Mild burns may be cared for at home. Cool water may be run over the injured tissue. Acetaminophen or ibuprofen may be administered for pain. Ointments and creams including butter, margarine, cocoa butter, and petroleum jelly should not be applied.

Format: Multiple Select

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1657, Fungal Infections

29. The nurse is caring for a school-age child with tinea capitis. The child has open lesions from the disease and has lost hair in the areas affected. Which nursing diagnoses would be a part of this client's care plan? Select all that apply.

- A) Impaired skin integrity
- B) Risk for infection
- C) Disturbed body image
- D) Bathing, self-care deficit
- E) Altered nutrition

Ans: A, B, C

Feedback:

Tinea is a fungal disease of the skin occurring on any part of the body, in this case the head (scalp, eyebrows, or eyelashes). Since this child has open lesions and hair loss from affected areas, there is impairment of skin integrity (which makes the areas at risk for infection). Body image is disturbed since the hair loss is visible. There is no indication of bathing deficit or altered nutrition.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Caring

Page and Header: 1653, Promoting Appropriate Body Image (Interventions with rationale)

30. A teenage girl with psoriasis tells the nurse that she is so embarrassed by the plaque on her skin that she doesn't want to go to school. What is the best response by the nurse?

- A) "Have you been applying your medication and emollients to your skin as directed by your healthcare provider?"
- B) "It must be really difficult for you. Tell me how you are taking care of your skin on a daily basis."
- C) "Sunlight really helps the plaque areas heal. Maybe going to a tanning bed routinely will help."
- D) "You can't miss school because of your skin. Can you wear clothes that will cover the areas?"

Ans: B

Feedback:

"It must be really difficult for you. Tell me how you are taking care of your skin on a daily basis" shows empathy and allows the nurse to determine how the girl is taking care of the psoriasis and if any suggestions to the treatment plan can be helpful. Questioning the client if she is doing what the healthcare provider has prescribed may make her defensive and does not show empathy. Suggesting tanning can cause too much exposure to unwanted UV rays; telling the girl that she can't miss school and to cover the areas does not elicit open discussion and does not promote self-esteem.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1660, Atopic Dermatitis

31. The mother of a 5-year-old child with eczema is getting a check-up for her child before school starts. What will the nurse do during the visit?

- A) Change the bandage on a cut on the child's hand.
- B) Assess the compliance with treatment regimens.
- C) Discuss systemic corticosteroid therapy.
- D) Assess the child's fluid volume.

Ans: B

Feedback:

Maintaining proper therapy for eczema can be exhausting both physically and mentally. Therefore, it is essential that the nurse assess compliance and support the parents' ability to cope if necessary. Changing a bandage is not part of a health maintenance visit. Hydration is important for a child with eczema; however, fluid volume is not the focus at this visit. Systemic corticosteroid therapy is very rarely used, and the success of the current therapy needs to be assessed first.

Chapter 46

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1727, Nursing Diagnosis

1. The nurse is caring for a 16-year-old boy with acute myelogenous leukemia who is having chemotherapy and who has incomplete records for varicella zoster immunization. Which is the priority nursing diagnosis?

- A) Pain related to adverse effects of treatment verbalized by the child
- B) Nausea related to side effects of chemotherapy verbalized by the child
- C) Constipation related to the use of opioid analgesics for pain
- D) Risk for infection related to neutropenia and immunosuppression

Ans: D

Feedback:

The priority nursing diagnosis is risk for infection related to neutropenia and immunosuppression. The incomplete records for varicella zoster immunization can cause a problem since exposure to chickenpox could cause sepsis, so the nurse should contact the oncologist for approval to administer the vaccine. Certain vaccines are not administered when the child is immunosuppressed, so timing is crucial. Diagnoses for pain and nausea are valid for this child because he is undergoing chemotherapy, but they are not a priority. Likewise, the need for constipation management would not be necessary unless opioid use begins.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1701, Teaching Guidelines 46.1

2. The nurse is caring for an 8-year-old girl who has been diagnosed with leukemia and will have a variety of tests, including a lumbar puncture, before beginning chemotherapy. What action would be the priority?

- A) Applying EMLA to the lumbar puncture site
- B) Educating the child and family about the testing procedures
- C) Administering promethazine as ordered for nausea
- D) Educating the family about chemotherapy and its side effects

Ans: B

Feedback:

The priority would be educating the child and family about the testing procedures, so they know what to expect and understand why the tests are being performed. Applying EMLA to the lumbar puncture site will be done prior to the procedure. The family will be educated about chemotherapy and its side effects prior to the therapy beginning, and promethazine or other antiemetics will be administered once chemotherapy has begun.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1695, Interventions with Rationale: Promoting Child and Family Coping

3. The nurse is caring for a 13-year-old boy with acute myelogenous leukemia who is experiencing feelings of powerlessness due to the effects of chemotherapy. What intervention will best help the teen's sense of control?

- A) Involving the boy in decisions whenever possible
- B) Acknowledging the boy's feelings of anger with the disease

- C) Providing realistic expectations of treatments and outcomes
- D) Recognizing abilities that are unaffected by the disease

Ans: A

Feedback:

Involving the boy in the decision-making process will best help his sense of control. Whether he is included in important decisions about therapy or minor decisions like menus or dress, it will give him a sense of control over his situation. Acknowledging feelings of anger, recognizing his abilities, and providing realistic expectations will reduce body image disturbance and build self-esteem.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1696, Interventions with Rationale: Supporting the Grieving Family

4. The nurse is caring for a 5-year-old girl with a disseminated medulloblastoma. What intervention would be most appropriate for this situation?

- A) Providing emotional support to the parents and siblings of the child
- B) Recommending support groups for people whose children have cancer
- C) Encouraging the family to cry and express feelings away from the child
- D) Educating the family about the disease, its treatments, and side effects

Ans: C

Feedback:

The outcome of this highly malignant medulloblastoma is often not positive. Helping the family through anticipatory grieving by encouraging the family to cry and express feelings away from the child would be unique to this child's situation. Educating the family about the disease, its treatments, and side effects; recommending support groups; and providing emotional support to the parents and siblings would be appropriate for any child with cancer.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1729, Health History

5. The nurse is assessing a 3-year-old boy whose parents brought him to the clinic when they noticed that the right side of his abdomen was swollen. What finding would suggest this child has a neuroblastoma?

- A) The child has a maculopapular rash on his palms.
- B) The parents report that their son is vomiting and not eating well.
- C) The parents report that their son is irritable and not gaining weight.
- D) Auscultation reveals wheezing with diminished lung sounds.

Ans: B

Feedback:

Along with the swollen abdomen on one side, the parents reporting that the child is vomiting and anorexic points to the possibility of a neuroblastoma. Observing a maculopapular rash on the child's palms is a sign of graft-versus-host disease. The parents reporting that the child is irritable and not gaining weight suggests a possible brain tumor as well as malabsorption problems. Auscultation revealing wheezing with diminished lung sounds would suggest other problems, not a neuroblastoma.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Safety and Infection Control

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1703, Teaching Guidelines 46.2

6. The nurse is educating the parents of a 4-year-old boy with a Wilms tumor who is about to have chemotherapy prior to surgery. Which statement by the parents indicates that the nurse should review the instructions about preventing infection?

- A) "He takes his antibiotic twice a day."
- B) "We check his temperature orally."
- C) "We keep him away from crowds."
- D) "He must be clean, and his teeth brushed."

Ans: A

Feedback:

The parents have heard the instructions for the antibiotic administration incorrectly. The trimethoprim-sulfamethoxazole should be administered twice daily for 3 consecutive days each week to prevent *Pneumocystis pneumoniae*. The parents understand to avoid rectal temperatures and crowds, and to maintain his hygiene meticulously.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1683, 1684, Childhood Cancer versus Adult Cancer, Comparison Chart 46.1

7. The nurse is assessing a 13-year-old girl with a family history of kidney cancer who has come to the clinic complaining of abdominal pain, nausea, and vomiting. Which finding would the nurse identify as least likely indicative of cancer in a child?

- A) The child reports rectal bleeding and diarrhea.
- B) Observation reveals an asymmetric abdomen.
- C) The child experiences a broken bone without trauma.
- D) Palpation determines an abdominal mass.

Ans: A

Feedback:

Rectal bleeding and diarrhea are symptoms of rectal cancer in adults and are not typical of children with cancer. The child reporting that a bone broke without any trauma, the nurse observing asymmetric swelling in the abdomen, or palpation revealing a mass in the abdomen are findings in children with cancer.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Teaching and Learning

Page and Header: 1692, Interventions with Rationale: Promoting Adequate Nutrition

8. The nurse is caring for a 9-year-old boy who is having chemotherapy. The nurse is developing a teaching plan for the child and family about nutrition. What instruction would the nurse be least likely to include?

- A) Emphasizing the intake of grains, fruits, and vegetables
- B) Featuring high-fiber foods if opioid analgesics are being taken
- C) Concentrating on consuming primarily high-calorie shakes and puddings
- D) Avoiding milk products if diarrhea is a problem

Ans: C

Feedback:

Providing high-calorie shakes and puddings with diet restrictions can help with weight gain, if that is a problem. However, concentrating on high-calorie shakes and puddings is not a good strategy. It is best to provide a balanced diet emphasizing grains, fruits, and vegetables. If pain is being treated with opioid analgesics, featuring high-fiber foods is important to help relieve constipation. Avoiding milk products is a good idea if diarrhea is a problem because lactose can make diarrhea worse.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1705, Nursing Management of the Child During the HSCT Posttransplant Phase

9. The nurse is caring for a 7-year-old girl who is undergoing a stem cell transplant. What information would the nurse include in the child's postoperative plan of care?

- A) Assessing for petechiae, purpura, bruising, or bleeding
- B) Limiting blood draws to the minimum volume required
- C) Administering antiemetics around the clock as ordered
- D) Monitoring for severe diarrhea and maculopapular rash

Ans: D

Feedback:

In the posttransplant phase, monitor closely for symptoms of graft-versus-host disease (GVHD) such as severe diarrhea and maculopapular rash progressing to redness or desquamation of the skin (especially on the palms of the hands or soles of the feet). During chemotherapy in the pretransplant phase, assess for petechiae, purpura, bruising, or bleeding to prevent hemorrhage; administer antiemetics around the clock as ordered to prevent the cycle of nausea, vomiting, and anorexia; and limit blood draws to the minimum volume required to prevent anemia.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1685, Radiation Therapy

10. The nurse is caring for a 5-year-old boy undergoing radiation treatment for a neuroblastoma. Which nursing diagnosis would be most applicable for this child?

- A) Activity intolerance related to anemia and weakness from medications
- B) Impaired skin integrity related to desquamation from cellular destruction
- C) Impaired oral mucosa related to the presence of oral lesions from malnutrition
- D) Imbalanced nutrition, less than body requirements related to nausea and vomiting

Ans: B

Feedback:

A nursing diagnosis for impaired skin integrity evidenced by desquamation of the radiation site would only be made for a child undergoing radiation therapy. Activity intolerance due to anemia and weakness, impaired oral mucosa evidenced by oral lesions, and malnutrition and anorexia due to nausea and vomiting are diagnoses that are common to both radiation and chemotherapy.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1683, 1684, Childhood Cancer Versus Adult Cancer, Comparison Chart 46.1

11. The nurse is planning a discussion group for parents with children who have cancer. How would the nurse describe a difference between cancer in children and adults?

- A) Most childhood cancers affect the tissues rather than organs.
- B) Childhood cancers are usually localized when found.
- C) Unlike adult cancers, childhood cancers are less responsive to treatment.

D) The majority of childhood cancers can be prevented.

Ans: A

Feedback:

Childhood cancers usually affect the tissues, not the organs, as in adults. Metastasis often is present when the childhood cancer is diagnosed. Childhood cancers, unlike adult cancers, are very responsive to treatment. Unfortunately, little is known about cancer prevention in children.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1684, 1698, Common Medical Treatments, Drug Guide 46.1

12. A child is receiving carboplatin as part of a chemotherapy protocol. What would be most important for the nurse to include in the child's plan of care?

- A) Monitoring for visual changes
- B) Maintaining adequate hydration
- C) Using prescribed eye drops to prevent conjunctivitis
- D) Avoiding administration with food or meals

Ans: B

Feedback:

When carboplatin is administered, the nurse must ensure adequate hydration. Monitoring for visual changes is appropriate when giving fludarabine. Eye drops are necessary to prevent conjunctivitis when high doses of cytarabine are administered. Oral mercaptopurine should not be given with meals or food.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1731, Neuroblastoma, Table 46.10

13. A child diagnosed with stage IV neuroblastoma has undergone abdominal surgery to remove the tumor. He is now receiving chemotherapy. Which nursing diagnosis would be most important?

- A) Risk for infection related to chemotherapy
- B) Impaired skin integrity related to abdominal surgery
- C) Grieving related to advanced disease and poor prognosis
- D) Imbalanced nutrition related to adverse effects of chemotherapy

Ans: C

Feedback:

In stage IV neuroblastoma, there is metastasis to the bone, bone marrow, other organs, or distant lymph nodes. Additionally, the tumor was located in the abdomen, which is associated with a poor prognosis. Therefore, the most important diagnosis would be grieving. Although infection, skin integrity, and imbalanced nutrition may be relevant, they would not be the most important.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1730, Positioning the Child in the Postoperative Period

14. What would be most appropriate to include in the plan of care for a child who has undergone surgery for removal of an astrocytoma?

- A) Elevating the foot of the bed
- B) Positioning the child on his unaffected side
- C) Raising the head of the bed at least 45 degrees

- D) Administering large volumes of intravenous fluids

Ans: B

Feedback:

Postoperatively, the nurse should position the child on his unaffected side, with the head of the bed flat or at the level prescribed by the neurosurgeon. The foot of the bed is not elevated to prevent increasing intracranial pressure and contributing to bleeding. Fluids are administered carefully to avoid excess fluid intake, which would cause or worsen cerebral edema.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1735, Laboratory and Diagnostic Testing

15. Which test result would the nurse least likely expect to find in a child diagnosed with Wilms tumor?

- A) Complete blood count (CBC) within normal limits
- B) Urinalysis positive for blood
- C) Mass on kidney
- D) Elevated homovanillic acid (HVA) with 24-hour urine collection

Ans: D

Feedback:

Levels of HVA and vanillylmandelic acid (VMA) will not be elevated with Wilms tumor; they are elevated with neuroblastoma. CBC, blood urea nitrogen (BUN), and creatinine usually are within normal limits. Urinalysis may reveal hematuria or leukocytes. Renal or abdominal ultrasound would reveal a mass on the kidney.

Format: Multiple Select

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1705, 1706, Preventing and Treating Oncologic Emergencies, Table 46.3

16. The parents bring their 4-year-old son to the emergency department. The child is receiving chemotherapy for acute lymphoblastic leukemia. The parents report that the child has become lethargic and has had significant episodes of vomiting and diarrhea. What findings would lead the nurse to suspect the child may be experiencing tumor lysis syndrome? Select all that apply.

- A) Hyperkalemia
- B) Hypophosphatemia
- C) Polyuria
- D) Hypocalcemia
- E) Hyperuricemia

Ans: A, D, E

Feedback:

Tumor lysis syndrome is characterized by hyperuricemia, hyperkalemia, hyperphosphatemia, decreased or absent urine output, and hypocalcemia.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1724, 1725, Therapeutic Management, Table 46.7

17. The nurse is describing the phases of treatment to a child who was diagnosed with leukemia and his parents. How would the nurse describe the induction stage?

- A) Intense therapy to strengthen remission
- B) Rapid promotion of complete remission

- C) Elimination of all residual leukemic cells
- D) Reduction of risk for central nervous system (CNS) disease

Ans: B

Feedback:

Induction is done to rapidly produce a complete remission. Consolidation or intensification is the stage when remission is strengthened, and leukemic cell burden is reduced. Maintenance attempts to eliminate all residual leukemic cells, and CNS prophylaxis is the stage that attempts to reduce the development of CNS disease.

Format: Multiple Select

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1727, Nursing Assessment

18. A 14-year-old boy is diagnosed with Hodgkin disease. When palpating for enlarged lymph nodes, the nurse would expect to find which nodes as most commonly enlarged? Select all that apply.

- A) Cervical
- B) Axillary
- C) Supraclavicular
- D) Occipital
- E) Inguinal

Ans: A, C

Feedback:

Enlarged lymph nodes may feel rubbery and tend to occur in clusters. Although any lymph nodes may be involved, the lymph nodes most commonly affected are in the cervical and supraclavicular areas.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1729, Brain Tumors, Table 46.9

19. The nurse is preparing a presentation for a parent group about childhood cancers, focusing on brain tumors in children. What would the nurse describe as the most common type of brain tumor?

- A) Brain stem glioma
- B) Medulloblastoma
- C) Ependymoma
- D) Astrocytoma

Ans: B

Feedback:

Of all the types of brain tumors listed, a medulloblastoma is the most common type. It is invasive, is highly malignant, and grows rapidly.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1698--1701, Drug Guide 46.1

20. A child is receiving methotrexate as part of his chemotherapy protocol. The nurse would anticipate administering which agent to counteract the toxic effects of methotrexate?

- A) Mesna
- B) Cyclosporine

C) Leucovorin

D) Nystatin

Ans: C

Feedback:

Leucovorin is given as an antidote to methotrexate to reduce its toxic effects. Mesna is given when cyclophosphamide and ifosfamide are used to prevent hemorrhagic cystitis. Cyclosporine is an immunosuppressant used to treat graft-versus-host disease after hematopoietic stem cell transplant. Nystatin is used to treat mucositis or systemic fungal infection.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1698--1701, Drug Guide 46.1

21. A group of nursing students are reviewing the various drug classes used for cancer chemotherapy. The students demonstrate an understanding of these classes when they identify which agent as an example of a nitrosourea?

A) Busulfan

B) Thiotepa

C) Cisplatin

D) Carmustine

Ans: D

Feedback:

Carmustine is an example of a nitrosourea. Busulfan, thiotepa, and cisplatin are alkylating agents.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1698--1701, Drug Guide 46.1

22. The nurse is developing a plan of care for a child who is receiving cyclophosphamide. What advice would the nurse expect to include?

- A) Withholding food and fluids from the child during the infusion
- B) Encouraging frequent voiding during and after the infusion
- C) Monitoring for signs of anaphylaxis during infusion
- D) Assessing the child for complaints of bone pain

Ans: B

Feedback:

Cyclophosphamide may cause hemorrhagic cystitis. Therefore, the nurse needs to provide adequate hydration and have the child void frequently during and after the infusion to decrease the risk of hemorrhagic cystitis. Fluids need to be encouraged, not withheld. Monitoring for anaphylaxis would be appropriate when asparaginase or etoposide is given. Bone pain is associated with the administration of filgrastim or sargramostim.

Format: Multiple Select

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1702, 1703, Preventing Infection, Box 46.2

23. The nurse is reviewing the laboratory test results of a child who is receiving chemotherapy. To calculate the child's absolute neutrophil count, in addition to the total number of white blood cells, which results would the nurse use? Select all that apply.

- A) Bands

- B) Segs
- C) Eosinophils
- D) Basophils

Ans: A, B

Feedback:

To calculate the absolute neutrophil count, the nurse would add together the percentage of banded and segmented neutrophils and then multiply the total number of white blood cells reported on the complete blood count by the sum.

Format: Multiple Select

Client Needs: Safe and Effective Care Environment: Safety and Infection Control

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1702, Preventing Infection

24. A nurse is instituting neutropenic precautions for a child. What information would the nurse most likely include? Select all that apply.

- A) Placing the child in a semiprivate room
- B) Avoiding rectal exams, suppositories, and enemas
- C) Placing a mask on the child when outside the room
- D) Encouraging an intake of raw fruits and vegetables
- E) Discouraging fresh flowers in the child's room

Ans: B, C, E

Feedback:

Generally, neutropenic precautions include placing the child in a private room; avoiding rectal suppositories, enemas, and examinations; placing a mask on the child when outside the room; avoiding the intake of raw fruits and vegetables; and not permitting fresh flowers or live plants in the room.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1704, Monitoring the Child Receiving Radiation Therapy

25. A child is scheduled to undergo radiation therapy as part of his treatment plan for newly diagnosed cancer. After teaching the child and parents about this treatment, the nurse determines that additional teaching is needed when the parents state:

- A) "We should not wash off the markings on his skin."
- B) "He can use petroleum jelly if the skin becomes reddened."
- C) "He needs to use a sunscreen with an SPF of 30 or more."
- D) "He should not apply deodorant to the treatment site."

Ans: B

Feedback:

Aqueous creams and moisturizers may be used on the skin, but not petroleum jelly. Markings on the skin should not be removed or washed off. During and after radiation treatment, the skin will be more photosensitive so the child should use a high-SPF sunscreen of 30 or more. Deodorants and perfumed lotions should not be applied to the radiation treatment site.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1709, 1710, Nursing Management, Table 46.4

26. The nurse is conducting a physical examination of a toddler with suspected lead poisoning. Lab results indicate blood lead level 52 mcg/dL. Which action would the nurse expect to happen next?

- A) Repeat testing within 2 days and prepare to begin chelation therapy as ordered.
- B) Repeat testing within 1 week with education to decrease lead exposure.
- C) Confirm with repeat testing in 1 month and referral to local health department.
- D) Prepare to admit child to begin chelation therapy.

Ans: A

Feedback:

The recommendation for blood lead levels of 45 to 69 mcg/dL is to confirm the level with a repeat laboratory test within 2 days and educate the parents to decreased lead exposure. She should also expect to begin chelation therapy as ordered and refer the case to the local health department for investigation of home lead reduction with referrals for support services. Repeat testing in 1 week with parent education is appropriate for lead levels between 20 and 44 mcg/dL. Repeat testing in 1 month and education would be appropriate for levels between 15 and 19 mcg/dL. Preparing to admit the child to begin chelation therapy immediately would be appropriate for lead levels greater than 70 mcg/dL.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1707, Physical Examination

27. A nurse is conducting a physical examination of a 5-year-old with suspected iron-deficiency anemia. How would the nurse evaluate for changes in neurologic functioning?

- A) "Open your mouth so I can look inside your cheeks and lips."
- B) "Do you have any bruises on your feet or shins?"
- C) "Will you show me how you walk across the room?"
- D) "Let me see the palms of your hands and soles of your feet."

Ans: C

Feedback:

Neurologic effects of iron deficiency may be demonstrated when the child's ability to sit, stand, and walk are impaired. Inspecting the mouth, looking for bruises, and checking the hands and feet provide information about signs of petechiae, purpura, or pallor.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Safety and Infection Control

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1720, Nursing Management

28. The nurse is caring for a 12-year-old boy with idiopathic thrombocytopenia. The nurse is providing discharge instructions about home care and safety recommendations to the boy and his parents. Which response indicates a need for further teaching?

- A) "We should avoid aspirin and drugs like ibuprofen."
- B) "He can resume participation in football in 2 weeks."
- C) "Swimming would be a great activity."
- D) "Our son cannot take any antihistamines."

Ans: B

Feedback:

The nurse must emphasize to the parents that they need to prevent trauma to their son by avoiding activities that may cause injury. Participation in contact sports like football is not recommended. Aspirin, nonsteroidal anti-inflammatory drugs, and antihistamines should be avoided because they could precipitate anemia. Swimming, a noncontact sport, is an appropriate choice.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1717, Nursing Assessment

29. The nurse is assessing a child with suspected thalassemia. What would the nurse expect to assess?

- A) Dactylitis
- B) Frontal bossing
- C) Presence of clubbing
- D) Presence of spooning

Ans: B

Feedback:

The nurse would expect to find skeletal deformities such as frontal or maxillary bossing. Dactylitis is associated with sickle cell anemia. Clubbing and spooning are associated with chronic decreases in oxygen supply.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1718, Glucose-6-Phosphate Dehydrogenase Deficiency

30. The nurse is caring for a child recently diagnosed with glucose-6-phosphate dehydrogenase (G6PD) deficiency. The nurse is teaching the parents about triggers that may result in oxidative stress. Which response indicates a need for further teaching?

- A) "I doubt he will ever eat fava beans, but they could trigger hemolysis."
- B) "He must avoid exposure to naphthalene, an agent found in mothballs."

- C) "He must never take methylene blue for a urinary tract infection."
- D) "My son can never take penicillin for an infection."

Ans: D

Feedback:

The nurse should emphasize that penicillin is not a known trigger that may result in oxidative stress and hemolysis. Fava beans, naphthalene, and methylene blue can trigger oxidative stress.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Evaluation

Integrated Process: Nursing Process

Page and Header: 1723, Nursing Management

31. The nurse is caring for a 13-year-old girl with von Willebrand disease. After teaching the adolescent and her parents about this disorder and care, which response by the parents indicates a need for additional teaching?

- A) "We need to administer Stimate prior to dental work."
- B) "We should be aware that she may suffer from menorrhagia."
- C) "We should administer desmopressin as often as needed."
- D) "We understand that she may have frequent nosebleeds."

Ans: C

Feedback:

The parents need to know that desmopressin spray Stimate is used for controlling bleeding; the other brands are used for homeostasis and enuresis. Additionally, Stimate should only be used 3 days in a row as lessening of the response (tachyphylaxis) occurs with frequent use. Stimate should be used before dental work. Menorrhagia and nosebleeds may occur.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1715, Managing Vaso-Occlusive Episodes

32. The nurse is caring for a child who has been admitted for a sickle cell crisis. What would the nurse do first to provide adequate pain management?

- A) Administer a nonsteroidal anti-inflammatory drug (NSAID) as ordered.
- B) Use guided imagery and therapeutic touch.
- C) Administer meperidine as ordered.
- D) Initiate pain assessment with a standardized pain scale.

Ans: D

Feedback:

The nurse should first initiate pain assessment with a standardized pain scale upon admission and provide frequent evaluations of pain. Administering NSAIDs or meperidine and the use of nonpharmacologic pain management techniques are all appropriate. However, the first action is to assess the child's pain to provide a baseline for future comparison.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Safety and Infection Control

Cognitive Level: Apply

Integrated Process: Communication/Documentation

Page and Header: 1723, Managing a Bleeding Episode

33. The nurse is caring for a 2-year-old boy with hemophilia. His parents are upset by the possibility that he will become infected with hepatitis or HIV from the clotting factor replacement therapy. Which response by the nurse would be most appropriate?

- A) "Parents commonly fear the worst; however, the factor will help your child lead a normal life."

- B) "There are risks with any treatment including using blood products, but these are very minor."
- C) "Although factor replacement is expensive, there's more financial strain from missing work if he has a bleeding episode."
- D) "Since dry heat treatment of the factor began in 1986, there have been no reports of virus transmission."

Ans: D

Feedback:

The nurse needs to emphasize that since 1986, there have been no reports of virus transmission from factor infusion since the inception of heat treatment of the factor. Telling the parents that there is a minor risk does not teach. Telling the parents that factor is expensive or that it is common to worry does not teach, nor does it address their concerns.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Evaluation

Integrated Process: Teaching/Learning

Page and Header: 1715, Educating the Family

34. The nurse is caring for a child with thalassemia who is receiving chelation therapy at home using a battery-operated pump. After teaching the parents about this treatment, which statement by the mother indicates a need for additional teaching?

- A) "I can have the nurse administer the chelation therapy if I am uncomfortable."
- B) "I must be very careful to strictly adhere to the chelation regimen."
- C) "The deferoxamine binds to the iron so it can be removed from the body."
- D) "The medication can be administered while my child is sleeping."

Ans: A

Feedback:

The nurse needs to emphasize to the mother that therapy must be maintained at home to continuously decrease the iron levels in the child's body. Family members need to be taught to administer deferoxamine subcutaneously with a small battery-powered infusion pump over a several-hour period each night (usually while the child is sleeping).

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1683, Hemoglobin

35. When evaluating the hemogram of an 8-month-old infant, the nurse would identify which type of hemoglobin as being the predominant type?

- A) Hemoglobin A
- B) Hemoglobin F
- C) Hemoglobin A2
- D) Hemoglobin S

Ans: A

Feedback:

Three types of normal hemoglobin are present at any given time in the blood: A, F, and A2. By 6 months of age, hemoglobin A is the predominant type. Hemoglobin S is associated with sickle cell disease.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1686, 1887, Laboratory and Diagnostic Testing, Table 46.1

36. The nurse is evaluating the laboratory test results of a 7-year-old child with a suspected hematologic disorder. Which finding would cause the nurse to be concerned?

- A) WBC: $5.6 \times 10^3/\text{mm}^3$
- B) RBC: $2.8 \times 10^6/\text{mm}^3$
- C) Hemoglobin: 11.4 mg/dL
- D) Hematocrit: 35%

Ans: B

Feedback:

The RBC listed is below the normal range for a child between the ages of 6 and 16 years (4.0 to $5.2 \times 10^6/\text{mm}^3$). The WBC count, hemoglobin, and hematocrit are within acceptable parameters for a child this age.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1710, Nursing Management

37. When providing care to a child with aplastic anemia, which nursing diagnosis would be the priority?

- A) Risk for injury
- B) Imbalanced nutrition, less than body requirements
- C) Ineffective tissue perfusion
- D) Impaired gas exchange

Ans: A

Feedback:

For the child with aplastic anemia, safety is of the utmost concern, with injury prevention essential to prevent hemorrhage. Nutrition, tissue perfusion, and gas exchange may or may not be associated with the child's condition.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1721, Nursing Assessment

38. The nurse is reviewing the laboratory test results of a child diagnosed with disseminated intravascular coagulation (DIC). What would the nurse interpret as indicative of this disorder?

- A) Shortened prothrombin time
- B) Increased fibrinogen level
- C) Positive fibrin split products
- D) Increased platelets

Ans: C

Feedback:

Laboratory test results associated with DIC include positive fibrin split products; prolonged prothrombin time, partial thromboplastin time, bleeding time, and thrombin time; decreased fibrinogen levels, platelets, clotting factors II, V, VIII, and X, and antithrombin III; and increased levels of fibrinolysin, fibrinopeptide A, and positive D-dimers.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1719, Idiopathic Thrombocytopenia Purpura

39. A nurse is providing care to a child with idiopathic thrombocytopenic purpura with a platelet count of 18,000/mm³. Which medication would the nurse most likely expect to be ordered?

- A) Folic acid
- B) Intravenous immune globulin
- C) Dimercaprol
- D) Deferoxamine

Ans: B

Feedback:

Intravenous immune globulin would be used to treat idiopathic thrombocytopenic purpura. Folic acid is used to treat folic acid--deficiency anemia. Dimercaprol is used to remove lead from the soft tissue and bone to allow for excretion by the kidneys. Deferoxamine is used to treat iron toxicity.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1686, 1688, Laboratory and Diagnostic Testing, Table 46.2

40. The nurse is reviewing the white blood cell differential of a 4-year-old girl. Which value would lead the nurse to be concerned?

- A) Bands: 8%
- B) Segs: 28%
- C) Eosinophils: 10%
- D) Basophils: 0%

Ans: C

Feedback:

For a 4-year-old, normally eosinophils range from 0% to 3%; therefore, a result of 10% would be abnormal and a cause for concern. Bands of 8%, segs of 28%, and basophils of 0% are normal values for this age.

Format: Multiple Choice

Client Needs: Nursing Process

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1690, Laboratory and Diagnostic Testing, Common Laboratory and Diagnostic Tests 46.1

41. A child with suspected sickle cell disease is scheduled for a hemoglobin electrophoresis. When reviewing the child's history, what would the nurse identify as potentially interfering with the accuracy of the results?

- A) Use of iron supplementation
- B) Blood transfusion 1 month ago
- C) Lack of fasting for 12 hours
- D) History of recent infection

Ans: B

Feedback:

Blood transfusion within the previous 12 weeks may alter the results of the hemoglobin electrophoresis. Iron supplements can increase serum ferritin levels. Children should fast for 12 hours before having a specimen obtained for iron levels. A history of infection might interfere with the white blood cell count results, not hemoglobin electrophoresis.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analysis

Integrated Process: Nursing Process

42. The mother of a 5-year-old girl brings the child to the clinic for an evaluation. The mother tells the nurse, "She seems to be so tired and irritable lately. And she looks so pale." Further assessment reveals pale conjunctiva and oral mucous membranes. The nurse suspects iron-deficiency anemia. Which additional finding would help provide additional evidence for this suspicion?

- A) Spooned nails
- B) Negative splenomegaly
- C) Oxygen saturation: 99%
- D) Bradycardia

Ans: A

Feedback:

Spooning or concave shape of the nails suggests iron-deficiency anemia. Other findings would include decreased oxygen saturation levels, tachycardia, and possible splenomegaly.

Format: Multiple Select

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Evaluation

Integrated Process: Teaching/Learning

43. The nurse is teaching the parents of a child diagnosed with iron-deficiency anemia about ways to increase their child's intake of iron. The parents demonstrate understanding of the teaching when they identify which foods as good choices for the child? Select all that apply.

- A) Tuna
- B) Salmon
- C) Tofu
- D) Cow's milk

E) Dried fruits

Ans: A, B, C, E

Feedback:

Foods high in iron include red meats, tuna, salmon, eggs, tofu, enriched grains, dried beans and peas, dried fruits, leafy green vegetables, and iron-fortified breakfast cereals.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1709, Other Nutritional Causes of Anemia, Comparison Chart
46.2

44. A child is prescribed monthly injections of vitamin B12. When developing the teaching plan for the family, the nurse would focus on which type of anemia?

- A) Aplastic anemia
- B) Pernicious anemia
- C) Folic acid anemia
- D) Sickle cell anemia

Ans: B

Feedback:

Monthly injections of vitamin B12 are used to treat pernicious anemia. Aplastic anemia is characterized by a decrease in all blood cells necessitating a bone marrow transplant. Folic acid--deficiency anemia is treated with dietary measures and possible folic acid supplementation. Sickle cell anemia is treated supportively with a focus on preventing sickling crisis, infection, and other complications.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1683, Iron

45. A nurse is leading a discussion with a group of new mothers about newborn nutrition and its importance for growth and development. One of the mothers asks, "Doesn't the baby get iron from me before birth?" Which response by the nurse would be most appropriate?

- A) "You give the baby some iron, but it is not enough to sustain him after birth."
- B) "Because the baby grows rapidly during the first months, he uses up what you gave him."
- C) "The iron you give him before birth is different from what he needs once he is born."
- D) "If the baby didn't use up what you gave him before birth, he excretes it soon after birth."

Ans: B

Feedback:

In the term infant, a period of physiologic anemia occurs between the age of 2 and 6 months. This is due to the fact that the infant demonstrates rapid growth and an increase in blood volume over the first several months of life, and maternally derived iron stores are depleted by age 4 to 6 months of age. Sufficient iron intake is critical for the appropriate development of hemoglobin and RBCs. Therefore, the infant must ingest adequate quantities of iron either from breast milk or from iron-fortified formula in early infancy and other food sources in later infancy.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Evaluation

Integrated Process: Teaching/Learning

Page and Header: 1708, Teaching About Iron Supplement Administration

46. A 5-year-old girl is diagnosed with iron-deficiency anemia and is to receive iron supplements. The child has difficulty swallowing tablets, so a liquid formulation is prescribed. After teaching the parents about administering the iron supplement, which statement indicates the need for additional teaching?

- A) "She needs to eat foods that are high in fiber, so she doesn't get constipated."
- B) "We'll try to get her to drink lots of fluids throughout the day."
- C) "We will place the liquid in the front of her gums, just below her teeth."
- D) "We need to measure the liquid carefully so that we give her the correct amount."

Ans: C

Feedback:

When giving liquid iron supplements, the liquid should be placed behind the teeth because it can stain the teeth. Iron can lead to constipation, so increased fluid and fiber intake is appropriate. The dosage needs to be measured carefully to prevent overdosing the child, leading to iron toxicity.

Format: Multiple Select

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Comprehension

Integrated Process: Nursing Process

Page and Header: 1710, Nursing Assessment

47. The nurse is assessing a child with aplastic anemia. What would the nurse expect to assess? Select all that apply.

- A) Ecchymoses
- B) Tachycardia
- C) Guaiac-positive stool
- D) Epistaxis

- E) Severe pain
- F) Warm tender joints

Ans: A, B, C, D

Feedback:

Assessment findings associated with aplastic anemia include ecchymoses, epistaxis, guaiac-positive stools, and tachycardia. Severe pain and warm tender joints are most often associated with sickle cell crisis.

Format: Multiple Select

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1717, Administering Packed Red Blood Cell Transfusions

48. The nurse is developing a plan of care for a child with thalassemia. What information would the nurse expect to include? Select all that apply.

- A) Packed RBC transfusions
- B) Deferoxamine therapy
- C) Heparin therapy
- D) Opioid analgesics
- E) Platelet transfusions
- F) Intravenous immunoglobulin

Ans: A, B

Feedback:

RBC transfusions and deferoxamine for chelation are used to treat thalassemia. Heparin therapy is used for treating DIC. Opioid analgesics would be used to treat severe pain associated with sickle cell crisis. Platelet transfusions and intravenous immunoglobulin would be used to treat idiopathic thrombocytopenia purpura.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1718, Glucose-6-Phosphate Dehydrogenase Deficiency

49. A group of students is reviewing information about glucose-6-phosphate dehydrogenase (G6PD) deficiency. The students demonstrate understanding of the material what as the cause of the disorder?

- A) X-linked recessive inheritance
- B) Deficiency in clotting factors
- C) An excess supply of iron
- D) Autosomal recessive inheritance

Ans: A

Feedback:

G6PD deficiency is an X-linked recessive disorder that affects the functioning of the red blood cells. A deficiency in clotting factors is associated with disorders such as idiopathic thrombocytopenia purpura, DIC, or hemophilia. An excess supply of iron refers to hemosiderosis, a complication of thalassemia, an autosomal recessive disorder.

Chapter 47

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1763, Food Allergies

1. While providing care to a 5-month-old girl whose family has a history of food allergies, the nurse instructs the parents about foods to be avoided in the first year of life. Which response by the parents indicates a need for further teaching?

- A) "She cannot have any cow's milk."
- B) "I should continue breastfeeding until at least 6 months."
- C) "Peanuts in any form should be avoided."
- D) "Any kind of fruit is acceptable."

Ans: D

Feedback:

The nurse should caution the parents that kiwifruit should be avoided. Other foods to avoid include cow's milk, eggs, peanuts, tree nuts, sesame seeds, fish, and shellfish. Breastfeeding also is recommended for at least the first 6 months.

Format:

Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Caring

Page and Header: 1765, 1766, Preventing and Managing Future Episodes

2. A nurse is caring for a 12-year-old girl with a severe peanut allergy. The girl's parents are upset because the school does not permit her to carry her EpiPen with her. It must remain in the school's office per school regulations. Which response by the nurse would be most appropriate?

- A) "She is allowed by law to carry her EpiPen with her; I will talk to school authorities."
- B) "Let's file an action plan and keep it in the school office in the event of anaphylaxis."
- C) "Make sure she wears a medical alert bracelet so that school staff know she has allergies."
- D) "I will be happy to train school authorities and staff to recognize anaphylaxis."

Ans: A

Feedback:

Public Law No. 108-377, the Asthmatic Schoolchildren's Treatment and Health Management Act of 2004, was passed by the U.S. Congress. This law is intended to ensure that students with severe allergies can carry prescribed medications such as an EpiPen with them at all times. The nurse must contact the school and inform them of this law so that the girl is allowed to carry her EpiPen on her person at all times. The school staff should be trained to recognize anaphylaxis, there should be an action plan on file, and the girl should wear a medical alert bracelet as well. However, the most important action is to notify school authorities of the law.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1745, 1750, Common Medical Treatments, Drug Guide 47.1

3. The nurse is caring for a newborn whose mother is HIV positive. The nurse would expect to administer a 6-week course of which medication?

- A) Lopinavir

- B) Ritonavir
- C) Nevirapine
- D) Zidovudine

Ans: D

Feedback:

Children born to HIV-positive mothers should receive a 6-week course of zidovudine therapy. Lopinavir, ritonavir, and nevirapine are medications used for treatment of HIV-1 infections as part of a three-drug regimen.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1765, Nursing Management

4. The nurse is caring for a child who is having an anaphylactic reaction with bronchospasm. The nurse would expect to administer what medication for bronchospasm as ordered?

- A) Epinephrine
- B) Corticosteroid
- C) Albuterol
- D) Diphenhydramine

Ans: C

Feedback:

The nurse would expect to administer bronchodilator inhalation treatment (albuterol) if bronchospasm is present. Epinephrine, diphenhydramine, and/or corticosteroids are administered to reverse the allergic process.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1745, 1750, Common Medical Treatments, Drug Guide 47.1

5. The nurse is caring for a child undergoing highly active antiretroviral therapy (HAART) for HIV infection. The nurse is preparing to administer the prescribed medication. In addition to the nucleoside analog reverse transcriptase inhibitors (NRTIs) and the nonnucleoside analog reverse transcriptase inhibitors (NNRTIs), the nurse is cognizant that the child will be taking which additional medication as part of the three-drug regimen?

- A) Protease inhibitors
- B) Corticosteroids
- C) Cytotoxic drugs
- D) Disease-modifying antirheumatic drugs (DMARDs)

Ans: A

Feedback:

The nurse understands that the child will be taking protease inhibitors as part of the three-drug regimen for HAART. Corticosteroids, cytotoxic agents, and DMARDs are typically used for the treatment of juvenile idiopathic arthritis (JIA).

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1759, Preventing and Monitoring for Complications

6. The nurse is providing home care instructions for a 13-year-old girl recently diagnosed with systemic lupus erythematosus. Which response by the girl indicates a need for further teaching?

- A) "I need to wear sunscreen in the summer to prevent rashes."

- B) "I need to eat a healthy diet, exercise, and get plenty of sleep."
- C) "I need an eye examination every year."
- D) "I need to be careful when it is cold; I should always wear gloves."

Ans: A

Feedback:

The nurse needs to emphasize that the girl should apply sunscreen every day, not just in the summer, to prevent rashes resulting from photosensitivity. A healthy diet, sleep, yearly eye examinations, and protection from cold weather are appropriate measures.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1745, 1750, Common Medical Treatments, Drug Guide 47.1

7. The nurse is caring for a child who is taking corticosteroids for systemic lupus erythematosus. The nurse closely monitors the child based on the understanding that corticosteroids exert which major action?

- A) They increase liver enzymes.
- B) They can mask signs of infection.
- C) They cause bone marrow suppression.
- D) They decrease renal function.

Ans: B

Feedback:

The nurse understands that corticosteroids may mask signs of infection. Cytotoxic drugs cause bone marrow suppression. Nonsteroidal anti-inflammatory drugs can increase liver enzymes and decrease renal function.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1763, Food Allergies

8. The school nurse is walking through the lunchroom when one of the children says she started to feel strange after trading lunches with a friend. Which assessment would be most important?

- A) Asking if she has a rash anywhere
- B) Checking if she has any nausea
- C) Determining if her throat itches
- D) Asking if she has abdominal pain

Ans: C

Feedback:

Asking if the child's throat itches is most important because this aids in determining airway patency, which is always the priority. Asking about a rash, nausea, or abdominal pain can be done after the nurse is certain the child's airway is not jeopardized.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1754, Take Note!

9. The nurse is caring for a child who has undergone stem cell transplantation for severe combined immune deficiency. What finding would the nurse interpret as indicative of graft-versus-host disease?

- A) Presence of wheezing

- B) Splenomegaly
- C) Maculopapular rash
- D) Chronic or recurrent diarrhea

Ans: C

Feedback:

The nurse should monitor the stem cell transplant child closely for a maculopapular rash that usually starts on the palms and soles for indication that graft-versus-host disease is developing. Wheezing and recurrent diarrhea are not typical clinical manifestations of graft-versus-host disease. Splenomegaly is associated with hypogammaglobulinemia.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1751, 1752, Administering Intravenous Immunoglobulin

10. The nurse is administering intravenous immune globulin (IVIG). The nurse assesses vital signs and for adverse reactions every 15 minutes for the first hour of administration. After the first hour, the nurse most likely would continue to assess the child at which frequency?

- A) Every 30 minutes
- B) Every 45 minutes
- C) Every 60 minutes
- D) Every 2 hours

Ans: A

Feedback:

The nurse needs to continue assessments according to institutional protocol. Every 15 minutes for the first hour and every 30 minutes through the remainder of the infusion is the standard assessment.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1751, Primary Immunodeficiencies, Box 47.1

11. When reviewing the history of a child with suspected primary immunodeficiency, what would the nurse be least likely to find?

- A) Weight appropriate for height
- B) Antibiotic therapy for the past 3 months without effect
- C) Ten episodes of otitis media in the last year
- D) Three bouts of sinusitis within a year's time

Ans: A

Feedback:

Weight appropriate for height would not be associated with primary immunodeficiency. Rather, failure to thrive is considered a warning sign. Other warning signs of primary immunodeficiency include four or more episodes of acute otitis media in 1 year; two or more episodes of severe sinusitis in 1 year; treatment with antibiotics for 2 months or longer with little effect; two or more episodes of pneumonia in 1 year; recurrent deep skin or organ abscesses; persistent oral thrush or skin candidiasis after age 1 year; history of infections that do not clear with antibiotics; two or more serious infections; and a family history of primary immunodeficiency.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1753, 1754, Wiskott–Aldrich Syndrome, Nursing Assessment

12. What would the nurse expect to find in a male infant with Wiskott--Aldrich syndrome?

- A) Eczema
- B) Thrombocytosis
- C) Lymphadenopathy
- D) Pneumonia

Ans: A

Feedback:

Wiskott--Aldrich syndrome is manifested by eczema that usually worsens with time, petechiae, bloody diarrhea, or a bleeding episode in the first 6 months of life. Thrombocytopenia is present. Lymphadenopathy is associated with hypogammaglobulinemia. Pneumonia is associated with severe combined immune deficiency.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Remember

Integrated Process: Teaching/Learning

Page and Header: 1744, Variations in Pediatric Anatomy and Physiology, Comparison Chart 47.1

13. After teaching a class about humoral and cellular immunity, the nurse recognizes that additional teaching is needed when the class states that:

- A) humoral immunity crosses the placenta.
- B) cellular immunity involves the T lymphocytes.
- C) cellular immunity recognizes antigens.
- D) humoral immunity does not destroy the foreign cell.

Ans: C

Feedback:

Humoral immunity recognizes antigens and cellular immunity does not. Humoral immunity crosses the placenta in the form of IgG. Cellular immunity involves the action of T lymphocytes, and humoral immunity does not destroy the foreign cell.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Remember

Integrated Process: Teaching/Learning

Page and Header: 1745, Humoral Immunity

14. When teaching a group of new parents about newborn care and development, which immunoglobulin would the nurse explain as being primarily responsible for the passive immunity exhibited by newborns?

- A) IgA
- B) IgG
- C) IgM
- D) IgE

Ans: B

Feedback:

IgG is acquired transplacentally, providing the newborn with passive immunity to antigens to which the mother had developed antibodies. IgA, IgD, IgE, and IgM do not cross the placenta and require an antigenic challenge for production.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1760, Managing Pain and Maintaining Mobility

15. Which exercise would the nurse suggest as most helpful to maintain mobility in a child with juvenile idiopathic arthritis?

- A) Jogging every other day
- B) Using a treadmill
- C) Swimming
- D) Playing basketball

Ans: C

Feedback:

Swimming is a particularly useful exercise to maintain joint mobility without placing pressure on the joints. Jogging, using a treadmill, and playing basketball would place pressure on the joints of the lower extremities.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1759, Juvenile Idiopathic Arthritis

16. A child is diagnosed with juvenile idiopathic arthritis and is receiving several different medications listed in the medication administration record. Which agent would the nurse identify as being used to prevent disease progression?

- A) Aspirin
- B) Prednisone
- C) Ibuprofen
- D) Methotrexate

Ans: D

Feedback:

Disease-modifying antirheumatic drugs (DMARDs), such as methotrexate, are necessary to prevent disease progression. Other agents, such as aspirin and ibuprofen, are helpful with pain relief. Prednisone helps for relief of inflammation.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1744, Variations in Pediatric Anatomy and Physiology,
Comparison Chart 47.1

17. A group of nursing students are reviewing information about humoral and cellular immunity. The students demonstrate understanding of this material when they identify what is involved in cellular immunity?

- A) B cells
- B) Antibodies
- C) Antigens
- D) T cells

Ans: D

Feedback:

Cellular immunity involves T cells, which do not recognize antigens. B cells, antibodies, and antigens are involved in humoral immunity.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1751, Primary Immunodeficiencies

18. A nurse is preparing a plan of care for a child with a primary immunodeficiency. Which nursing diagnosis is the priority?

- A) Imbalanced nutrition, less than body requirements related to poor appetite
- B) Ineffective protection related to impaired humoral defenses
- C) Acute pain related to inflammatory processes
- D) Risk for delayed growth and development related to chronic illness

Ans: B

Feedback:

The child with a primary immunodeficiency lacks the necessary immune responses that provide protection from infection. Therefore, the priority nursing diagnosis would be ineffective protection. Imbalanced nutrition and risk for delayed growth and development may be appropriate, but these would not be the priority. Acute pain would be more appropriate for a child with juvenile idiopathic arthritis.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1751, Administering Intravenous Immunoglobulin

19. A child with hypogammaglobulinemia is to receive intravenous immunoglobulin (IVIG). What action would not be correct to take?

- A) Shake the vial after reconstituting it
- B) Premedicate the child with acetaminophen
- C) Obtain preinfusion vital signs
- D) Check serum blood urea nitrogen and creatinine levels

Ans: A

Feedback:

Many IVIG products are packed as two vials, one the IVIG powder and one the sterile diluents. Once reconstituted, the IVIG should not be shaken because this leads to foaming and may cause the immunoglobulin protein to degrade. The child can be premedicated with acetaminophen or diphenhydramine. Baseline serum blood urea nitrogen and creatinine should be assessed because acute renal insufficiency may occur as a serious adverse reaction.

Format: Multiple Select

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Teaching/Learning

Page and Header: 1751, 1752, Hypogammaglobulinemia, Wiskott--Aldrich Syndrome

20. A nursing student is reviewing information about primary immunodeficiencies. The student demonstrates understanding of the material by identifying which immunodeficiencies as affecting only males? Select all that apply.

- A) X-linked agammaglobulinemia
- B) Wiskott--Aldrich syndrome
- C) Selective IgA deficiency
- D) X-linked hyper-IgM syndrome
- E) IgG subclass deficiency
- F) Severe combined immune deficiency

Ans: A, B, D

Feedback:

X-linked agammaglobulinemia, Wiskott--Aldrich syndrome, and X-linked hyper-IgM syndrome affect males only. Selective IgA deficiency, IgG subclass deficiency, and severe combined immune deficiency affect boys and girls.

Format: Multiple Select

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1758, Laboratory and Diagnostic Findings

21. The nurse is reviewing the laboratory test results of a child who is suspected of having systemic lupus erythematosus (SLE). What would the nurse identify as supporting this diagnosis? Select all that apply.

- A) Positive antinuclear antibody (ANA)
- B) Increased C3 levels
- C) Thrombocytopenia
- D) Decreased C4 levels
- E) Increased hematocrit

Ans: A, C, D

Feedback:

Laboratory findings may include decreased hemoglobin and hematocrit, decreased platelet count, and low white blood cell count. Complement levels, C3 and C4, will also be decreased. Though not specific to SLE, the ANA is usually positive in children with SLE.

Format: Multiple Select

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1764, 1765, Managing the Child's Diet, Box 47.5

22. A child is diagnosed with a food allergy to milk. When teaching the parents about this allergy, what would the nurse suggest as possible substitutions for milk? Select all that apply.

- A) Fruit juice

- B) Rice milk
- C) Yogurt
- D) Nondairy creamers
- E) Soy milk

Ans: A, B, E

Feedback:

Milk can be replaced with water, fruit juice, rice milk, or soy milk. Yogurt contains milk and some nondairy products such as creamers may contain milk and should be avoided.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Understand

Integrated Process: Communication and Documentation

Page and Header: 1753, Severe Combined Immune Deficiency

23. The nurse is talking to the parents of a child who has been diagnosed with severe combined immune deficiency (SCID). Which statement by the parents best indicates that they understand their child's condition?

- A) "He'll need to receive intravenous immunoglobulin routinely."
- B) "We'll need to prepare him and ourselves for a bone marrow transplant."
- C) "He'll need to receive several different types of antiviral medications."
- D) "We'll make sure that he has his EpiPen with him at all times."

Ans: B

Feedback:

SCID is a potentially fatal disorder requiring emergency intervention at the time of diagnosis. Gene therapy provides some promise for the future treatment of SCID, but until then bone marrow or stem cell transplantation is necessary. IVIG may be used to help decrease the number of infections until bone marrow or stem cell

transplantation can be done. Antiviral medications are used to treat HIV infection. An EpiPen is used for anaphylaxis.

Format: Multiple Choice

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1759, Juvenile Idiopathic Arthritis, Table 47.2

24. The nurse is assessing a child with pauciarticular-type juvenile idiopathic arthritis. What would the nurse expect to assess?

- A) Fever
- B) Rash
- C) Eye inflammation
- D) Splenomegaly

Ans: C

Feedback:

With pauciarticular juvenile idiopathic arthritis, eye inflammation may be noted. Fever, rash, and enlarged spleen would be noted with systemic juvenile idiopathic arthritis.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1753, Take Note!

25. A child with systemic lupus erythematosus is receiving high-dose corticosteroid therapy over the long term. The nurse would instruct the parents and child to report:

- A) difficulty urinating.
- B) visual changes.
- C) joint pain.
- D) rash.

Ans: C

Feedback:

Avascular necrosis (lack of blood supply to a joint, resulting in tissue damage) may occur as an adverse effect of long-term or high-dose corticosteroid use. Teach families to report new onset of joint pain, particularly with weight bearing, or limited range of motion. Complications of systemic lupus erythematosus include nephritis manifested by urinary changes and visual changes. Rash may develop secondary to photosensitivity. These are unrelated to the long-term or high-dose corticosteroid use.

Format: Multiple Select

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1766, 1767, Nursing Assessment

26. A nurse is assessing a child who may have a latex allergy. The nurse asks the child about allergic reactions to certain foods. Which foods if identified by the child as experiencing an allergic reaction would help support the suspected latex allergy? Select all that apply.

- A) Peaches
- B) Plums
- C) Carrots
- D) Tomatoes
- E) Milk
- F) Lettuce

Ans: A, B, C, D

Feedback:

Foods with a known cross-sensitivity to latex include pear, peach, passion fruit, plum, pineapple, kiwi, fig, grape, cherry, melon, nectarine, papaya, apple, apricot, banana, chestnut, carrot, celery, avocado, tomato, or potato. Milk and lettuce are not associated with a cross-sensitivity.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1763, Food Allergies

27. The mother of a 5-year-old child with allergies to a variety of foods including eggs, milk, peanuts and shellfish, asks if her child will "always have these problems." What response by the nurse is most accurate?

- A) "Sadly, allergies to foods will persist."
- B) "Most children with allergies will outgrow them."
- C) "We cannot be sure at this point but most children who are allergic to peanuts will not have this allergy in adulthood."
- D) "In most cases allergies to peanuts and shellfish persist into adulthood but the others may diminish and disappear."

Ans: D

Feedback:

Foods such as peanuts, milk, soy, shellfish, and tree nuts are common allergens. By adulthood many allergies will diminish or disappear. Allergies to shellfish, peanuts and tree nuts often persist into adulthood.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Remember

Integrated Process: Teaching/Learning

Page and Header: 1763, Food Allergies

28. The nurse is providing a class for a group of childcare providers. When discussing allergic reactions, which statement by a participant indicates the need for further instruction?

- A) "Most allergic reactions will happen within a few minutes of eating a problematic food."
- B) "If a child has previously eaten a food and not had a reaction they are not 'truly' allergic to it."
- C) "Allergic reactions can happen hours after eating something."
- D) "In addition to hives some children may also have vomiting and diarrhea when having an allergic reaction to a food."

Ans: B

Feedback:

Previous exposure with no incident does not mean an individual cannot develop a hypersensitivity to a food or other substance. An allergy may develop at any time. The remaining statements are correct.

Format: Multiple Select

Client Needs: Safe, Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1758, Nursing Diagnoses

29. While performing an assessment of a client who is immunocompromised, the nurse notes the child to have thrush in the mouth, tenderness over the spleen upon palpation, and a white blood cell count of 3,000. Which nursing diagnoses will the nurse include in the care plan of this child based on these findings? Select all that apply.

- A) Ineffective protection

- B) Risk for imbalanced nutrition, less than body requirements
- C) Pain
- D) Impaired skin integrity
- E) Delayed growth and development

Ans: A, B, C

Feedback:

Based on these symptoms the diagnosis of Ineffective protection is related to the decreased white blood cell count; Risk for imbalanced nutrition, less than body requirements, is related to the thrush; and Pain is related to the tenderness over the spleen and the thrush. There is no evidence to support the diagnoses of Impaired skin integrity or Delayed growth and development.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1754, HIV Infection

30. A 16-year-old client has just been diagnosed with HIV. Which statement by the parent indicates understanding of the diagnosis?

- A) "It is important for our child to get started on drug therapy for a better chance of a cure of the infection."
- B) "I must be infected with HIV and passed it to our child while in the uterus for the infection to have occurred."
- C) "We don't want to face the fact that it is likely our child contracted HIV through sexual contact or IV drug use."
- D) "Infections as a result of being HIV positive are a low risk since the diagnosis came early."

Ans: C

Feedback:

In teenagers, HIV is primarily contracted through sexual intercourse with an infected person or sharing of needles with an infected person during IV drug use. There is no cure for HIV, infants primarily contract the virus from their mothers, and infections as a result of having HIV are not dependent on when the diagnosis occurred.

Chapter 48

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1789, Physical Examination

1. The nurse is obtaining a health history from parents whose 4-month-old boy has congenital hypothyroidism. What would the nurse most likely assess?

- A) The child has above-normal growth for his age.
- B) The child is active and playful.
- C) The skin is pink and healthy looking.
- D) It is difficult to keep the child awake.

Ans: D

Feedback:

The parents may state, during the health history, that it is difficult to keep the child awake. Physical examination would reveal that the child is below the normal weight and height for his age, that his skin is pale and mottled, and that he is lethargic and irritable.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1772, 1781, Common Medical Treatments, Drug Guide 48.1

2. The nurse is caring for an 8-year-old girl with hyperpituitarism. What ordered treatment will the nurse expect to perform?

- A) Give desmopressin acetate intranasally
- B) Inject octreotide acetate
- C) Give 1 mg/kg/day of methimazole
- D) Administer glipizide orally

Ans: B

Feedback:

The nurse would give the child a subcutaneous injection of octreotide acetate every 12 hours as directed. Desmopressin is a synthetic antidiuretic hormone used to treat diabetes insipidus. Methimazole is an antithyroid drug used to treat hyperthyroidism. Glipizide is a hypoglycemic drug that assists insulin production in children with diabetes mellitus type 2.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1786, Pathophysiology

3. The nurse is developing a plan of care for a 7-year-old boy with diabetes insipidus. What is the priority nursing diagnosis?

- A) Deficient fluid volume related to dehydration
- B) Excess fluid volume related to edema
- C) Deficient knowledge related to fluid intake regimen
- D) Imbalanced nutrition, more than body requirements related to excess weight

Ans: A

Feedback:

The priority nursing diagnosis most likely would be deficient fluid volume related to dehydration, due to a deficiency in the secretion of antidiuretic hormone (ADH). Excess fluid would result from a disorder that leads to water retention, such as

syndrome of inappropriate antidiuretic hormone (SIADH). Deficient knowledge related to fluid intake regimen is a nursing diagnosis for this child, but a secondary one. Imbalanced nutrition, more than body requirements related to excess weight would be inappropriate for this child since he probably has lost weight secondary to the fluid loss.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1793, 1795, Disorders Related to Adrenal Gland Function, Table 48.3

4. The nurse is assessing a 9-year-old girl with a history of tuberculosis at age 6 years. She has been losing weight and has no appetite. The nurse suspects Addison disease based on which assessment findings?

- A) Arrested height and increased weight
- B) Thin, fragile skin and multiple bruises
- C) Hyperpigmentation and hypotension
- D) Blurred vision and enuresis

Ans: C

Feedback:

Hyperpigmentation and hypotension would point to Addison disease. Arrested height and increased weight are typical of acquired hypothyroidism; this girl has lost weight. Thin, fragile skin and multiple bruises are indicative of Cushing syndrome. Blurred vision, headaches, and enuresis would be complaints of a child with diabetes mellitus.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1785, Delayed Puberty

5. The nurse is caring for a 13-year-old girl with delayed puberty. Based on the nurse's knowledge of this condition, the nurse would include which nursing diagnosis in the child's plan of care?

- A) Disabled family coping related to the child's disorder
- B) Imbalanced nutrition, less than body requirements related to the child's short stature
- C) Noncompliance related to the need for lifelong hormone therapy
- D) Deficient knowledge related to the administration of estradiol

Ans: D

Feedback:

Deficient knowledge related to the administration of estradiol is an appropriate nursing diagnosis for this child. There are oral, transdermal, topical, injectable, and vaginal preparations available. Disabled family coping due to the child's disorder and noncompliance due to long-term therapy are not likely diagnoses because of the simplicity and brevity of the treatment for this disorder. Imbalanced nutrition evidenced by short stature would be appropriate for a child with growth hormone deficiency.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1799, Therapeutic Management

6. The nurse is preparing a teaching plan for the family and their 6-year-old son who has just been diagnosed with diabetes mellitus. What would the nurse identify as the initial goal for the teaching plan?

- A) Developing management and decision-making skills
- B) Educating the parents about diabetes mellitus type 1

- C) Developing a nutritionally sound, 30-day meal plan
- D) Promoting independence with self-administration of insulin

Ans: A

Feedback:

Developing basic management and decision-making skills related to the diabetes is the initial goal of the teaching plan for this child and family. The nurse would have provided a basic description of the disorder after it was diagnosed. Development of a detailed monthly meal plan would come later, perhaps after consulting with a nutritionist. It is too soon to expect the boy to administer his own insulin.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1786, Diabetes Insipidus

7. The nurse is caring for an 8-year-old girl with an endocrine disorder involving the posterior pituitary gland. What care would the nurse expect to implement?

- A) Instructing the parents to report adverse reactions to the growth hormone treatment
- B) Teaching the parents how to administer the desmopressin acetate
- C) Informing the parents that treatment stops when puberty begins
- D) Educating the parents to report signs of acute adrenal crisis

Ans: B

Feedback:

The nurse would teach the parents how to administer desmopressin acetate, which treats diabetes insipidus, a disorder related to the posterior pituitary gland. Instructing parents to report adverse reactions to growth hormone is an intervention for growth hormone deficiency. Informing the parents that treatment stops at the normal time of puberty is a teaching intervention for precocious puberty. Educating the parents to report signs of an acute adrenal crisis is an

intervention for congenital adrenal hyperplasia. All three of these other disorders are related to the anterior pituitary.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1803, Health History and Physical Examination

8. The nurse is assessing a 13-year-old boy with type 2 diabetes mellitus. What would the nurse correlate with disorder?

- A) The parents report that their child had "a cold or flu" recently.
- B) Blood pressure is decreased when checking vital signs.
- C) The parents report that their son "can't drink enough water."
- D) Auscultation reveals Kussmaul breathing.

Ans: C

Feedback:

Unquenchable thirst (polydipsia) is a common finding associated with diabetes mellitus, type 1 and 2. However, reports of flu-like illness and Kussmaul breathing are more commonly associated with type 1 diabetes. Blood pressure is normal with type 1 diabetes and elevated with type 2 diabetes.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1791, Hyperthyroidism

9. The nurse is preparing a teaching plan for a 10-year-old girl with hyperthyroidism. What information would the nurse include in the plan?

- A) Describing surgery to remove an anterior pituitary tumor
- B) Teaching her parents to give injections of growth hormone
- C) Explaining about the radioactive iodine procedure
- D) Showing her parents how to give DDAVP intranasally

Ans: C

Feedback:

Explaining about the radioactive iodine procedure would be part of the teaching plan for a child with hyperthyroidism because this is a less invasive type of therapy for the disorder. Describing surgery to remove an anterior pituitary tumor would be included for a child with hyperpituitarism. Teaching a parent to give injections of growth hormone would be appropriate for a child with a growth hormone deficiency. Showing parents how to give DDAVP intranasally is appropriate for a child with diabetes insipidus.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1789, Nursing Assessment

10. What finding would the nurse expect to assess in a child with hypothyroidism?

- A) Nervousness
- B) Heat intolerance
- C) Smooth velvety skin
- D) Weight gain

Ans: D

Feedback:

Hypothyroidism is manifested by weight gain, fatigue, cold intolerance, and dry skin. Nervousness, heat intolerance, and smooth velvety skin are associated with hyperthyroidism.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1796, Preventing and Monitoring for Acute Adrenal Crisis

11. The parents of a child with congenital adrenal hyperplasia bring the child to the emergency department for evaluation because the child has had persistent vomiting. What finding would lead the nurse to suspect that the child is experiencing an acute adrenal crisis?

- A) Hypernatremia
- B) Bradycardia
- C) Hypertension
- D) Hyperkalemia

Ans: D

Feedback:

Signs and symptoms of an acute adrenal crisis include hyperkalemia, hyponatremia, tachycardia, hypotension, persistent vomiting, dehydration, and shock.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1805, Monitoring for and Managing Complications

12. A child with diabetes reports that he is feeling a little shaky. Further assessment reveals that the child is coherent but with some slight tremors and sweating. A fingerstick blood glucose level is 70 mg/dL. What would the nurse do next?

- A) Administer a sliding-scale dose of insulin.
- B) Give 10 to 15 g of a simple carbohydrate.
- C) Offer a complex carbohydrate snack.
- D) Administer glucagon intramuscularly.

Ans: B

Feedback:

The child is experiencing hypoglycemia as evidenced by the assessment findings and blood glucose level. Since the child is coherent, offering the child 10 to 15 g of a simple carbohydrate would be appropriate. Insulin is not used because the child is hypoglycemic. A complex carbohydrate snack would be used after offering the simple carbohydrate to maintain the glucose level. Intramuscular glucagons would be used if the child was not coherent.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1783, Promoting Growth

13. A child with growth hormone deficiency is receiving growth hormone. What result would the nurse interpret as indicating effectiveness of this therapy?

- A) Rapid weight gain
- B) Complaints of headaches
- C) Height increase of 4 in
- D) Growth plate closure

Ans: C

Feedback:

Effectiveness of growth hormone therapy is indicated by at least a 3- to 5-in increase in linear growth in the first year of treatment. Rapid weight gain and headaches are adverse reactions of this therapy. The drug is stopped when the epiphyseal growth plates close.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1785, Providing Education

14. After teaching the parents of a daughter with central precocious puberty about medication therapy, which statement by the parents indicates successful teaching?

- A) "She needs to use the nasal spray once every day."
- B) "She will start puberty again when the medication stops."
- C) "This medication will slow down the changes but not reverse them."
- D) "Once therapy is done, she'll need surgery."

Ans: B

Feedback:

Treatment for central precocious puberty involves administering a gonadotropin-releasing hormone (GnRH) analog. When it is stopped, puberty resumes according to the appropriate developmental stages. This analog can be given by depot injection every 3 to 4 weeks, a daily subcutaneous injection, or an intranasal spray two or three times per day. With GnRH analog treatment, secondary sexual development stabilizes or regresses. Surgery is indicated only if there is a tumor.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1772, Variations in Anatomy and Physiology

15. A group of nursing students are reviewing information about the endocrine system in infants and children. The students demonstrate understanding of the information when they state:

- A) Endocrine glands begin developing in the third trimester of gestation.
- B) At birth, the endocrine glands are completely functional.
- C) Infants have difficulty balancing glucose and electrolytes.
- D) A child's endocrine system has little effect on growth and development.

Ans: C

Feedback:

Typically, most endocrine glands begin to develop during the first trimester of gestation, but their development is incomplete at birth. Thus, complete hormonal control is lacking during the early years of life, and the infant cannot appropriately balance fluid concentration, electrolytes, amino acids, glucose, and trace substances.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1772, 1781, Common Medical Treatments, Drug Guide 47.1

16. A child is diagnosed with hyperthyroidism. Which agent would the nurse expect the healthcare provider to prescribe?

- A) Mineralocorticoid
- B) Methimazole
- C) Levothyroxine

D) Dexamethasone

Ans: B

Feedback:

Methimazole is an antithyroid drug that is used to treat hyperthyroidism.

Mineralocorticoid is used to treat adrenal insufficiency. Levothyroxine is used to treat hypothyroidism. Dexamethasone is used to treat congenital adrenal hyperplasia.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1788, Syndrome of Inappropriate Antidiuretic Hormone

17. A child with diabetes insipidus is being treated with vasopressin. The nurse would assess the child closely for signs and symptoms of which condition?

- A) Syndrome of inappropriate antidiuretic hormone (SIADH)
- B) Thyroid storm
- C) Cushing syndrome
- D) Vitamin D toxicity

Ans: A

Feedback:

SIADH, although rare in children, is a potential complication of excessive administration of vasopressin. Thyroid storm may result from overadministration of levothyroxine (thyroid hormone replacement). Cushing syndrome is associated with corticosteroid use. Vitamin D toxicity may result from the use of vitamin D as treatment of hypoparathyroidism.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1793, 1795, Disorders Related to Adrenal Gland Function, Table 48.3

18. The nurse is reviewing the laboratory test results of a child with Addison disease. What would the nurse expect to find?

- A) Hypernatremia
- B) Hyperkalemia
- C) Hyperglycemia
- D) Hypercalcemia

Ans: B

Feedback:

With Addison disease, the child would exhibit hyperkalemia, hyponatremia, and hypoglycemia. Hypercalcemia would be associated with hyperparathyroidism.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1796, Preventing and Monitoring for Acute Adrenal Crisis

19. A nurse is teaching the parents of an infant with congenital adrenal hyperplasia about the signs and symptoms of adrenal crisis. The nurse determines that the teaching was successful when the parents correctly identify what sign of adrenal crisis?

- A) Bradycardia
- B) Constipation
- C) Fluid overload
- D) Persistent vomiting

Ans: D

Feedback:

Signs and symptoms of acute adrenal crisis include persistent vomiting, dehydration, hyponatremia, hyperkalemia, hypotension, tachycardia, and shock.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1800, 1801, Insulin Replacement Therapy, Table 48.5

20. A group of students are reviewing information about the various types of insulin used to treat type 1 diabetes. The students demonstrate understanding of the information when they identify which of these insulins as having the longest duration?

- A) Lispro
- B) Regular
- C) NPH
- D) Glargine

Ans: D

Feedback:

Of the insulins listed, glargine (Lantus) has the longest duration of action, that is, 12 to 24 hours. Lispro lasts approximately 3 to 5 hours; regular lasts 5 to 8 hours; and NPH lasts approximately 10 to 16 hours.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Analyze

Integrated Process: Nursing Process

21. A 5-year-old child with type 1 diabetes is brought to the clinic by his mother for a follow-up visit after having his hemoglobin A1C level drawn. Which result would indicate to the nurse that the child is achieving long-term glucose control?

- A) 9.0%
- B) 8.2%
- C) 7.3%
- D) 6.9%

Ans: B

Feedback:

For a child 6 years of age and younger, the target HbA1C level should be less than 8.5% but greater than 7.5%. For children between the ages of 6 and 12 years, the target HbA1C level is less than 8%. For children and adolescents between 13 and 19 years of age, the target HbA1C level would be less than 7.5%.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Analyze

Integrated Process: Nursing Process

22. The parents of a 7-year-old girl with type 1 diabetes has been recording her blood glucose measurements before meals and at bedtime for the past 4 days; they are as follows:

Monday	Tuesday	Wednesday	Thursday
B: 120 mg/dL	135 mg/dL	124 mg/dL	200 mg/dL
L: 110 mg/dL	120 mg/dL	140 mg/dL	220 mg/dL
D: 90 mg/dL	140 mg/dL	130 mg/dL	200 mg/dL
Bed: 110 mg/dL	110 mg/dL	160 mg/dL	240 mg/dL

The parents bring the child in for a follow-up visit and show the nurse the results. Based on the results, the nurse would need to obtain additional information from the parents and child about which day?

- A) Monday
- B) Tuesday
- C) Wednesday
- D) Thursday

Ans: D

Feedback:

Blood glucose levels for a child who is 7 years of age should range from 90 to 180 mg/dL before meals and from 100 to 180 mg/dL before bedtime. On Thursday, the results for each testing were above normal. Therefore, the nurse needs to gather additional information about this day.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1800, 1801, Insulin Replacement Therapy, Table 48.5

23. The nurse is administering 10 units of NPH insulin to a child at 8 AM. The nurse would expect this insulin to begin acting at which time?

- A) By 8:15 AM
- B) Between 8:30 and 9 AM
- C) Between 9 and 11 AM
- D) Around 12 noon

Ans: C

Feedback:

NPH insulin has an onset of action of 1 to 3 hours, so the drug would begin to act between 9 and 11 AM. A rapid-acting insulin would begin to act by 8:15 AM; regular insulin would begin to act between 8:30 and 9 AM. No type of insulin would begin acting around 12 noon.

Format: Multiple Select

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1805, Monitoring for and Managing Complications

24. The nurse suspects that a 4 year old with type 1 diabetes is experiencing hypoglycemia based on what findings? Select all that apply.

- A) Blurred vision
- B) Dry, flushed skin
- C) Diaphoresis
- D) Slurred speech
- E) Fruity breath odor
- F) Tachycardia

Ans: C, D, F

Feedback:

Manifestations of hypoglycemia include behavioral changes, confusion, slurred speech, belligerence, diaphoresis, tremors, palpitation, and tachycardia. Blurred vision; dry, flushed skin; and fruity breath odor suggest hyperglycemia.

Format: Multiple Select

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1797, 1798, Diabetes Mellitus, Table 48.4

25. A nurse is preparing a presentation for a group of parents of adolescents diagnosed with type 1 diabetes. What issues would the nurse need to address? Select all that apply.

- A) Self-monitoring of blood glucose levels
- B) Feelings of being different
- C) Deficient decision-making skills
- D) Body image conflicts
- E) Struggle for independence

Ans: C, D, E

Feedback:

Adolescents are undergoing rapid physical, emotional, and cognitive growth. Working toward a separate identity from parents and the demands of diabetic care can hinder this. This struggle for independence can lead to nonadherence of the diabetic care regimen. Conflicts develop with self-management, body image, and peer group acceptance. Teens may acquire the skills to perform tasks related to diabetic care but may lack decision-making skills needed to adjust treatment plan. Teens do not always foresee the consequences of their activities. Self-monitoring of blood glucose levels and feelings of being different are issues common to school-age children.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1772, Introduction

26. A group of nursing students are reviewing the components of the endocrine system. The students demonstrate understanding of the review when they identify what as the primary function of this system?

- A) Regulation of water balance

- B) Hormonal secretion
- C) Cellular metabolism
- D) Growth stimulation

Ans: B

Feedback:

The endocrine system consists of various glands, tissues, or clusters of cells that produce and release hormones. Hormones are chemical messengers that stimulate and/or regulate the actions of other tissues, organs, or endocrine glands that have specific receptors to a hormone. Along with the nervous system, the endocrine milieu influences all physiologic effects such as growth and development, metabolic processes related to fluid and electrolyte balance and energy production, sexual maturation and reproduction, and the body's response to stress. The release patterns of the hormones vary, but the level in the body is maintained within specified limits to preserve health.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Analyze

Integrated Process: Nursing process

Page and Header: 1784, Educating the Family

27. A child has been prescribed growth hormone. When collecting data from this client, which report is of the greatest concern?

- A) "I sometimes have headaches."
- B) "I feel tired."
- C) "My hips often hurt."
- D) "I take this medication with food."

Ans: C

Feedback:

Limping or complaints of hip pain are of concern. This may signal issues with the epiphysis and warrants further evaluation. Headaches and fatigue are not associated with medication. Taking this medication with food is not contraindicated.

Format: Multiple Select

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1782, Pathophysiology

28. A 6-year-old child has been diagnosed with growth hormone deficiency. The child's mother requests more information about this condition. Which statements should be included in the nurse's response? Select all that apply.

- A) "The majority of children who have this condition are born of normal weight and length."
- B) "There are several potential causes of this condition."
- C) "This condition is most likely related to dwarfism in past generations of your family."
- D) "Most children with this condition are nutritionally deprived."
- E) "Your child most likely does not eat adequate amounts of protein."

Ans: A, B

Feedback:

Growth hormone deficiency can result from a variety of causes. These causes may include genetic mutations, tumors, infection, and birth trauma. Some cases have not identifiable causes. Most children diagnosed with this condition are of normal length and weight at birth but in childhood fall behind in growth. A small proportion of children may have nutritional concerns.

Format: Multiple Select

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1783, Nursing Diagnoses

29. The nurse is caring for a 9-year-old client newly diagnosed with diabetes. The client has polyuria, polydipsia, and weight loss. Which nursing diagnoses will the nurse include in the care plan? Select all that apply.

- A) Imbalanced nutrition: less than body requirements
- B) Deficient fluid volume
- C) Deficient knowledge regarding disease process
- D) Noncompliance
- E) Delayed growth and development

Ans: A, B, C

Feedback:

Polyuria (excessive urination), polydipsia (excessive thirst), and weight loss support the diagnoses of deficient fluid volume and imbalanced nutrition: less than body requirements. Being newly diagnosed with the disease at the age of 9 supports the diagnosis of Deficient knowledge regarding disease process. There is no data to support noncompliance or delayed growth and development.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Analyze

Integrated Process: Communication/Documentation

Page and Header: 1797, Nursing Management

30. A teenage girl diagnosed with polycystic ovary syndrome tells the nurse, "I refuse to take oral contraceptives since I am not sexually active." What is the best response to the girl?

- A) "It's important for you to take the pills even if you're not sexually active in order to prevent unwanted symptoms of the disease."

- B) "The healthcare provider has prescribed these for you because it is an effective treatment method for the disease."
- C) "I know it's hard remembering to take those pills every day. Tell me more about what is making you not want to take the oral contraceptives."
- D) "Do your parents know that you are not taking the treatment medication your healthcare provider prescribed?"

Ans: C

Feedback:

This response shows empathy to the client and encourages her to further discuss the reasons they are noncompliant with the prescribed treatment regimen. "It's important for you to take the pills even if you're not sexually active..." and "The healthcare provider has prescribed these for you because it is an effective treatment..." are accurate statements, but they are not methods of therapeutic communication and do not lead to further discussion about the noncompliance. Asking if the parents know she isn't taking the medications leads to mistrust of the nurse.

Chapter 49

1. The nurse is caring for a couple who is having a triple screen done. The nurse would least likely expect what level to be tested?
 - A. α -Fetoprotein
 - B. Human chorionic gonadotropin
 - C. Unconjugated estriol
 - D. Testosterone

Answer: D

Rationale: A triple screen tests α -fetoprotein (AFP), human chorionic gonadotropin (hCG), and unconjugated estriol (uE3). Testosterone is not included.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 1817

2. The nurse is caring for 3-day-old girl with Down syndrome whose mother had no prenatal care. What is the **priority** nursing diagnosis?
 - A. Imbalanced nutrition, less than body requirements related to the effects of hypotonia
 - B. Deficient knowledge related to the presence of a genetic disorder
 - C. Delayed growth and development related to a cognitive impairment
 - D. Impaired physical mobility related to poor muscle tone

Answer: A

Rationale: Children with Down syndrome may have difficulty sucking and feeding due to lack of muscle tone and the structure of their mouths and tongues. This can lead to poor nutritional intake and makes this the priority diagnosis. This also uses the strategy that physiologic needs have priority using Maslow's hierarchy of needs. Deficient knowledge due to lack of information about the disorder is a close second in priority, as the mother did not know of her daughter's condition before birth and has much to learn now. This child is at risk for a number of complications such as infection, heart disease, and leukemia and will require frequent assessment. Most children with Down syndrome experience some degree of intellectual disability, but early intervention will allow the child maximum development within the limits of the disease. Mobility is delayed but should not be a problem at this time.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Analyze

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 1827

3. The nurse is teaching the parents of a 1-month-old girl with Down syndrome how to maintain good health for the child. Which instruction would the nurse be least likely to include?
- A. Getting cervical radiographs between 3 and 5 years of age
 - B. Adhering to the special dietary needs of the child
 - C. Getting an echocardiogram before 3 months of age
 - D. Monitoring for symptoms of respiratory infection

Answer: B

Rationale: Children with Down syndrome do not require a special diet unless underlying gastrointestinal disease is present. However, a balanced, high-fiber diet and regular exercise are important. Getting cervical radiographs between 3 and 5 years of age is the screening method for atlantoaxial instability, which is seen in about 14% of children with Down syndrome. Evaluation by a pediatric cardiologist before 3 months of age, including an echocardiogram, is important since children with Down syndrome are at higher risk for heart disease. The child will be more susceptible to infectious diseases.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1827

4. The nurse is counseling a couple who suspect that they could bear a child with a genetic abnormality. What would be **most** important for the nurse to incorporate into the plan of care when working with this family?

- A. Gathering information from at least three generations
- B. Informing the family of the need for a wide range of information
- C. Maintaining the confidentiality of the information
- D. Presenting the information in a nondirective manner

Answer: D

Rationale: It is essential to respect client autonomy and present information in a factual, nondirective manner. In these situations, the nurse needs to understand that the choice is the couple's to make. Gathering information for three generations obtains a broad overview of what has been seen in both sides of the family. Maintaining confidentiality of the information is as important as with any other client information gathered. Informing family of the need for information is necessary because of its personal nature.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Communication and Documentation

Reference: p. 1814

5. The nurse is obtaining the health history for a 15-month-old boy from the parents. The child is not yet speaking. Which finding would be eliminated as a risk factor for a possible genetic disorder?
- A. The child is male and white.
 - B. The grandmother and father have hearing impairments.
 - C. The child was a breech delivery 3 weeks early.
 - D. The mother was 37 when she became pregnant.

Answer: A

Rationale: Being male and white are risk factors for acute lymphoblastic leukemia, not genetic disorders. The fact that the child's grandmother and father have hearing impairments suggests a genetic disorder. The facts that the mother was 37 when she became pregnant and had a breech delivery 3 weeks early are also risk factors for genetic disorders.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Communication and Documentation

Reference: p. 1814-1815

6. The nurse is caring for a 1-month-old girl with low-set ears and severe hypotonia who was diagnosed with trisomy 18. Which nursing diagnosis would the nurse identify as **most** likely?
- A. Interrupted family process related to the child's diagnosis
 - B. Deficient knowledge deficit related to the genetic disorder
 - C. Grieving related to the child's poor prognosis
 - D. Ineffective coping related to stress of providing care

Answer: C

Rationale: Grieving related to the child's prognosis is a diagnosis specific to this child's care. The prognosis for trisomy 18 is that the child will not survive beyond the first year of life. Ineffective coping related to the stress of providing care, deficient knowledge related to the genetic disorder, and interrupted family process due to the child's diagnosis could be appropriate for any family of a child with a genetic disorder.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Analyze

Client Needs: Psychosocial Integrity

Integrated Process: Caring

Reference: p. 1828

7. The nurse is caring for a 9-year-old boy with achondroplasia. What will the nurse's assessment reveal?

- A. Narrow passages from the nose to the throat
- B. Slim stature, hypotonia, and a narrow face
- C. Craniosynostosis and a small nasopharynx
- D. Trident hand and persistent otitis media

Answer: D

Rationale: Achondroplasia results in disordered growth with an average adult height of 4 feet for males or females. Other distinguishing symptoms are a separation between the middle and ring fingers, called trident hand, and persistent otitis media and middle ear dysfunction. Narrow passages from nose to throat are a symptom of CHARGE syndrome. Slim stature, hypotonia, and a narrow face are symptoms of Marfan syndrome. Craniosynostosis and a small nasopharynx are symptoms of Apert syndrome.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 1835

8. When teaching a class about trisomy 21, the instructor would identify the cause of this disorder as:

- A. nondisjunction.
- B. X-linked recessive inheritance.
- C. genomic imprinting.
- D. autosomal dominant inheritance.

Answer: A

Rationale: Trisomy 21 is an example of a genetic disorder involving an abnormality in chromosomal number due to nondisjunction. X-linked recessive inheritance disorders, such as hemophilia and Duchenne muscular dystrophy, involve altered genes on the X chromosome. Genomic imprinting disorders, such as Prader-Willi syndrome, involve expression of only the maternal or paternal allele, with the other being inactive. Autosomal dominant inheritance disorders, such as neurofibromatosis and achondroplasia, involve a single gene in the heterozygous state that is capable of producing the phenotype, thus overshadowing the normal gene.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1821

9. The nurse is preparing a presentation to a local community group about genetic disorders and the types of congenital anomalies that can occur. What would the nurse include as a major congenital anomaly?

- A. Overlapping digits
- B. Polydactyly
- C. Umbilical hernia
- D. Cleft palate

Answer: D

Rationale: Cleft palate is considered a major congenital anomaly, one that creates a significant medical problem or requires surgical or medical management. Overlapping digits, polydactyly, and umbilical hernia are considered minor congenital anomalies because they do not cause an increase in morbidity in and of themselves.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1815

10. The nurse is caring for a couple who have just learned that their infant has a genetic disorder. What would be least appropriate for the nurse to do at this time?

- A. Actively listening to the parents' concerns
- B. Teaching the parents about the child's medical needs
- C. Providing time for the parents to ask questions
- D. Offering suggestions for support services

Answer: B

Rationale: The parents are most likely overwhelmed with learning the diagnosis and are dealing with a wide range of emotions and reactions. Therefore, it would be inappropriate at this time to attempt teaching them. Rather, the nurse would provide emotional support, actively listening to the parents, allowing time for questions, and offering suggestions for support to assist them in dealing with this new challenge. Teaching can be done at a later time.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Integrated Process: Caring

Reference: p. 1814

11. When providing guidance to the parents of a child with Down syndrome, which interaction would be **most** appropriate?

- A. Encourage the parents to home-school the child.
- B. Advise the parents that the child will need monthly thyroid testing.

- C. Instruct them on the need for yearly dental visits.
- D. Teach the parents about the need for a high-fiber diet.

Answer: D

Rationale: A high-fiber intake is important for children with Down syndrome because their lack of muscle tone may decrease peristalsis, leading to constipation. Early intervention programs with special education are important to promote growth and development. The child should be integrated into mainstream education whenever possible. Children with Down syndrome should undergo thyroid testing yearly and see the dentist every 6 months.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1827

12. What finding would lead the nurse to suspect that a child has Turner syndrome?
- A. Webbed neck
 - B. Microcephaly
 - C. Gynecomastia
 - D. Cognitive delay

Answer: A

Rationale: Manifestations of Turner syndrome include webbed neck, low posterior hairline, wide-spaced nipples, edema of the hands and feet, amenorrhea, and absence of secondary sex characteristics, along with short stature and slow growth. Microcephaly is commonly associated with trisomy 13. Gynecomastia and cognitive delay are associated with Klinefelter syndrome.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Remember

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1829

13. When performing a physical examination on a small child, the nurse observes approximately 8 to 10 light-brown spots concentrated primarily on the trunk and extremities, two small lumps on the posterior trunk, and axillary freckling. What condition do these findings suggest?
- A. Klinefelter syndrome
 - B. Neurofibromatosis
 - C. Fragile X syndrome
 - D. Sturge-Weber syndrome

Answer: B

Rationale: The hallmark of neurofibromatosis is café-au-lait spots appearing all over the body, particularly the trunk and extremities. Additional findings include benign tumors, axillary freckling, and pigmented nevi. Klinefelter syndrome is associated with a lack of secondary sex characteristics, decreased facial hair, gynecomastia, decreased pubic hair, and hypogonadism. Fragile X syndrome is manifested by minor dysmorphic features and developmental delay. Sturge-Weber syndrome is associated with facial nevus, seizures, hemiparesis, and intracranial calcifications.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Remember

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1833

14. After teaching a class about inborn errors of metabolism, the instructor determines that additional teaching is needed when the class identifies what as an example of an inborn error of metabolism?

- A. Galactosemia
- B. Maple syrup urine disease
- C. Achondroplasia
- D. Tay-Sachs disease

Answer: C

Rationale: Achondroplasia is an autosomal dominant genetic disorder, not an inborn error of metabolism. Galactosemia, maple syrup urine disease, and Tay-Sachs are considered inborn errors of metabolism.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Remember

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1816

15. When teaching the parents of a child with phenylketonuria, the nurse would instruct them to include which food in the child's diet?

- A. Milk
- B. Oranges
- C. Meat
- D. Eggs

Answer: B

Rationale: Foods that contain phenylalanine are to be avoided. These include milk, meat, and eggs. Foods such as oranges would be allowed.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Teaching/Learning

Reference: p. 1836

16. When providing support and education to the family of a child who is diagnosed with a serious genetic abnormality, what would be the **priority**?

- A. Assisting with scheduling follow-up visits
- B. Establishing a trusting relationship
- C. Teaching the family what to expect
- D. Using measures to promote growth and development

Answer: B

Rationale: Regardless of the genetic abnormality, learning of a genetic abnormality may be shattering to the family. Therefore, the initial priority is to establish a trusting relationship. Once this is accomplished, other aspects of care, such as assisting with scheduling follow-up visits, teaching, and implementing measures to promote growth and development, can be addressed.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Apply

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Caring

Reference: p. 1820

17. A group of students are reviewing information about major and minor congenital disorders. The students demonstrate understanding of the information when they identify what condition as a minor disorder?

- A. Webbed neck
- B. Omphalocele
- C. Cutaneous hemangioma
- D. Facial asymmetry

Answer: A

Rationale: A minor congenital anomaly is webbed neck. Omphalocele, cutaneous hemangioma, and facial asymmetry are considered major congenital anomalies.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1816

18. The nurse is assessing an infant and notes that the infant's urine has a mousy or musty odor. What would the nurse suspect?

- A. Maple syrup urine disease
- B. Tyrosinemia
- C. Phenylketonuria
- D. Trimethylaminuria

Answer: C

Rationale: The urine of a child with phenylketonuria has a mousy or musty odor. For the child with maple syrup urine disease, excretions have a maple syrup odor. With tyrosinemia, excretions have a cabbage-like or rancid butter odor. With trimethylaminuria, excretions smell like rotting fish.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Remember

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Teaching/Learning

Reference: p. 1816

19. A pregnant woman is to undergo testing to evaluate for chromosomal abnormalities. Which test would the nurse expect to be done the earliest?

- A. Amniocentesis
- B. Chorionic villi sampling
- C. Triple screen
- D. Fetal nuchal translucency

Answer: B

Rationale: Chorionic villi sampling is performed at 7 to 11 weeks' gestation. Amniocentesis usually is performed after 15 weeks' gestation. A triple screen is usually done between 16 and 19 weeks' gestation. Fetal nuchal translucency must be performed between 11 and 14 weeks.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Remember

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching/Learning

Reference: p. 1817

20. A child is diagnosed with cri-du-chat syndrome. What findings would the nurse expect to assess? Select all that apply.

- A. Hypertonia
- B. Short stature
- C. Simian crease
- D. Wide and flat nasal bridge
- E. Hydrocephaly

Answer: B, C, D

Rationale: Manifestations of cri-du-chat syndrome include hypotonia, short stature, microcephaly, moon-like round face, bilateral epicanthal folds, wide and flat nasal bridge, and simian crease.

Question format: Multiple Select

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Remember

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1822

21. When describing Prader-Willi syndrome to a group of nursing students, the instructor would describe this condition as one affecting which chromosome?

- A. 4
- B. 5
- C. 11
- D. 15

Answer: D

Rationale: Prader-Willi syndrome involves an abnormality on chromosome 15. Cri-du-chat involves an abnormality on chromosome 5; Wolf-Hirschhorn syndrome involves an abnormality on chromosome 4; and Beckwith-Wiedemann syndrome involves an abnormality on chromosome 11.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Teaching/Learning

Reference: p. 1822

22. A group of nursing students are reviewing information about neurocutaneous syndromes.

What is an example of these disorders?

- A. Sturge-Weber syndrome
- B. Marfan syndrome
- C. Apert syndrome
- D. Achondroplasia

Answer: A

Rationale: Sturge-Weber syndrome is an example of a neurocutaneous syndrome. Marfan syndrome, Apert syndrome, and achondroplasia are autosomal dominantly inherited genetic disorders.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Remember

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1832

23. The nurse is assessing a 4-year-old client. Which finding suggests to the nurse this child may have a genetic disorder?

- A. Inquiry determines the child had feeding problems.
- B. The child weighs 40 lb (18.2 kg) and is 40 in (101.6 cm) in height.
- C. The child has low-set ears with lobe creases.
- D. The child can hop on one foot but cannot skip.

Answer: C

Rationale: Low-set ears are associated with numerous genetic dysmorphisms. Feeding problems could have been due to low birthweight, prematurity, or a variety of other reasons. The height and weight are average for this age. At this age, it is expected for the child to be able to hop on one foot. The child may or may not be able to skip at this age.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Understand

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1815

24. The nurse is assessing a newborn in the delivery room and determines the umbilical cord has a single artery. What further assessment(s) should the nurse complete based on this finding?

Select all that apply.

- A. Anal patency
- B. Cardiac murmurs
- C. Extra digits
- D. Dysmorphic facial features
- E. Cyanosis

Answer: A, B, C, E

Rationale: A single umbilical artery is commonly seen with Vater or VACTERL syndrome. The defects of these syndromes include vertebral defects, anal atresia, tracheoesophageal (TE) fistula or esophageal atresia, radial and renal dysplasia cardiac anomalies and limb deficiencies. The nurse in the delivery room could easily assess the newborn for anal atresia by attempting to insert a rectal thermometer or gloved finger in the anus. If suspected, further testing could be done to confirm. One of the cardiac defects associated with this syndrome is Tetrology of Fallot. Because this is a defect with four components, cyanosis and a murmur could occur. Cyanosis could also occur from a TE fistula, which could cause respiratory distress. Children with this syndrome may

have polydactyly of either fingers or toes. Dysmorphic facial features are not associated with this syndrome.

Question format: Multiple Select

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Apply

Client Needs: Physiological Integrity: Reduction of Risk Potential

Integrated Process: Nursing Process

Reference: p. 1834

25. A child with Apert syndrome is undergoing a craniotomy to reduce the effects of craniosynostosis. During postoperative care it is important for the nurse to include a short-term goal which meets which need?

- A. Management of anemia
- B. Prevention of straining at stool
- C. Increased oxygenation
- D. Decreasing crying

Answer: A

Rationale: During craniosynostosis surgery there is usually a large blood loss. It is important for the nurse to recognize the signs of anemia, notify the health care provider, and intervene to correct the problem. This may mean the administration of blood products, administering oxygen, or obtaining regular laboratory reports to determine the child's hemoglobin and hematocrit levels. Decreasing crying, preventing straining at stool are also important as these will increase intracranial pressure, but too much blood loss can lead to hypovolemic shock and potentially death. Increasing oxygenation may or may not be required. This would depend upon the child's oxygen saturation, breathing difficulties and anemia status.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1835

26. An infant has been diagnosed with galactosemia and placed on a soy formula. When taking the health history, which question should the nurse ask the parent?

- A. "Did you receive a prescription for calcium supplements?"
- B. "Is your infant prescribed a daily vitamin B supplement?"
- C. "Have you been instructed to give your infant folic acid?"
- D. "Were iron supplements prescribed for your infant?"

Answer: A

Rationale: Galactosemia occurs from an inborn error of metabolism where there is a deficiency in a liver enzyme needed to break down galactose to lactose. It can lead to damage to many major organs. The treatment is that the infant should not ingest any dairy products (milk, butter,

cheese, or any food products containing milk). The infant should not breastfeed. The formula is soy milk. Because this diet is limited in calcium this should be supplemented along with vitamin D for adequate bone growth and strength. B vitamins, folic acid and iron are not supplements needed to treat this condition. They should be included in the daily diet.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Apply

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 1837

27. An infant is brought to the clinic for a well child check-up. During the assessment the nurse palpates an enlarged liver and spleen. Based on this finding, what question is essential for the nurse to ask the parent?

- A. "Do you notice any unusual smell from your infant?"
- B. "Have you noticed if your infant's skin is yellow?"
- C. "Is your infant eating well?"
- D. "Has your infant been sick recently?"

Answer: A

Rationale: Hepatosplenomegaly can be an indication the infant has a metabolic disorder. These disorders have associated smells with them. Phenylketonuria smells are musty or mousy odors. The odors associated with maple syrup urine disease is that of burnt sugar, curry or maple syrup. The smells of cabbage or rancid butter are associated with tyrosinemia. The smell of rotting fish is associated with trimethylaminuria. The yellow skin is associated with jaundice. Not eating well could be a sign of illness or infection. Asking the question about recent illness gives more clues as to the overall health of the infant.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Apply

Client Needs: Physiological Integrity: Physiological Adaptation

Integrated Process: Nursing Process

Reference: p. 1816

28. On a routine pregnancy ultrasound at 18 weeks' gestation, the fetus is found to have a mildly enlarged ventricle in the brain. The pregnant client is referred for genetic testing. What testing would most likely be recommended for this client?

- A. Triple screen
- B. Amniocentesis
- C. Chorionic villi sampling
- D. Gene testing

Answer: A

Rationale: A triple/quadruple screen blood test is the least invasive test and is performed before more invasive testing is performed. This test is used for low-risk pregnancies which may be at risk for open neural tube defects, Down syndrome and trisomy 18. The results from this testing do not guarantee the fetus will be born healthy, but an abnormal result does not guarantee the infant will have problems. If this screening test is positive then more invasive testing will be recommended. An amniocentesis is the most common invasive procedure and it can be performed after 15 weeks' gestation. It is useful for high-risk pregnancies to determine chromosomal and congenital defects. Chorionic villi sampling does not detect neural tube defects and can only be performed between 7 and 11 weeks' gestation. Gene testing is used to detect abnormalities in chromosomes and genes. It is used in the diagnosis of an actual disease.

Question format: Multiple Choice

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Understand

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process

Reference: p. 1817

29. The child with a genetic disorder has some gross and fine motor deficits. What recommendation(s) will the nurse provide to the parents to help their child? Select all that apply.
- A. "Physical and occupational therapy may be a good resource for your child."
 - B. "I can help you find adaptive toys for your child."
 - C. "It is important to provide stimulation and interaction with your child."
 - D. "I can refer you to a support group for parents who have a child with similar problems."
 - E. "Praise your child's accomplishments even if they are small."

Answer: A, B, C, E

Rationale: It is important for the nurse to reinforce to the parents that deficits can be improved, even slightly. A physical or occupational therapist can work with the child with activities and exercises to promote function and developmental skills. These activities and exercises can be taught to the parents to be done in the home setting. Adaptive toys and therapeutic play facilitate developmental functioning. Providing a stimulating environment for the child maximizes the potential for growth and development. It is important for the parents to praise the child for accomplishments. This improves the child's self-esteem and encourages feeling of confidence and competence. The parents may need the support of other parents to stay positive and not be overwhelmed, but a referral to a support group affects the child indirectly, not directly. The other options can best help the child.

Question format: Multiple Select

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Apply

Client Needs: Physiological Integrity: Basic Care and Comfort

Integrated Process: Teaching/Learning

Reference: p. 1819

30. A family has been given the news that their expected child has a serious genetic condition. Which therapeutic communication technique(s) will be beneficial for the nurse to use when helping this family? Select all that apply.
- A. "I know you have been given a large amount of information. I am interested in what you think."
 - B. "This has been a lot of information to take in, but if you keep a positive attitude about decisions it will be helpful."
 - C. "I know this news has been hard. I am going to just sit with you and not talk while you begin to process your thoughts."
 - D. "The health care provider suggested you seek genetic testing. Does this make you more upset?"
 - E. "You have been given some sad news today. I think you should take some time before you make a final decision."

Answer: A, C, D

Rationale: Families can become overwhelmed when they are given news about serious conditions that will affect the rest of their child's life. It is very important that the nurse use therapeutic communication techniques while interacting with these families. Stating "I am interested in what you think" is the nurse offering self. This technique allows the nurse to offer his or her presence to the family and show a desire to understand their feelings. Stating "I am going to not talk" is the therapeutic technique of silence. Silence gives the family time to organize their thoughts and feelings. Asking whether the referral for genetic testing makes the family more upset is a way of seeking information. This helps the family to voice their feelings and prevent the nurse from making assumptions. Stating "staying positive" is a nontherapeutic technique that offers no support and may make the family feel guilty if they have negative feelings. Telling the family they need to take some time to make a decision is nontherapeutic because the nurse is advising what the family needs to do instead of allowing the family to make the decision of what length of time they need.

Question format: Multiple Select

Chapter 49: Nursing Care of the Child With an Alteration in Genetics

Cognitive Level: Apply

Client Needs: Psychosocial Integrity

Integrated Process: Communication and Documentation

Reference: p. 1820

Chapter 50

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1850, 1851, Nursing Assessment

1. The nurse is teaching the mother of a 12-year-old boy about the risk factors associated with drug and alcohol abuse. Which response by the mother indicates a need for further teaching?

- A) "A family history of alcoholism is a risk factor for substance abuse."
- B) "Just because his friends are experimenting does not mean that he will."
- C) "If my husband or I have a substance abuse problem it could increase his risk."
- D) "Negative life events are a potential risk factor."

Ans: B

Feedback:

The nurse needs to emphasize that a peer group that abuses substances is a risk factor associated with substance abuse and increases the chances of a child experimenting. Other risk factors include a family history of substance abuse, current parental substance abuse, and negative life events.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1856, Nursing Management

2. The nurse is caring for an adolescent girl with anorexia nervosa. What findings would indicate to the nurse that the girl requires hospitalization?

- A) Weight gain of one-half pound per week
- B) Food refusal
- C) Body mass index of 18
- D) Soft, sparse body hair and dry, sallow skin

Ans: B

Feedback:

Food refusal, severe weight loss, unstable vital signs, arrested pubertal development, and the need for enteral nutrition warrant hospitalization. Soft, sparse body hair and dry, sallow skin are signs of anorexia, but do not warrant hospitalization. A weight gain of one-half pound per week indicates progress toward therapeutic goals. A body mass index of 18 is on the low end of the normal range of body mass.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1858, Types of Anxiety Disorders

3. The nurse is caring for an adolescent girl with a suspected anxiety disorder. The girl states that she is constantly double-checking that she has unplugged her curling iron and must make sure that everything is in perfect order in her room before she leaves the house. The nurse interprets these findings as indicating which disorder?

- A) Generalized anxiety disorder
- B) Posttraumatic stress disorder
- C) Social phobia
- D) Obsessive-compulsive disorder

Ans: D

Feedback:

Obsessive-compulsive disorder is characterized by compulsions (repetitive behaviors such as cleaning, washing, or checking something) to reduce anxiety about obsessions (unwanted and intrusive thoughts). Posttraumatic stress disorder is an anxiety disorder that occurs after a child is subjected to a traumatic event, later experiencing physiologic arousal when a stimulus triggers memories of the event. Generalized anxiety disorder is characterized by unrealistic concerns over past behavior, future events, and personal competency. Social phobia is characterized by a persistent fear of formal speaking, using public restrooms, or eating in front of others.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1854, Tourette Syndrome

4. The nurse is caring for a 7-year-old with Tourette syndrome. The nurse would be alert for which comorbid condition?

- A) Depression
- B) Anxiety disorder
- C) Attention deficit/hyperactivity disorder
- D) Asperger syndrome

Ans: C

Feedback:

Attention deficit/hyperactivity disorder and obsessive-compulsive disorders occur in 50% of children with Tourette syndrome. Depression, anxiety disorder, and Asperger syndrome are not typical comorbid conditions associated with Tourette syndrome.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1847, Goal/Outcome

5. A nurse is caring for a 10-year-old boy with a nursing diagnosis of ineffective coping related to an inability to deal with stressors secondary to anxiety. What action should the nurse take first?

- A) Set clear limits on the child's behavior
- B) Teach the child problem-solving skills
- C) Encourage a discussion of the child's thoughts and feelings
- D) Role model appropriate social and conversation skills

Ans: C

Feedback:

The priority action is to encourage the child to discuss his thoughts and feelings. This is the initial step toward learning to deal with them appropriately. Setting clear limits, teaching problem-solving skills, and role modeling skills would be appropriate as the child begins to learn how to acknowledge and deal with his feelings.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1852, Take Note!

6. The nurse is caring for a 3-year-old boy. The parents are concerned that he is exhibiting signs of cognitive delays. Which statement by the parents would lead the nurse to suspect autism spectrum disorder rather than possible learning disability?

- A) "He is not speaking in complete sentences."
- B) "We can understand a lot of what he says, but no one else can."
- C) "He seems to be speaking words less and less frequently."
- D) "He is unable to sit still for a short story."

Ans: C

Feedback:

Reports of regression or the loss of previously acquired skills points to autism rather than intellectual disability. Not speaking in complete sentences, others not being able to understand what the child is saying, and an inability to sit still for a short story suggest a learning disability.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1843, 1844, Common Medical Treatments, Table 50.1

7. A nurse is caring for a 5-year-old girl with depression. The girl is having difficulty coping with her feelings of sadness and fear, which stem from her parents' separation and recent divorce. The girl has been prescribed antidepressant medication but the mother thinks the girl would benefit from therapy. The nurse anticipates a referral to a therapist that specializes in:

- A) individual therapy.
- B) play therapy.
- C) behavioral therapy.
- D) hypnosis.

Ans: B

Feedback:

Play therapy is designed to change emotional status and encourages the child to act out feelings of sadness, fear, hostility, or anger. It is particularly beneficial for the

younger child. Play therapy, rather than individual therapy, is recommended for the younger child. Hypnosis promotes deep relaxation, which is not the therapeutic goal for this child. Behavioral therapy is used to encourage appropriate behavior and would not address the girl's sadness.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1852, 1853, Attention Deficit/Hyperactivity Disorder, Comparison Chart 50.1

8. The nurse is caring for a 13-year-old boy with a history of inappropriate behavior. Which statement by the mother would lead the nurse to suspect oppositional defiant disorder rather than conduct disorder?

- A) "He has frequent temper tantrums."
- B) "He was pulling the neighbor's dog around by his leash."
- C) "He is constantly lying to me."
- D) "He has stolen hundreds of dollars from my purse."

Ans: A

Feedback:

Reports of frequent temper tantrums point to oppositional defiant disorder rather than conduct disorder. Reports of cruelty to animals, excessive lying, and stealing point to conduct disorder.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1848, 1849, Learning Disabilities, Box 50.1

9. The nurse is caring for a 5 year old. The child's mother reports that he is extremely sensitive to sounds that most people do not notice and that he prefers complete silence. She explains that the boy is resisting going to school due to the noise and commotion. Additionally, the mother states that he will only wear 100% cotton clothing with all of the tags cut out. The nurse interprets these findings as indicating which disorder or condition?

- A) Anxiety disorder
- B) Sensory processing disorder
- C) Depression
- D) Obsessive-compulsive disorder

Ans: B

Feedback:

Sensory processing disorder (sensory integration dysfunction) results in overreaction to different textures and hypersensitivity or hyposensitivity to sensory input. The reported sensitivities to sound and clothing do not point to an anxiety disorder, depression, or obsessive-compulsive disorder.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1843, 1847, Common Medical Treatments, Drug Guide 50.1

10. The nurse is caring for a child with bipolar disorder. The child is taking lithium as ordered. The parents inquire about the potential side effects. Which response by the nurse would be most appropriate?

- A) "You might see excessive urination and thirst, tremor, nausea, weight gain, and diarrhea."
- B) "He might experience a significant decrease in his appetite and difficulty sleeping."
- C) "You need to watch for dry mouth, urinary retention, and constipation."

- D) "This medication can cause seizures, agitation, headache, and nausea."

Ans: A

Feedback:

The nurse needs to explain that the potential side effects of lithium include polyuria, polydipsia, tremors, nausea, weight gain, and diarrhea. Decreased appetite and difficulty sleeping are associated with psychostimulants. Anticholinergic effects such as dry mouth, urinary retention, and constipation are often associated with tricyclic antidepressants as well as α-agonist antihypertensive agents such as clonidine. Seizures, agitation, headache, and nausea are associated with atypical antipsychotic agents.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1843, 1847, Common Medical Treatments, Drug Guide 50.1

11. A child with attention deficit/hyperactivity disorder is prescribed long-acting methylphenidate. What information would the nurse include when teaching the child and his parents about this drug?

- A) "Give the drug three times a day: morning, midday, and after school."
- B) "This drug may cause drowsiness, so be careful when doing things."
- C) "Some increase in appetite may occur, so watch how much you eat."
- D) "Take this drug every day in the morning when you wake up."

Ans: D

Feedback:

Long-acting methylphenidate is administered once daily in the morning, whereas the other forms are given three times a day. The drug typically causes difficulty sleeping and decreased appetite.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1852, Take Note!

12. When reviewing the medical record of a child, what would the nurse interpret as the most sensitive indicator of intellectual disability?

- A) History of seizures
- B) Preterm birth
- C) Vision deficit
- D) Language delay

Ans: D

Feedback:

Due to the extent of cognition required to understand and produce speech, the most sensitive early indicator of intellectual disability is delayed language development. A history of seizures, preterm birth, and vision deficit may be associated with intellectual disability but are not the most sensitive indicators.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1844, Health History

13. A school-age child diagnosed with depression is receiving antidepressant therapy. What behavior would the nurse instruct the parents to watch for and to notify the healthcare provider immediately if the child demonstrates it?

- A) Loss of interest
- B) Gastric upset

- C) Sedation
- D) Urinary retention

Ans: A

Feedback:

Children taking antidepressants are at risk for the development of presuicidal behavior, which may be indicated by a loss of interest or pleasure. Gastric upset, sedation, and urinary retention may or may not occur, but none of these would be as important to report as the potential for self-harm.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1855, Nursing Assessment

14. What would lead the nurse to suspect that an adolescent has bulimia?

- A) Body mass index less than 17
- B) Calluses on back of knuckles
- C) Nail pitting
- D) Bradycardia

Ans: B

Feedback:

The adolescent with bulimia would exhibit calluses on the back of the knuckles and split fingernails and would be of normal weight or slightly overweight. A body mass index of 17, nail pitting, and bradycardia would suggest anorexia.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1843, 1847, Common Medical Treatments, Drug Guide 50.1

15. A child with depression is prescribed fluoxetine. The nurse identifies this as belonging to which class of drugs?

- A) Atypical antidepressant
- B) Tricyclic antidepressant
- C) Selective serotonin reuptake inhibitor
- D) Psychostimulant

Ans: C

Feedback:

Fluoxetine (Prozac) is a selective serotonin reuptake inhibitor. Trazodone is an atypical antidepressant; amitriptyline, desipramine, imipramine, and nortriptyline are tricyclic antidepressants. Methylphenidate and the amphetamines are psychostimulants.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1843, 1844, Common Medical Treatments, Table 50.1

16. A child is receiving therapy in which he is learning to replace automatic negative thought patterns with alternative ones. The nurse interprets this as which type of therapy?

- A) Cognitive therapy
- B) Behavioral therapy
- C) Milieu therapy
- D) Individual therapy

Ans: A

Feedback:

Cognitive therapy teaches children to change reactions so that automatic negative thought patterns are replaced with alternative ones. Behavioral therapy uses stimulus and response conditioning to manage or alter behavior, reinforcing desired behaviors and replacing the inappropriate ones. Milieu therapy involves a specially structured setting designed to promote the child's adaptive and social skills. With individual therapy, the child and therapist work together to resolve the conflicts, emotions, or behavior problems.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1843, Common Medical Treatments

17. A nurse is preparing a program for a parent group about various techniques that can be used to manage behavior. What would the nurse be least likely to include?

- A) Focus the child's attention on the negative behavior.
- B) Set limits with the child for responsible behavior.
- C) Ignore inappropriate behaviors.
- D) Provide positive feedback for self-control efforts.

Ans: A

Feedback:

Behavior management techniques include redirecting the child's attention when needed, setting limits for responsible behavior, ignoring inappropriate behaviors, and providing praise and positive feedback for the child's self-control efforts.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1848, Learning Disabilities

18. The nurse is reviewing the medical record of a child who has dyspraxia. This child will experience difficulty with:

- A) reading and writing.
- B) mathematics and computation.
- C) manual dexterity and coordination.
- D) composition and spelling.

Ans: C

Feedback:

Dyspraxia refers to problems with manual dexterity and coordination. Dyslexia involves difficulty with reading, writing, and spelling. Dyscalculia involves problems with mathematics and computation. Dysgraphia involves difficulty producing the written word in composition, spelling, and writing.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1853, Take Note!

19. A nurse is conducting a screening program for autism in infants and children. What would the nurse identify as a warning sign?

- A) Lack of babbling by 6 months
- B) Inability to say a single word by 16 months
- C) Lack of gestures by 8 months

- D) Inability to use two words by 18 months

Ans: B

Feedback:

Warning signs of autism include no babbling by 12 months, no pointing or using gestures by 12 months, no single words by 16 months, no two-word utterances by 24 months, and loss of language or social skills at any age.

Format: Multiple Select

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1852, Attention Deficit/Hyperactivity Disorder

20. A nurse is preparing a teaching session for a group of parents with children newly diagnosed with attention deficit/hyperactivity disorder (ADHD). When explaining this disorder to the parents, what would the nurse include as being involved? Select all that apply.

- A) Impulsivity
- B) Inattention
- C) Distractibility
- D) Hyperactivity
- E) Defiance
- F) Anxiety

Ans: A, B, C, D

Feedback:

ADHD is characterized by inattention, impulsivity, distractibility, and hyperactivity. Anxiety disorder and oppositional defiant disorder may be comorbidities associated with ADHD.

Format: Multiple Select

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Communication/Documentation

Page and Header: 1855, Nursing Management

21. A school nurse is working with the parents of an 8-year-old who has Tourette syndrome on how best to accommodate the child. What advice would be most helpful? Select all that apply.

- A) Allowing for breaks when tics occur
- B) Providing for "time-outs" during the day
- C) Using a tape recorder to take notes
- D) Ensuring a specified amount of time for test taking
- E) Implementing a reward system for behavior

Ans: A, C

Feedback:

Together the school nurse and parents should arrange for classroom accommodations such as allowing for "tic breaks," taking untimed tests or tests in another room, or using note takers or tape recorders. Time-outs and reward systems are more appropriate for the child with ADHD.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1854, Nursing Assessment

22. When assessing the adolescent with anorexia, what would the nurse expect to find?

- A) Tachycardia

- B) Hypertension
- C) Fever
- D) Sparse body hair

Ans: D

Feedback:

An adolescent with anorexia often exhibits a low body temperature; bradycardia; and hypotension; as well as soft, sparse body hair and thinning scalp hair.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1854, Nursing Management

23. After teaching the parents of a child with attention deficit/hyperactivity disorder about ways to control the child's behavior, the nurse determines a need for additional teaching when the parents state:

- A) "If he starts to act out, we'll have him do a time-out to help him refocus."
- B) "We can use a reward system when he behaves appropriately."
- C) "If he misbehaves, we need to punish him instead of reward him."
- D) "We need to help him set realistic goals that he can achieve."

Ans: C

Feedback:

Punishment for misbehaving would be inappropriate because it would lead to negative feelings and further decrease self-esteem. Appropriate behavior management strategies include time-outs, positive reinforcement, reward or privilege withdrawal, or a token system. Setting realistic goals also is helpful to foster self-esteem and independence.

Format: Multiple Select

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1852, 1853, Attention Deficit/Hyperactivity Disorder, Comparison Chart 50.1

24. A nurse is reviewing the medical record of an 11-year-old child with a conduct disorder. What would the nurse identify as characteristics of this disorder? Select all that apply.

- A) Easily annoyed
- B) Initiator of physical fights
- C) Temper tantrums
- D) Truancy
- E) Arrest for arson

Ans: B, D, E

Feedback:

Behaviors associated with conduct disorder include initiation of physical fights, arson, and truancy. Becoming easily annoyed and experiencing temper tantrums are associated with oppositional defiant disorder.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1846, Interventions with Rationale: Promoting Appropriate Social Interaction

25. The nurse identifies a nursing diagnosis of impaired social interaction related to altered social skills as evidenced by impulsivity and intrusive behavior. The nurse plans to identify factors that aggravate the child's behavior for which reason?

- A) Minimize stimuli that exacerbate the child's undesired behaviors.
- B) Improve the child's ability to deal with external stressors.
- C) Promote increased ability to follow through.
- D) Encourage the child to adopt expectations into his routine.

Ans: A

Feedback:

The nurse identifies aggravating factors to help minimize stimuli that exacerbate the child's undesired behaviors. This must be accomplished first before any other interventions would be effective. Improving the child's ability to deal with external stressors is achieved by modifying the environment to decrease distracting stimuli. Actions such as speaking directly to the child and maintaining eye contact promote engagement and an increased ability to follow through. Providing positive feedback encourages the child to adopt expectations into his routine.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1843, 1847, Common Medical Treatments, Drug Guide 50.1

26. A child is prescribed trazodone. What would the nurse be least likely to include in the plan of care related to this drug?

- A) Monitoring blood pressure for orthostatic hypotension
- B) Assessing the child for sedation and drowsiness
- C) Administering the drug with a snack
- D) Monitoring for tardive dyskinesia

Ans: D

Feedback:

Trazodone does not cause tardive dyskinesia; antipsychotics do. It can cause orthostatic hypotension, sedation, and drowsiness. It should be given after meals or with snacks to minimize gastrointestinal upset.

Format: Multiple Select

Client Needs: Psychosocial Integrity

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1843, Common Medical Treatments

27. The nurse is preparing an educational program on behavioral management techniques used in children to help alter negative behavior. What information should the nurse include? Select all that apply.

- A) Set limits and hold the child responsible for their behavior.
- B) Do not argue, bargain, or negotiate about the limits once established.
- C) Change caregivers occasionally so the child learns to respond to different people.
- D) Use a high-pitched voice and remain calm when speaking with the child.
- E) Ignore inappropriate behaviors.

Ans: A, B

Feedback:

Behavior management techniques include setting limits and holding the child responsible for his or her behavior. Not arguing, bargaining, or negotiating about the limits once established. Inappropriate behaviors should be ignored. Provide consistent caregivers and establish a daily routine. Use a low-pitched, not high-pitched voice and remain calm when speaking with the child.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Analyze

Integrated Process: Nursing process

Page and Header: 1852, 1853, Attention Deficit/Hyperactivity Disorder, Comparison Chart 50.1

28. The nurse is speaking with a parent regarding their child's recent diagnosis of oppositional defiant disorder. Which statement by the parent would cause the nurse to question the diagnosis?

- A) "I am so tired of arguing with my daughter all the time."
- B) "My son purposely does exactly the opposite of what his father tells him to do."
- C) "I feel so bad that my daughter intentionally hurt the neighbor's cat."
- D) "My daughter gets so annoyed at me when she doesn't get her way."

Ans: C

Feedback:

Common behaviors in oppositional defiant disorder include excessive arguing with adults, active defiance, noncompliance with adult requests or limits and easily annoyed. Physical cruelty to animals or people is associated with conduct disorder, not oppositional defiant disorder.

Format: Multiple Select

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1843, 1847, Common Medical Treatments, Drug Guide 50.1

29. The nurse is caring for a child who takes dextroamphetamine for treatment of ADHD. Which comments by the client or family would concern the nurse? Select all that apply.

- A) "I take my sustained released capsule at night before I go to bed."

- B) "We have noticed that our child shows very little emotion over the last few weeks."
- C) "I haven't noticed any difference in my appetite."
- D) "Sometimes my head hurts a little for a short time after I take my medicine."
- E) "We notice our child gets a little irritable occasionally."

Ans: A, B

Feedback:

Psychostimulants, such as dextroamphetamine, should be taken in the morning in order to avoid difficulty sleeping. A flat affect is a sign of dosages that are too high. Decreased appetite, headache, and irritability are common side effects.

Format: Multiple Choice

Client Needs: Psychosocial Integrity

Cognitive Level: Remember

Integrated Process: Caring

Page and Header: 1843, 1844, Common Medical Treatments, Table 50.1

30. The nurse working in a pediatric mental health clinic is assessing a 4-year-old child who has suffered from physical abuse. Which type of therapy does the nurse anticipate will be most helpful in developing a trusting relationship as well as assisting in determining the client's current emotional state?

- A) Behavioral therapy
- B) Play therapy
- C) Cognitive behavioral therapy
- D) Family therapy

Ans: B

Feedback:

Play therapy will be most helpful, especially in the initial phase of assessment, because it encourages the child to act out feelings of sadness, fear, hostility, or anger.

Chapter 51

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1867, Health History

1. The nurse is caring for a 6-year-old girl who was injured in a bicycle accident. Which question would be most important for the nurse to ask during the health history?

- A) "Has she been diagnosed with any chronic disorders?"
- B) "Is your daughter currently taking any medications?"
- C) "Is she allergic to any medications or drugs?"
- D) "Tell me how the bicycle accident happened."

Ans: D

Feedback:

The priority inquiry is to determine the nature of the emergency so that appropriate interventions may be initiated. This will also provide direction for obtaining more in-depth information as time permits. Information about allergic reactions to drugs, medications being taken, and chronic disorders that may affect treatment will be gathered next.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1879, 1884, Laboratory and Diagnostic Testing, Box 51.1

2. The nurse is caring for a 7-year-old boy experiencing respiratory distress who is scheduled to have a chest radiograph. What would be most important for the nurse to include in the child's plan of care?

- A) Administering a sedative to help calm the child
- B) Assisting the child to lie still during the chest radiograph
- C) Accompanying the child to continue observation
- D) Informing the child that he might hear a loud banging noise

Ans: B

Feedback:

Chest radiographs that disclose alterations in normal anatomy or lung expansion, or evidence of pneumonia, tumor, or foreign body, are commonly performed for respiratory emergencies. Therefore, the nurse would need to assist the child in remaining still during the procedure. A sedative may be ordered for magnetic resonance imaging (MRI). Accompanying the child to continue observation would be necessary if the child was to undergo a computed tomography scan. Telling the child about a loud banging noise would be appropriate if the child was having an MRI.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1866, 1884, Common Medical Treatments, Box 51.1

3. A 5-year-old girl is cyanotic, dusky, and anxious when she arrives in the emergency department. Which action would be most appropriate?

- A) Ventilating the child with a bag-valve-mask
- B) Estimating the child's weight using a Broselow tape
- C) Providing therapy using automated external defibrillation
- D) Using rescue breathing and chest compressions

Ans: A

Feedback:

The child is exhibiting signs of ineffective oxygenation and ventilation. Therefore, ventilating the child with a bag-valve-mask and 100% oxygen would be effective and efficient. Estimating the child's weight with a Broselow tape is typically done by ambulatory care providers. According to the American Heart Association, automated external defibrillators are recommended for use in children who are older than age 1 year who have no pulse and have suffered a sudden, witnessed collapse outside the hospital setting. Rescue breathing and chest compressions are implemented for children who are not breathing and do not have a pulse or when the pulse rate is less than 60 beats per minute.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1886, Shock

4. When caring for an 8-year-old boy injured in an automobile accident, the nurse demonstrates understanding of the principles of Pediatric Advanced Life Support (PALS) by which action?

- A) Assisting ventilation with a bag-valve-mask (BVM) device
- B) Treating ventricular fibrillation using a defibrillator
- C) Managing compensated shock to prevent decompensated shock
- D) Treating supraventricular tachycardia using cardioversion

Ans: C

Feedback:

The principles of PALS stress evaluating and managing compensated shock with the goal of preventing decompensated shock and thereby preventing cardiopulmonary arrest. Assisting ventilation with a BVM device, treating ventricular fibrillation using a defibrillator, and treating supraventricular tachycardia using cardioversion are interventions that may be used to treat both children and adults.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1867, Airway Evaluation and Management

5. A 9-year-old girl who has fallen from a second-story window is brought to the emergency department. Which assessment would be the priority?

- A) Evaluating pupils for equality and reactivity
- B) Monitoring oxygen saturation levels
- C) Asking the child if she knows where she is
- D) Using the appropriate pain assessment scale

Ans: B

Feedback:

Airway is always the priority in any emergency situation. Therefore, monitoring oxygen saturation levels, part of the rapid cardiopulmonary assessment, would be performed before any of the other assessments. Evaluating pupils for equality and reactivity, asking the child if she knows where she is, and using an appropriate pain assessment scale are assessments that would follow the ABCs.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Safety and Infection Control

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1877, Physical Examination

6. The parents bring their 3-year-old son to the emergency department after he ingested some of his mother's medicine. Which assessment would be of critical importance for this child?

- A) Assessing mental status and skin moisture and color
- B) Evaluating the effectiveness of the child's breathing
- C) Noting the child's pulse rate and quality
- D) Auscultating all lung fields for signs of edema

Ans: A

Feedback:

In cases of poisoning, clinical manifestations vary widely depending on the medication or chemical ingested. Therefore, it is important to pay particular attention to the child's mental status, skin moisture and color, and bowel sounds. Evaluating the effectiveness of the child's breathing and noting the child's pulse rate and quality are basic to any rapid cardiopulmonary assessment. Auscultating all lung fields for signs of pulmonary edema would be critically important for a child who is a near-drowning victim.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1892, Managing Bradyarrhythmias

7. What would the nurse do first for a 5-year-old girl with profound bradycardia?

- A) Provide oxygen at 100%
- B) Administer epinephrine as ordered
- C) Use warming blankets
- D) Perform gastric lavage

Ans: A

Feedback:

The most common cause of profound bradycardia is respiratory compromise, hypoxia, and shock; thus, oxygenation and ventilation are the priorities. If the

bradycardia persists, the next step would be to administer epinephrine or atropine as ordered. Hypothermia or toxic ingestion can cause bradycardia. Treating the underlying problem will relieve the bradycardia.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1884, Ensuring and Maintaining Correct Tube Placement

8. Which measure would be most appropriate for the nurse to do to ensure that a child's endotracheal (ET) tube is correctly positioned?

- A) Auscultate for abdominal breath sounds
- B) Mark the tracheal tube at the child's lip
- C) Watch for a yellow display on a CO₂ monitor
- D) Inspect for water vapor in the tracheal tube

Ans: C

Feedback:

The best way to verify correct tracheal tube placement is to use a CO₂ monitor. If the tube is properly placed, the monitor display will turn yellow with each exhalation. Auscultation for breath sounds and inspecting the tube for signs of water vapor are valid confirmations, but not as good as CO₂ monitors. Marking the tube alerts the nurse if the tube becomes misplaced.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1882, Preventing Complications Related to Bag-Valve-Mask Ventilation

9. Which intervention would be most helpful in preventing barotrauma when ventilating a 3-year-old girl with a bag-valve-mask?

- A) Choosing the correct size bag and face mask
- B) Setting the flow rate at exactly 10 L/minute
- C) Maintaining the airway in the open position
- D) Delivering one breath every 3 to 5 seconds

Ans: D

Feedback:

Barotrauma is often the result of healthcare provider or nurse practitioners ventilating the child too rapidly using too much tidal volume. Therefore, delivering one breath every 3 to 5 seconds is the best way to prevent barotrauma. Choosing the correct size bag and face mask and setting the correct flow rate are important for effective ventilation, as is maintaining the airway in the open position. However, these actions would have little impact on preventing barotrauma.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1890, Tachyarrhythmias

10. The nurse is providing care to a 4-year-old boy with a broken arm and an infected laceration from a fall. The nurse notes a significant elevation in the child's heart rate. Which intervention would be least appropriate?

- A) Administering antipyretics as ordered for fever
- B) Using a defibrillator to reduce the heart rate
- C) Administering analgesics to reduce pain
- D) Allowing the parents to comfort the child

Ans: B

Feedback:

Fever, fear, and pain are common explanations for significant increases in the heart rate of a child. This normal elevation in heart rate is known as sinus tachycardia and can be managed by treating the underlying causes. Antipyretics, analgesics, and comfort from the parents would be appropriate. However, defibrillation should be avoided.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1871, Providing Defibrillation or Synchronized Cardioversion

11. A child weighing 51 lb (23.1 kg) requires defibrillation. How many joules would the nurse expect to give initially?

- A) 46
- B) 92
- C) 102
- D) 204

Ans: A

Feedback:

The initial amount of energy or joules for defibrillation is 2 joules/kg. The child weighs 51 lb, which is 23 kg, so 46 joules would be used.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1877, Inspection and Observation

12. A 1-month-old infant admitted to the emergency department in respiratory distress exhibits a regular pattern of breathing followed by brief periods of apnea, then tachypnea for a short time, eventually returning to a normal respiratory rate. This type of breathing is:

- A) hypoventilation.
- B) hyperventilation.
- C) periodic breathing
- D) stridor.

Ans: C

Feedback:

Periodic breathing is regular breathing with occasional short pauses followed by rapid breathing for a short period, then eventually resumption of a normal respiratory rate. Hypoventilation refers to a decrease in the depth and rate of respirations. Hyperventilation refers to an increased depth and rate of respirations. Stridor refers to a high-pitched, easily audible inspiratory noise.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Safety and Infection Control

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1882, Setting Up Equipment

13. The nurse is gathering the necessary equipment for tracheal intubation for a child who is 2 years old. Which tracheal tube size would the nurse obtain?

- A) 4.5
- B) 5
- C) 5.5
- D) 6

Ans: A

Feedback:

To calculate tracheal tube size, divide the child's age by 4 and add 4. For a 2-year-old child, 2 divided by 4 equals 0.5 plus 4 equals 4.5. The nurse also should have one size smaller ready.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1890, Tachyarrhythmias, Comparison Chart 51.3

14. What would lead the nurse to suspect that a 5-year-old child is experiencing supraventricular tachycardia?

- A) Heart rate 160 beats per minute
- B) Flattened P waves
- C) Normal QRS complex
- D) History of fever

Ans: B

Feedback:

Supraventricular tachycardia is manifested by flattened P waves, a heart rate greater than 180 beats per minute, a narrow QRS complex, and usually no significant history. A heart rate of 160 beats per minute, normal QRS complex, and history of fever, fluid loss, hypoxia, pain, or fear would suggest sinus tachycardia.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction of Risk Potential

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1879, Nursing Management

15. What would be most appropriate to use to help maintain a patent airway in an infant experiencing a respiratory emergency?

- A) Neck hyperextension
- B) Head tilt-chin lift technique
- C) Jaw-thrust maneuver
- D) Small towel under shoulders

Ans: D

Feedback:

The infant will benefit from a small sheet or towel folded under the shoulders. This facilitates keeping the infant's airway in the sniff position as recommended by the American Heart Association's Basic Cardiac Life Support guidelines. Neck hyperextension and flexion should be avoided because these may occlude the airway. The head tilt-chin lift technique is appropriate to open the airway of a child older than age 1 year if a cervical spine injury is not suspected. The jaw-thrust maneuver is used if there is concern about the cervical spine.

Format: Multiple Choice

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1887, Types of Shock

16. After teaching a group of nursing students about shock in children, the instructor determines that the teaching was successful when the students identify which type of shock as most common?

- A) Septic
- B) Cardiogenic
- C) Hypovolemic
- D) Distributive

Ans: C

Feedback:

Although septic, cardiogenic, hypovolemic, and distributive shock can occur in children, hypovolemic shock is the most common type of shock that occurs in children.

Format: Multiple Choice

Client Needs: Physiological Integrity: Reduction for Risk Potential

Cognitive Level: Analyze

Integrated Process: Nursing Process

Page and Header: 1888, Restoring Fluid Volume

17. A child who weighs 53 lb is receiving fluid volume replacement as part of the treatment for shock. The nurse is evaluating the child's hourly urinary output to determine if the child's condition is improving. Which output would the nurse interpret as most indicative of improvement?

- A) 12 mL
- B) 15 mL
- C) 22 mL
- D) 30 mL

Ans: D

Feedback:

Improved urinary output of 1 to 2 mL/kg/hour is the goal. The child weighs 53 lb, which is equivalent to 24 kg. Thus, improvement in this child would be noted by an hourly urinary output between 24 and 48 mL/hour.

Format: Multiple Select

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1866, 1884, Common Medical Treatments, Box 51.1

18. A child has a tracheal tube in place and will be receiving medications via this tube. Which medications would the nurse expect to be administered in this manner? Select all that apply.

- A) Lidocaine
- B) Adenosine
- C) Atropine
- D) Dopamine
- E) Epinephrine
- F) Naloxone

Ans: A, C, E, F

Feedback:

Medications that may be administered via a tracheal tube include lidocaine, epinephrine, atropine, and naloxone. Adenosine is given intravenously; dopamine is given intravenously or intraosseously.

Format: Multiple Select

Client Needs: Physiological Integrity: Physiological Adaptation

Cognitive Level: Understand

Integrated Process: Teaching/Learning

Page and Header: 1878, Respiratory Arrest, Table 51.2

19. A group of students are reviewing information about respiratory arrest in children. The students demonstrate understanding of this information when they identify what common causes of respiratory arrest involving the upper airway? Select all that apply.

- A) Croup
- B) Asthma
- C) Pertussis

- D) Epiglottitis
- E) Pneumothorax

Ans: A, D

Feedback:

Common causes of respiratory arrest involving the upper airway include croup and epiglottitis. Asthma, pertussis, and pneumothorax are common causes involving the lower airway.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1879, Nursing Management

20. The nurse is preparing the plan of care for a child experiencing respiratory distress. What action would be the top priority?

- A) Providing supplemental oxygen
- B) Monitoring for changes in status
- C) Assisting ventilation
- D) Maintaining a patent airway

Ans: D

Feedback:

The priority when caring for any child with respiratory distress is to maintain a patent airway. Although providing supplemental oxygen, monitoring for changes in status, and assisting with ventilation are important, these measures would be futile if the child's airway was not patent.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1884, Monitoring the Child Who Is Intubated

21. The nurse is providing care to a child who is intubated, and the child's condition is deteriorating. What would the nurse do first?

- A) Check if the tracheal tube is obstructed
- B) Assess for displacement of the tracheal tube
- C) Look for signs of a possible pneumothorax
- D) Check the equipment for malfunction

Ans: B

Feedback:

The PALS mnemonic "DOPE" is useful for troubleshooting when the status of a child who is intubated deteriorates: D = Displacement: the tracheal tube is displaced from the trachea; O = Obstruction: the tracheal tube is obstructed (e.g., with a mucus plug); P = Pneumothorax: usually a pneumothorax results in a sudden change in the child's assessment manifested by decreased breath sounds and decreased chest expansion on the side of the pneumothorax, possible subcutaneous emphysema over the chest (with a tension pneumothorax, there may be a sudden drop in heart rate and blood pressure); E = Equipment failure: relatively simple problems such as a disconnected oxygen supply, leaks in the ventilator circuit, and loss of power can cause the child to deteriorate.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1888, Restoring Fluid Volume

22. The nurse is providing care to a child experiencing shock. Which intravenous solution would the nurse expect to administer?

- A) Ringer lactate

- B) Dextrose 5% and water
- C) Dextrose 5% and normal saline
- D) Dextrose 10% and water

Ans: A

Feedback:

Isotonic fluids, such as Ringer lactate or normal saline, are the fluids of choice given rapidly to children experiencing shock. Dextrose solutions are contraindicated in shock because of the risk of complications such as osmotic diuresis, hypokalemia, hyperglycemia, and worsening of ischemic brain injury

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1897, Take Note!

23. A child is brought to the emergency department with a suspected poisoning. What treatment would the nurse least likely expect to be used?

- A) Gastric lavage
- B) Syrup of ipecac
- C) Activated charcoal
- D) Whole bowel irrigation

Ans: B

Feedback:

Ipecac is rarely used in the health care setting to induce vomiting and is no longer recommended for use in the home setting. Gastric lavage, administration of activated charcoal (binds with the chemical substance in the bowel), or whole bowel irrigation with polyethylene glycol electrolyte solutions may be used.

Format: Multiple Choice

Client Needs: Health Promotion and Maintenance

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1897, Trauma

24. A group of students are working on a presentation for a local health fair about safety for children. When developing this presentation, the students would address what cause as the most common in pediatric injury?

- A) Sports
- B) Firearm use
- C) Falls
- D) Automobile accidents

Ans: C

Feedback:

Falls are the most common cause of pediatric injury. Automobile accidents continue to cause deaths of about five children daily. Childhood trauma also results from pedestrian accidents, sporting and bicycle injuries, and firearm use.

Format: Multiple Choice

Client Needs: Physiological Integrity: Basic Care and Comfort

Cognitive Level: Apply

Integrated Process: Teaching/Learning

Page and Header: 1871, Providing Cardiopulmonary Resuscitation, Table 51.1

25. As part of their orientation to their pediatric clinical rotation, an instructor is teaching a group of students how to perform cardiopulmonary resuscitation (CPR) on a child. Two students return demonstrate the skill using an infant manikin. What action indicates the proper technique?

- A) Compressing 30 times for every 2 breaths

- B) Placing the heel of the hand on the midsternum
- C) Giving 2 breaths followed by 15 compressions
- D) Using two hands to perform chest compressions

Ans: C

Feedback:

For two-person CPR on an infant, the rescuers would perform 15 compressions to 2 breaths, with two thumbs encircling the chest at the nipple line. The ratio of 30 compressions to 2 breaths is used for one-person CPR with an infant. The heel of the hand on the sternum at the nipple line is used for a child; two hands would be used for an older child.

Format: Multiple Choice

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

Cognitive Level: Understand

Integrated Process: Nursing Process

Page and Header: 1883, 1885, Administering Medications, Table 51.5

26. A child is undergoing rapid sequence intubation and is receiving atropine. The nurse understands that this agent is used to:

- A) lessen the vagal effects of intubation.
- B) reduce intracranial pressure.
- C) induce amnesia.
- D) provide short-term paralysis.

Ans: A

Feedback:

Atropine is used to decrease respiratory secretions and mitigate the vagal effects of intubation. Thiopental reduces intracranial pressure and oxygen demand.

Midazolam causes amnesia. Rocuronium or other neuromuscular blocking agents provide short-term paralysis during intubation.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1892, 1894, Managing Tachyarrhythmias, Table 51.6

27. A nurse determines that a child is exhibiting compensated supraventricular tachycardia (SVT). What action would be attempted first?

- A) Adenosine
- B) Synchronized cardioversion
- C) Vagal maneuvers
- D) Amiodarone

Ans: C

Feedback:

With compensated supraventricular tachycardia, vagal maneuvers are attempted first and then adenosine is used if vagal maneuvers fail. Adenosine or synchronized cardioversion is used to treat uncompensated SVT; synchronized cardioversion and IV amiodarone are used to treat ventricular tachycardia.

Format: Multiple Select

Client Needs: Safe and Effective Care Environment: Safety and Infection Control

Cognitive Level: Remember

Integrated Process: Teaching/Learning

Page and Header: 1872, Using Automated External Defibrillation

28. The nurse is teaching a CPR course for a group of nursing students. Which responses indicate an understanding of the content provided regarding the AED? Select all that apply.

- A) "When considering the use of the AED, the child must weigh at least 30 lb (13.6 kg)."

- B) "An AED must only be employed if the collapse is witnessed."
- C) "To use the device the child must be at least 1 year of age."
- D) "The AED can be used only if the victim demonstrates no heart rate."
- E) "The AED is safe for use prehospital."

Ans: B, C, D, E

Feedback:

An AED is an alternative to manually defibrillating an individual. The AED device consists of electrodes that are applied to the chest. These electrodes are used to monitor the heart rhythm and deliver the electrical current. AED devices are readily available in a variety of locations, such as airports, sports facilities, and businesses. Additionally, the AHA has recommended that an AED be used for children who are older than age 1 year who have no pulse and have suffered a sudden, witnessed collapse.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1866, Introduction

29. A nurse has just transferred from an adult medical-surgical unit to a pediatric unit. When reviewing CPR skills, what it is important for the nurse to realize?

- A) The pediatric chain of survival and the adult chain of survival are the same.
- B) Prevention of cardiac arrest and injuries is the first step in the chain of survival for children.
- C) Integrated post-cardiac arrest care is not part of the chain of survival for children.
- D) Early CPR should occur before any steps of the chain of survival are considered.

Ans: B

Feedback:

Prevention of cardiac arrest and injuries is the first step in the chain of survival in children in contrast to early emergency medical system (EMS) activation in adults. Integrated post-cardiac arrest care is the last step in the chain for both adults and children. Early CPR is the second step in the chain for both adults and children.

Format: Multiple Choice

Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Apply

Integrated Process: Nursing Process

Page and Header: 1867, Health History

30. Two nurses are driving to work and have just come upon the scene of a motor vehicle accident (MVA) involving a child being hit by a car. The nurses decide to stop and find that only the child was injured. One of the nurses begins providing care. What is the first question the other nurse should ask the witnesses of the accident?

- A) "Can I get your name and numbers in case someone needs to contact you later?"
- B) "How did the accident happen?"
- C) "Do you know if the children have any health history I should know about?"
- D) "How long ago did someone activate the EMS?"

Ans: B

Feedback:

The first question should be asking how the accident occurred in order to get an idea of the types of injuries the children may have sustained. All other questions can be asked after establishing this information; however, asking names and numbers of the witnesses would be the last question asked by the nurse, and would most likely be asked by someone else.