Chapter 04: Communication and Physical Assessment of the Child and Family
Hockenberry: Wong's Essentials of Pediatric Nursing, 10th Edition

MULTIPLE CHOICE

1. The nurse is seeing an adolescent boy and his parents in the clinic for the first time. What should the nurse do first?
   a. Introduce self.
   b. Make family comfortable.
   c. Explain purpose of interview.
   d. Give assurance of privacy.

   ANS: A
   The first thing that nurses should do is to introduce themselves to the patient and family. Parents and other adults should be addressed with appropriate titles unless they specify a preferred name. During the initial part of the interview, the nurse should include general conversation to help make the family feel at ease. Clarification of the purpose of the interview and the nurse's role is the next thing that should be done. The interview should take place in an environment as free of distraction as possible. In addition, the nurse should clarify which information will be shared with other members of the health care team and any limits to the confidentiality.

   DIF: Cognitive Level: Apply REF: p. 57
   TOP: Integrated Process: Communication and Documentation
   MSC: Area of Client Needs: Psychosocial Integrity

2. Which is most likely to encourage parents to talk about their feelings related to their child's illness?
   a. Be sympathetic.
   b. Use direct questions.
   c. Use open-ended questions.
   d. Avoid periods of silence.

   ANS: C
   Closed-ended questions should be avoided when attempting to elicit parents' feelings. Open-ended questions require the parent to respond with more than a brief answer. Sympathy is having feelings or emotions in common with another person rather than understanding those feelings (empathy). Sympathy is not therapeutic in helping the relationship. Direct questions may obtain limited information. In addition, the parent may consider them threatening. Silence can be an effective interviewing tool. It allows sharing of feelings in which two or more people absorb the emotion in depth. Silence permits the interviewee to sort out thoughts and feelings and search for responses to questions.

   DIF: Cognitive Level: Apply REF: p. 58
   TOP: Integrated Process: Communication and Documentation
   MSC: Area of Client Needs: Psychosocial Integrity

3. Which communication technique should the nurse avoid when interviewing children and their families?
   a. Using silence
   b. Using clichés
   c. Directing the focus
   d. Defining the problem

   ANS: B
   Using stereotyped comments or clichés can block effective communication, and this technique should be avoided. After use of such trite phrases, parents will often not respond. Silence can be an effective interviewing tool. Silence permits the interviewee to sort out thoughts and feelings and search for responses to questions. To be effective, the nurse must be able to direct the focus of the interview while allowing maximal freedom of expression. By using open-ended questions, along with guiding questions, the nurse can obtain the necessary information and maintain the relationship with the family. The nurse and parent must collaborate and define the problem that will be the focus of the nursing intervention.

   DIF: Cognitive Level: Understand REF: p. 59
   TOP: Integrated Process: Communication and Documentation
   MSC: Area of Client Needs: Psychosocial Integrity

4. What is the single most important factor to consider when communicating with children?
   a. The child's physical condition
   b. Presence or absence of the child's parent
   c. The child's developmental level
   d. The child's nonverbal behaviors

   ANS: C
   The nurse must be aware of the child's developmental stage to engage in effective communication. The use of both verbal and nonverbal communication should be appropriate to the developmental level. Although the child's physical condition is a consideration, developmental level is much more important. The parents' presence is important when communicating with young children but may be detrimental when speaking with adolescents. Nonverbal behaviors will vary in importance, based on the child's developmental level.

   DIF: Cognitive Level: Understand REF: p. 60
   TOP: Integrated Process: Communication and Documentation
   MSC: Area of Client Needs: Psychosocial Integrity

5. Which approach would be best to use to ensure a positive response from a toddler?
   a. Assume an eye-level position and talk quietly.
   b. Call the toddler's name while picking him or her up.
   c. Call the toddler's name and say, "I'm your nurse."
   d. Stand by the toddler, addressing him or her by name.

   ANS: A

It is important that the nurse assume a position at the child's level when communicating with the child. By speaking quietly and focusing on the child, the nurse should be able to obtain a positive response. The nurse should engage the child and inform the toddler what is going to occur. If the nurse picks up the child without explanation, the child is most likely going to become upset. The toddler may not understand the meaning of the phrase, "I'm your nurse." If a positive response is desired, the nurse should assume the child's level when speaking if possible.

DIF: Cognitive Level: Apply REF: p. 60
TOP: Integrated Process: Communication and Documentation
MSC: Area of Client Needs: Psychosocial Integrity

6. What is an important consideration for the nurse who is communicating with a very young child?
   a. Speak loudly, clearly, and directly.
   b. Use transition objects, such as a doll.
   c. Disguise own feelings, attitudes, and anxiety.
   d. Initiate contact with child when parent is not present.

ANS: B
Using a transition object allows the young child an opportunity to evaluate an unfamiliar person (the nurse). This will facilitate communication with a child this age. Speaking in this manner will tend to increase anxiety in very young children. The nurse must be honest with the child. Attempts at deception will lead to a lack of trust. Whenever possible, the parent should be present for interactions with young children.

DIF: Cognitive Level: Understand REF: p. 61
TOP: Integrated Process: Nursing Process: Planning
MSC: Area of Client Needs: Psychosocial Integrity

7. A nurse is preparing to assess a 3-year-old child. What communication technique should the nurse use for this child?
   a. Focus communication on child.
   b. Explain experiences of others to child.
   c. Use easy analogies when possible.
   d. Assure child that communication is private.

ANS: A
Because children of this age are able to see things only in terms of themselves, the best approach is to focus communication directly on them. Children should be provided with information about what they can do and how they will feel. With children who are egocentric, experiences of others, analogies, and assurances that the communication is private will not be effective because the child is not capable of understanding.

DIF: Cognitive Level: Apply REF: p. 61
TOP: Integrated Process: Communication and Documentation
MSC: Area of Client Needs: Psychosocial Integrity

8. A nurse is assigned to four children of different ages. In which age group should the nurse understand that body integrity is a concern?
   a. Toddler
   b. Preschooler
   c. School-age child
   d. Adolescent

   ANS: C
   School-age children have a heightened concern about body integrity. They place importance and value on their bodies and are oversensitive to anything that constitutes a threat or suggestion of injury. Body integrity is not as important a concern to toddlers, preschoolers, or adolescents.

   DIF: Cognitive Level: Understand REF: p. 61
   TOP: Integrated Process: Nursing Process: Planning
   MSC: Area of Client Needs: Health Promotion and Maintenance

9. An 8-year-old girl asks the nurse how the blood pressure apparatus works. What is the most appropriate nursing action?
   a. Ask her why she wants to know.
   b. Determine why she is so anxious.
   c. Explain in simple terms how it works.
   d. Tell her she will see how it works as it is used.

   ANS: C
   School-age children require explanations and reasons for everything. They are interested in the functional aspect of all procedures, objects, and activities. It is appropriate for the nurse to explain how equipment works and what will happen to the child. A nurse should respond positively for requests for information about procedures and health information. By not responding, the nurse may be limiting communication with the child. The child is not exhibiting anxiety, just requesting clarification of what will be occurring. The nurse must explain how the blood pressure cuff works so that the child can then observe during the procedure.

   DIF: Cognitive Level: Apply REF: p. 61
   TOP: Integrated Process: Teaching/Learning
   MSC: Area of Client Needs: Health Promotion and Maintenance

10. When the nurse interviews an adolescent, which is especially important?
    a. Focus the discussion on the peer group.
    b. Allow an opportunity to express feelings.
    c. Emphasize that confidentiality will always be maintained.
    d. Use the same type of language as the adolescent.

    ANS: B

Adolescents, like all children, need an opportunity to express their feelings. Often they will interject feelings into their words. The nurse must be alert to the words and feelings expressed. Although the peer group is important to this age group, the focus of the interview should be on the adolescent. The nurse should clarify which information will be shared with other members of the health care team and any limits to confidentiality. The nurse should maintain a professional relationship with adolescents. To avoid misinterpretation of words and phrases that the adolescent may use, the nurse should clarify terms frequently.

DIF: Cognitive Level: Understand REF: p. 62
TOP: Integrated Process: Communication and Documentation
MSC: Area of Client Needs: Psychosocial Integrity

11. The nurse is having difficulty communicating with a hospitalized 6-year-old child. What technique might be most helpful?
    a. Suggest that the child keep a diary.
    b. Suggest that the parent read fairy tales to the child.
    c. Ask the parent if the child is always uncommunicative.
    d. Ask the child to draw a picture.

ANS: D
Drawing is one of the most valuable forms of communication. Children's drawings tell a great deal about them because they are projections of the child's inner self. It would be difficult for a 6-year-old child who is most likely learning to read to keep a diary. Parents reading fairy tales to the child is a passive activity involving the parent and child. It would not facilitate communication with the nurse. The child is in a stressful situation and is probably uncomfortable with strangers.

DIF: Cognitive Level: Apply REF: p. 64
TOP: Integrated Process: Communication and Documentation
MSC: Area of Client Needs: Psychosocial Integrity

12. The nurse is meeting a 5-year-old child for the first time and would like the child to cooperate during a dressing change. The nurse decides to do a simple magic trick using gauze. How should this action be interpreted?
    a. Inappropriate, because of child's age
    b. A way to establish rapport
    c. Too distracting, when cooperation is important
    d. Acceptable, if there is adequate time

ANS: B
A magic trick or other simple game may help alleviate anxiety for a 5-year-old. It is an excellent method to build rapport and facilitate cooperation during a procedure. Magic tricks appeal to the natural curiosity of young children. The nurse should establish rapport with the child. Failure to do so may cause the procedure to take longer and be more traumatic.

DIF: Cognitive Level: Analyze REF: p. 64
TOP: Integrated Process: Communication and Documentation
MSC: Area of Client Needs: Psychosocial Integrity

13. The nurse must assess a 10-month-old infant. The infant is sitting on the father's lap and appears to be afraid of the nurse and of what might happen next. Which initial action by the nurse would be most appropriate?
    a. Initiate a game of peek-a-boo.
    b. Ask father to place the infant on the examination table.
    c. Undress the infant while he is still sitting on his father's lap.
    d. Talk softly to the infant while taking him from his father.

    ANS: A
    Peek-a-boo is an excellent means of initiating communication with infants while maintaining a safe, nonthreatening distance. The child will most likely become upset if separated from his father. As much of the assessment as possible should be done on the father's lap. The nurse should have the father undress the child as needed for the examination.

    DIF: Cognitive Level: Apply REF: p. 62
    TOP: Integrated Process: Communication and Documentation
    MSC: Area of Client Needs: Psychosocial Integrity

14. The nurse is taking a health history on an adolescent. Which best describes how the chief complaint should be determined?
    a. Ask for detailed listing of symptoms.
    b. Ask adolescent, "Why did you come here today?"
    c. Use what adolescent says to determine, in correct medical terminology, what the problem is.
    d. Interview parent away from adolescent to determine chief complaint.

    ANS: B
    The chief complaint is the specific reason for the child's visit to the clinic, office, or hospital. Because the adolescent is the focus of the history, this is an appropriate way to determine the chief complaint. A detailed listing of symptoms will make it difficult to determine the chief complaint. The adolescent should be prompted to tell which symptom caused him to seek help at this time. The chief complaint is usually written in the words that the parent or adolescent uses to describe the reason for seeking help. The parent and adolescent may be interviewed separately, but the nurse should determine the reason the adolescent is seeking attention at this time.

    DIF: Cognitive Level: Apply REF: p. 62
    TOP: Integrated Process: Nursing Process: Assessment
    MSC: Area of Client Needs: Health Promotion and Maintenance

15. Where in the health history should the nurse describe all details related to the chief complaint?
    a. Past history
    b. Chief complaint
    c. Present illness
    d. Review of systems

    ANS: C

The history of the present illness is a narrative of the chief complaint from its earliest onset through its progression to the present. The focus of the present illness is on all factors relevant to the main problem, even if they have disappeared or changed during the onset, interval, and present. Past history refers to information that relates to previous aspects of the child's health, not to the current problem. The chief complaint is the specific reason for the child's visit to the clinic, office, or hospital. It does not contain the narrative portion describing the onset and progression. The review of systems is a specific review of each body system.

DIF: Cognitive Level: Understand REF: p. 64
TOP: Integrated Process: Communication and Documentation
MSC: Area of Client Needs: Health Promotion and Maintenance

16. The nurse is interviewing the mother of an infant. She reports, "I had a difficult delivery, and my baby was born preterm." This information should be recorded under which of the following headings?
    a. Past history
    b. Present illness
    c. Chief complaint
    d. Review of systems

ANS: A
The past history refers to information that relates to previous aspects of the child's health, not to the current problem. The mother's difficult delivery and prematurity are important parts of the past history of an infant. The history of the present illness is a narrative of the chief complaint from its earliest onset through its progression to the present. Unless the chief complaint is directly related to the prematurity, this information is not included in the history of present illness. The chief complaint is the specific reason for the child's visit to the clinic, office, or hospital. It would not include the birth information. The review of systems is a specific review of each body system. It does not include the preterm birth. Sequelae such as pulmonary dysfunction would be included.

DIF: Cognitive Level: Understand REF: p. 65
TOP: Integrated Process: Communication and Documentation
MSC: Area of Client Needs: Health Promotion and Maintenance

17. Which is most important to document about immunizations in the child's health history?
    a. Dosage of immunizations received
    b. Occurrence of any reaction after an immunization
    c. The exact date the immunizations were received
    d. Practitioner who administered the immunizations

ANS: B
The occurrence of any reaction after an immunization was given is the most important to document in a history because of possible future reactions, especially allergic reactions. Exact dosage of the immunization received may not be recorded on the immunization record. Exact dates are important to obtain but not as important as a history of reaction to an immunization. The practitioner who administered the immunization does not need to be recorded in the health history. A potentially severe physiologic response is the most threatening and most important information to document for safety reasons.

DIF: Cognitive Level: Analyze REF: p. 65
TOP: Integrated Process: Communication and Documentation
MSC: Area of Client Needs: Health Promotion and Maintenance

18. When interviewing the mother of a 3-year-old child, the nurse asks about developmental milestones such as the age of walking without assistance. How should this question be considered?
    a. Unnecessary information because child is age 3 years
    b. An important part of the family history
    c. An important part of the child's past history
    d. An important part of the child's review of systems

    ANS: C
    Information about the attainment of developmental milestones is important to obtain. It provides data about the child's growth and development that should be included in the past history. Developmental milestones provide important information about the child's physical, social, and neurologic health and should be included in the history for a 3-year-old child. If pertinent, attainment of milestones by siblings would be included in the family history. The review of systems does not include the developmental milestones.

    DIF: Cognitive Level: Understand REF: p. 65
    TOP: Integrated Process: Communication and Documentation
    MSC: Area of Client Needs: Health Promotion and Maintenance

19. The nurse is taking a sexual history on an adolescent girl. Which is the best way to determine whether she is sexually active?
    a. Ask her, "Are you sexually active?"
    b. Ask her, "Are you having sex with anyone?"
    c. Ask her, "Are you having sex with a boyfriend?"
    d. Ask both the girl and her parent whether she is sexually active.

    ANS: B
    Asking the adolescent girl whether she is having sex with anyone is a direct question that is well understood. The phrase *sexually active* is broadly defined and may not provide specific information to the nurse to provide necessary care. The word *anyone* is preferred to using gender-specific terms such as boyfriend or girlfriend. Because homosexual experimentation may occur, it is preferable to use gender-neutral terms. Questioning about sexual activity should occur when the adolescent is alone.

    DIF: Cognitive Level: Apply REF: p. 65
    TOP: Integrated Process: Nursing Process: Assessment
    MSC: Area of Client Needs: Health Promotion and Maintenance

20. When doing a nutritional assessment on a Hispanic family, the nurse learns that their diet consists mainly of vegetables, legumes, and starches. How should the nurse assess this diet?
    a. Indicates they live in poverty
    b. Is lacking in protein
    c. May provide sufficient amino acids

d. Should be enriched with meat and milk

ANS: C
The diet that contains vegetable, legumes, and starches may provide sufficient essential amino acids, even though the actual amount of meat or dairy protein is low. Many cultures use diets that contain this combination of foods. It is not indicative of poverty. Combinations of foods contain the essential amino acids necessary for growth. A dietary assessment should be done, but many vegetarian diets are sufficient for growth.

DIF: Cognitive Level: Understand REF: p. 66
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

21. Which following parameters correlates best with measurements of the body's total protein stores?
a. Height
b. Weight
c. Skinfold thickness
d. Upper arm circumference

ANS: D
Upper arm circumference is correlated with measurements of total muscle mass. Muscle serves as the body's major protein reserve and is considered an index of the body's protein stores. Height is reflective of past nutritional status. Weight is indicative of current nutritional status. Skinfold thickness is a measurement of the body's fat content.

DIF: Cognitive Level: Understand REF: p. 72
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

22. A nurse is preparing to perform a physical assessment on a toddler. Which approach should the nurse use for this child?
a. Always proceed in a head-to-toe direction.
b. Perform traumatic procedures first.
c. Use minimal physical contact initially.
d. Demonstrate use of equipment.

ANS: C
Parents can remove clothing, and the child can remain on the parent's lap. The nurse should use minimal physical contact initially to gain the child's cooperation. The head-to-toe assessment can be done in older children but usually must be adapted in younger children. Traumatic procedures should always be performed last. These will most likely upset the child and inhibit cooperation. The nurse should introduce the equipment slowly. The child can inspect the equipment, but demonstrations are usually too complex for toddlers.

DIF: Cognitive Level: Apply REF: p. 77
TOP: Integrated Process: Nursing Process: Planning
MSC: Area of Client Needs: Health Promotion and Maintenance

23. The nurse is preparing to perform a physical assessment on a 10-year-old girl. The nurse gives her the option of her mother either staying in the room or leaving. How should this action be interpreted?
    a. Appropriate because of child's age
    b. Appropriate because mother would be uncomfortable making decisions for child
    c. Inappropriate because of child's age
    d. Inappropriate because child is same sex as mother

    ANS: A
    The older school-age child should be given the option of having the parent present or not. During the examination, the nurse should respect the child's need for privacy. Although the question was appropriate for the child's age, the mother is responsible for making decisions for the child. It is appropriate because of the child's age. During the examination, the nurse must respect the child's privacy. The child should help determine who is present during the examination.

    DIF: Cognitive Level: Apply REF: p. 77
    TOP: Integrated Process: Nursing Process: Assessment
    MSC: Area of Client Needs: Health Promotion and Maintenance

24. A nurse is counseling parents of a child beginning to show signs of being overweight. The nurse accurately relates which body mass index (BMI)-for-age percentile indicates a risk for being overweight?
    a. 10th percentile
    b. 9th percentile
    c. 85th percentile
    d. 95th percentile

    ANS: C
    Children who have BMI-for-age greater than or equal to the 85th percentile and less than the 95th percentile are at risk for being overweight. Children in the 9th and 10th percentiles are within normal limits. Children who are greater than or equal to the 95th percentile are considered overweight.

    DIF: Cognitive Level: Apply REF: p. 79
    TOP: Integrated Process: Nursing Process: Implementation
    MSC: Area of Client Needs: Health Promotion and Maintenance

25. The nurse is using the Centers for Disease Control and Prevention (CDC) growth chart for an African-American child. Which statement should the nurse consider?
    a. This growth chart should not be used.
    b. Growth patterns of African-American children are the same as for all other ethnic groups.
    c. A correction factor is necessary when the CDC growth chart is used for non-Caucasian ethnic groups.
    d. The CDC charts are accurate for US African-American children.

    ANS: D

The CDC growth charts can serve as reference guides for all racial or ethnic groups. US African-American children were included in the sample population. The growth chart can be used with the perspective that different groups of children have varying normal distributions on the growth curves. No correction factor exists.

DIF: Cognitive Level: Understand REF: p. 77
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

26. Which tool measures body fat most accurately?
    a. Stadiometer
    b. Calipers
    c. Cloth tape measure
    d. Paper or metal tape measure

ANS: B
Calipers are used to measure skinfold thickness, which is an indicator of body fat content. Stadiometers are used to measure height. Cloth tape measures should not be used because they can stretch. Paper or metal tape measures can be used for recumbent lengths and other body measurements that must be made.

DIF: Cognitive Level: Understand REF: p. 80
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

27. The nurse is using calipers to measure skinfold thickness over the triceps muscle in a school-age child. What is the purpose of doing this?
    a. To measure body fat
    b. To measure muscle mass
    c. To determine arm circumference
    d. To determine accuracy of weight measurement

ANS: A
Measurement of skinfold thickness is an indicator of body fat. Arm circumference is an indirect measure of muscle mass. The accuracy of weight measurement should be verified with a properly balanced scale. Body fat is just one indicator of weight.

DIF: Cognitive Level: Remember REF: p. 80
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

28. A nurse notes that a 10-month-old infant has a larger head circumference than chest. The nurse interprets this as a normal finding because the head and chest circumference become equal at which age?
    a. 1 month
    b. 6 to 9 months
    c. 1 to 2 years
    d. 2½ to 3 years

ANS: C
Head circumference begins larger than chest circumference. Between ages 1 and 2 years, they become approximately equal. Head circumference is larger than chest circumference before age 1. Chest circumference is larger than head circumference at $2\frac{1}{2}$ to 3 years.

DIF: Cognitive Level: Remember REF: p. 80
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

29. Which would be best for the nurse to use when determining the temperature of a preterm infant under a radiant heater?
a. Axillary sensor
b. Tympanic membrane sensor
c. Rectal mercury glass thermometer
d. Rectal electronic thermometer

ANS: A
The axillary sensor measures the infrared heat energy radiating from the axilla. It can be used on wet skin, in incubators, or under radiant warmers. Ear thermometry does not show sufficient correlation with established methods of measurement. It should not be used when body temperature must be assessed with precision. Mercury thermometers should never be used. The release of mercury, should the thermometer be broken, can cause harmful vapors. Rectal temperatures should be avoided unless no other suitable way exists for the temperature to be measured.

DIF: Cognitive Level: Apply REF: p. 85
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

30. What is the earliest age at which a satisfactory radial pulse can be taken in children?
a. 1 year
b. 2 years
c. 3 years
d. 6 years

ANS: B
Satisfactory radial pulses can be used in children older than 2 years. In infants and young children, the apical pulse is more reliable. The apical pulse can be used for assessment at these ages.

DIF: Cognitive Level: Remember REF: p. 103
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

31. Pulses can be graded according to certain criteria. Which is a description of a normal pulse?
a. 0
b. +1
c. +2
d. +3

ANS: D
A normal pulse is described as +3. A pulse that is easy to palpate and not easily obliterated with pressure is considered normal. A pulse graded 0 is not palpable. A pulse graded +1 is difficult to palpate, thready, weak, and easily obliterated with pressure. A pulse graded +2 is difficult to palpate and may be easily obliterated with pressure.

DIF: Cognitive Level: Remember REF: p. 85
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

32. Where is the best place to observe for the presence of petechiae in dark-skinned individuals?
a. Face
b. Buttocks
c. Oral mucosa
d. Palms and soles

ANS: C
Petechiae, small distinct pinpoint hemorrhages, are difficult to see in dark skin unless they are in the mouth or conjunctiva.

DIF: Cognitive Level: Remember REF: p. 89
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

33. The nurse observes yellow staining in the sclera of eyes, soles of feet, and palms of hands. How should the nurse document these findings?

a. Normal
b. Erythema
c. Jaundice
d. Ecchymosis

ANS: C
Jaundice is defined as the yellow staining of the skin, usually by bile pigments. Yellow staining is not a normal appearance of the skin. Erythema is redness that results from increased blood flow to the area. Ecchymosis is large, diffuse areas, usually black and blue, caused by hemorrhage of blood into the skin.

DIF: Cognitive Level: Understand REF: p. 89
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

34. When palpating the child's cervical lymph nodes, the nurse notes that they are tender, enlarged, and warm. What is the best explanation for this?
a. Some form of cancer
b. Local scalp infection common in children
c. Infection or inflammation distal to the site
d. Infection or inflammation close to the site

ANS: D

Small nontender nodes are normal. Tender, enlarged, and warm lymph nodes may indicate infection or inflammation close to their location. Tender lymph nodes are not usually indicative of cancer. A scalp infection would usually not cause inflamed lymph nodes. The lymph nodes close to the site of inflammation or infection would be inflamed.

DIF: Cognitive Level: Analyze REF: p. 89
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

35. During a routine health assessment, the nurse notes that an 8-month-old infant has significant head lag. Which is the nurse's most appropriate action?
    a. Teach parents appropriate exercises.
    b. Recheck head control at next visit.
    c. Refer child for further evaluation.
    d. Refer child for further evaluation if anterior fontanel is still open.

ANS: C
Significant head lag after age 6 months strongly indicates cerebral injury and is referred for further evaluation. Reduction of head lag is part of normal development. Exercises will not be effective. The lack of achievement of this developmental milestone must be evaluated.

DIF: Cognitive Level: Apply REF: p. 89
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

36. The nurse has just started assessing a young child who is febrile and appears very ill. There is hyperextension of the child's head (opisthotonos) with pain on flexion. Which is the most appropriate action?
    a. Refer for immediate medical evaluation.
    b. Continue assessment to determine cause of neck pain.
    c. Ask parent when neck was injured.
    d. Record "head lag" on assessment record, and continue assessment of child.

ANS: A
Hyperextension of the child's head with pain on flexion is indicative of meningeal irritation and needs immediate evaluation; it is not descriptive of head lag. The pain is indicative of meningeal irritation. No indication of injury is present.

DIF: Cognitive Level: Apply REF: p. 90
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

37. At what age should the nurse expect the anterior fontanel to close?
    a. 2 months
    b. 2 to 4 months
    c. 6 to 8 months
    d. 12 to 18 months

ANS: D

The anterior fontanel normally closes between ages 12 and 18 months. Two to 8 months is too early. The expected closure of the anterior fontanel occurs between ages 12 and 18 months; if it closes between ages 2 and 8 months, the child should be referred for further evaluation.

DIF: Cognitive Level: Remember REF: p. 90
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

38. During a funduscopic examination of a school-age child, the nurse notes a brilliant, uniform red reflex in both eyes. How should the nurse interpret this finding?
    a. Normal finding
    b. Abnormal finding, so child needs referral to ophthalmologist
    c. Sign of possible visual defect, so child needs vision screening
    d. Sign of small hemorrhages, which will usually resolve spontaneously

    ANS: A
    A brilliant, uniform red reflex is an important normal finding. It rules out many serious defects of the cornea, aqueous chamber, lens, and vitreous chamber.

    DIF: Cognitive Level: Understand REF: p. 91
    TOP: Integrated Process: Nursing Process: Assessment
    MSC: Area of Client Needs: Health Promotion and Maintenance

39. Parents of a newborn are concerned because the infant's eyes often "look crossed" when the infant is looking at an object. The nurse's response is that this is normal based on the knowledge that binocularity is normally present by what age?
    a. 1 month
    b. 3 to 4 months
    c. 6 to 8 months
    d. 12 months

    ANS: B
    Binocularity is usually achieved by ages 3 to 4 months. 1 month is too young. If binocularity is not achieved by ages 6 to 12 months, the child must be observed for strabismus.

    DIF: Cognitive Level: Understand REF: p. 91
    TOP: Integrated Process: Nursing Process: Assessment
    MSC: Area of Client Needs: Health Promotion and Maintenance

40. A nurse is preparing to test a school-age child's vision. Which eye chart should the nurse use?
    a. Denver Eye Screening Test
    b. Allen picture card test
    c. Ishihara vision test
    d. Snellen letter chart

    ANS: D
    The Snellen letter chart, which consists of lines of letters of decreasing size, is the most frequently used test for visual acuity for school-age children. Single cards (Denver—letter E; Allen—pictures) are used for children ages 2 years and older who are unable to use the Snellen letter chart. The Ishihara vision test is used for color vision.

DIF: Cognitive Level: Apply REF: p. 92
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

41. Which is the most appropriate vision acuity test for a child who is in preschool?
    a. Cover test
    b. Ishihara test
    c. HOTV chart
    d. Snellen letter chart

ANS: C
The HOTV test consists of a wall chart of these letters. The child is asked to point to a corresponding card when the examiner selects one of the letters on the chart. The cover test determines ocular alignment. The Ishihara test is used for the detection of color blindness. The Snellen letter chart is usually used for older children.

DIF: Cognitive Level: Understand REF: p. 93
TOP: Integrated Process: Nursing Process: Planning
MSC: Area of Client Needs: Health Promotion and Maintenance

42. The nurse is testing an infant's visual acuity. By what age should the infant be able to fix on and follow a target?
    a. 1 month
    b. 1 to 2 months
    c. 3 to 4 months
    d. 6 months

ANS: C
Visual fixation and following a target should be present by ages 3 to 4 months. One to 2 months is too young for this developmental milestone. If the infant is not able to fix and follow by 6 months, further ophthalmologic evaluation is needed.

DIF: Cognitive Level: Understand REF: p. 93
TOP: Integrated Process: Nursing Process: Problem Identification
MSC: Area of Client Needs: Health Promotion and Maintenance

43. Where is the appropriate placement of a tongue blade for assessment of the mouth and throat?
    a. Center back area of tongue
    b. Side of the tongue
    c. Against the soft palate
    d. On the lower jaw

ANS: B
Side of the tongue is the correct position. It avoids the gag reflex yet allows visualization. Placement in the center back area of the tongue will elicit the gag reflex. Against the soft palate and on the lower jaw are not appropriate places for the tongue blade.

DIF: Cognitive Level: Understand REF: p. 98
TOP: Integrated Process: Nursing Process: Assessment

MSC: Area of Client Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

44. What is an appropriate screening test for hearing that can be administered by the nurse to a 5-year-old child?
    a. The Rinne test
    b. The Weber test
    c. Conventional audiometry
    d. Eliciting the startle reflex

    ANS: C
    Conventional audiometry is a behavioral test that measures auditory thresholds in response to speech and frequency-specific stimuli presented through earphones. The Rinne and Weber tests measure bone conduction of sound. Eliciting the startle reflex may be useful in infants.

    DIF: Cognitive Level: Understand REF: p. 97
    TOP: Integrated Process: Nursing Process: Assessment
    MSC: Area of Client Needs: Health Promotion and Maintenance

45. What type of breath sound is normally heard over the entire surface of the lungs except for the upper intrascapular area and the area beneath the manubrium?
    a. Vesicular
    b. Bronchial
    c. Adventitious
    d. Bronchovesicular

    ANS: A

    Vesicular breath sounds are heard over the entire surface of lungs, with the exception of the upper intrascapular area and the area beneath the manubrium. Bronchial breath sounds are heard only over the trachea near the suprasternal notch. Adventitious breath sounds are not usually heard over the chest. These sounds occur in addition to normal or abnormal breath sounds. Bronchovesicular breath sounds are heard over the manubrium and in the upper intrascapular regions where trachea and bronchi bifurcate.

    DIF: Cognitive Level: Remember REF: p. 101
    TOP: Integrated Process: Nursing Process: Assessment
    MSC: Area of Client Needs: Health Promotion and Maintenance

46. A nurse is assessing a patient admitted for an asthma exacerbation. Which breath sounds does the nurse expect to assess?
    a. Rubs
    b. Rattles
    c. Wheezes
    d. Crackles

    ANS: C

Asthma causes bronchoconstriction and narrowed passageways. Wheezes are produced as air passes through narrowed passageways. Rubs are the sound created by the friction of one surface rubbing over another. Pleural friction rub is caused by inflammation of the pleural space. Rattles is the term formerly used for crackles. Crackles are the sounds made when air passes through fluid or moisture.

DIF: Cognitive Level: Analyze REF: p. 102
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

47. While caring for a critically ill child, the nurse observes that respirations are gradually increasing in rate and depth, with periods of apnea. What pattern of respiration will the nurse document?
    a. Dyspnea
    b. Tachypnea
    c. Cheyne-Stokes respirations
    d. Seesaw (paradoxic) respirations

    ANS: C
    Cheyne-Stokes respirations are a pattern of respirations that gradually increase in rate and depth, with periods of apnea. Dyspnea is defined as distress during breathing. Tachypnea is an increased respiratory rate. In seesaw respirations, the chest falls on inspiration and rises on expiration.

    DIF: Cognitive Level: Understand REF: p. 102
    TOP: Integrated Process: Communication and Documentation
    MSC: Area of Client Needs: Health Promotion and Maintenance

48. How does the nurse assess a child's capillary refill time?
    a. Inspecting the chest
    b. Auscultating the heart
    c. Palpating the apical pulse
    d. Palpating the skin to produce a slight blanching

    ANS: D
    Capillary refill time is assessed by pressing lightly on the skin to produce blanching, and then noting the amount of time it takes for the blanched area to refill. Inspecting the chest, auscultating the heart, and palpating the apical pulse will not provide an assessment of capillary refill time.

    DIF: Cognitive Level: Understand REF: p. 102
    TOP: Integrated Process: Nursing Process: Assessment
    MSC: Area of Client Needs: Health Promotion and Maintenance

49. A nurse is assessing a child with an unrepaired ventricular septal defect. Which heart sound does the nurse expect to assess?
    a. S_3
    b. S_4
    c. Murmur

d. Physiologic splitting

ANS: C
Murmurs are the sounds that are produced in the heart chambers or major arteries from the back-and-forth flow of blood. These are the sounds expected to be heard in a child with a ventricular septal defect because of the abnormal opening between the ventricles. S_3 is a normal heart sound sometimes heard in children. S_4 is rarely heard as a normal heart sound. If heard, medical evaluation is required. Physiologic splitting is the distinction of the two sounds in S_2, which widens on inspiration. It is a significant normal finding.

DIF: Cognitive Level: Analyze REF: p. 103
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

50. The nurse has determined the rate of both the child's radial pulse and heart. What is the normal finding when comparing the two rates?
a. Are the same
b. Differ, with heart rate faster
c. Differ, with radial pulse faster
d. Differ, depending on quality and intensity

ANS: A
Pulses are the fluid wave through the blood vessel as a result of each heartbeat. Therefore, they should be the same.

DIF: Cognitive Level: Understand REF: p. 103

TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

51. A nurse is performing an otoscopic exam on a school-age child. Which direction should the nurse pull the pinna for this age of child?
a. Up and back
b. Down and back
c. Straight back
d. Straight up

ANS: A
With older children, usually those older than 3 years of age, the canal curves downward and forward. Therefore, pull the pinna *up* and *back* during otoscopic examinations. In infants, the canal curves upward. Therefore, pull the pinna *down* and *back* to straighten the canal. Pulling the pinna straight back or straight up will not open the inner ear canal.

DIF: Cognitive Level: Understand REF: p. 95
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

52. The nurse has a 2-year-old boy sit in "tailor" position during palpation for the testes. What is the rationale for this position?
a. It prevents cremasteric reflex.
b. Undescended testes can be palpated.

c. This tests the child for an inguinal hernia.
d. The child does not yet have a need for privacy.

ANS: A
The tailor position stretches the muscle responsible for the cremasteric reflex. This prevents its contraction, which pulls the testes into the pelvic cavity. Undescended testes cannot be predictably palpated. Inguinal hernias are not detected by this method. This position is used for inhibiting the cremasteric reflex. Privacy should always be provided for children.

DIF: Cognitive Level: Understand REF: p. 107
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

53. During examination of a toddler's extremities, the nurse notes that the child is bowlegged. What should the nurse recognize regarding this finding?
a. Abnormal and requires further investigation
b. Abnormal unless it occurs in conjunction with knock-knee
c. Normal if the condition is unilateral or asymmetric
d. Normal because the lower back and leg muscles are not yet well developed

ANS: D
Lateral bowing of the tibia (bowlegged) is common in toddlers when they begin to walk. It usually persists until all their lower back and leg muscles are well developed. Further evaluation is needed if it persists beyond ages 2 to 3 years, especially in African-American children.

DIF: Cognitive Level: Understand REF: p. 108
TOP: Integrated Process: Nursing Process: Problem Identification
MSC: Area of Client Needs: Health Promotion and Maintenance

54. At about what age does the Babinski sign disappear?
a. 4 months
b. 6 months
c. 1 year
d. 2 years

ANS: C
The presence of the Babinski reflex after about age 1 year, when walking begins, is abnormal. Four to 6 months is too young for the disappearance of the Babinski reflex. Persistence of the Babinski reflex requires further evaluation.

DIF: Cognitive Level: Understand REF: p. 109
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

55. A 5-year-old girl is having a checkup before starting kindergarten. The nurse asks her to do the "finger-to-nose" test. What is the nurse testing for?
a. Deep tendon reflexes
b. Cerebellar function
c. Sensory discrimination

d. Ability to follow directions

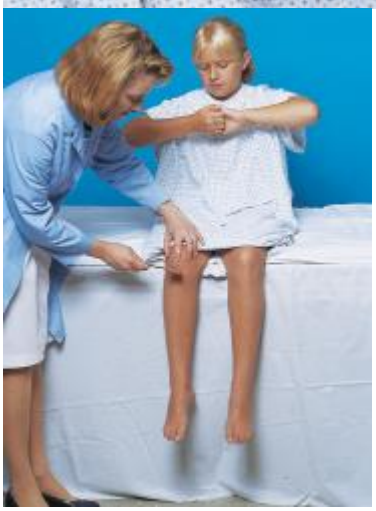
ANS: B
The finger-to-nose test is an indication of cerebellar function. This test checks balance and coordination. Each deep tendon reflex is tested separately. Each sense is tested separately. Although this test enables the nurse to evaluate the child's ability to follow directions, it is used primarily for cerebellar function.

DIF: Cognitive Level: Apply REF: p. 109
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

56. Which figure depicts a nurse performing a test for the triceps reflex?

a. 

b. 

c. 

d. 

ANS: A
To test the triceps reflex, the child is placed supine, with the forearm resting over the chest and the triceps tendon is struck with the reflex hammer. The other figures depict tests for biceps reflex (slightly above the antecubital space) patellar (knee), and Achilles (behind the foot).

DIF: Cognitive Level: Analyze REF: p. 110
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. The nurse must check vital signs on a 2-year-old boy who is brought to the clinic for his 24-month checkup. What criteria should the nurse use in determining the appropriate-size blood pressure cuff? (*Select all that apply.*)
   a. The cuff is labeled "toddler."
   b. The cuff bladder width is approximately 40% of the circumference of the upper arm.
   c. The cuff bladder length covers 80% to 100% of the circumference of the upper arm.
   d. The cuff bladder covers 50% to 66% of the length of the upper arm.

   ANS: B, C
   Research has demonstrated that cuff selection with a bladder width that is 40% of the arm circumference will usually have a bladder length that is 80% to 100% of the upper arm circumference. This size cuff will most accurately reflect measured radial artery pressure. The name of the cuff is a representative size that may not be suitable for any individual child. Choosing a cuff by limb circumference more accurately reflects arterial pressure than choosing a cuff by length.

   DIF: Cognitive Level: Understand REF: p. 86
   TOP: Integrated Process: Nursing Process: Assessment
   MSC: Area of Client Needs: Health Promotion and Maintenance

2. Which of the following data would be included in a health history? (*Select all that apply.*)
   a. Review of systems
   b. Physical assessment
   c. Sexual history
   d. Growth measurements
   e. Nutritional assessment
   f. Family medical history

   ANS: A, C, E, F
   The review of systems, sexual history, nutritional assessment, and family medical history are part of the health history. Physical assessment and growth measurements are components of the physical examination.

   DIF: Cognitive Level: Apply REF: p. 64
   TOP: Integrated Process: Nursing Process: Assessment
   MSC: Area of Client Needs: Health Promotion and Maintenance

3. A nurse is performing an assessment on a school-age child. Which findings suggest the child is getting an excess of vitamin A? (*Select all that apply.*)
   a. Delayed sexual development
   b. Edema
   c. Pruritus
   d. Jaundice
   e. Paresthesia

   ANS: A, C, D

   Excess vitamin A can cause delayed sexual development, pruritus, and jaundice. Edema is seen with excess sodium. Paresthesia occurs with excess riboflavin.

   DIF: Cognitive Level: Apply REF: p. 73
   TOP: Integrated Process: Nursing Process: Assessment
   MSC: Area of Client Needs: Health Promotion and Maintenance

4. A nurse is planning to use an interpreter during a health history interview of a non-English speaking patient and family. Which nursing care guidelines should the nurse include when using an interpreter? (*Select all that apply.*)
   a. Elicit one answer at a time.
   b. Interrupt the interpreter if the response from the family is lengthy.
   c. Comments to the interpreter about the family should be made in English.
   d. Arrange for the family to speak with the same interpreter, if possible.
   e. Introduce the interpreter to the family.

   ANS: A, D, E

When using an interpreter, the nurse should pose questions to elicit only one answer at a time, such as: “Do you have pain?” rather than “Do you have any pain, tiredness, or loss of appetite?” Refrain from interrupting family members and the interpreter while they are conversing. Introduce the interpreter to family and allow some time before the interview for them to become acquainted. Refrain from interrupting family members and the interpreter while they are conversing. Avoid commenting to the interpreter about family members because they may understand some English.

DIF: Cognitive Level: Apply REF: p. 60
TOP: Integrated Process: Nursing Process: Assessment
MSC: Area of Client Needs: Health Promotion and Maintenance

OTHER

1. What is the correct sequence used when performing an abdominal assessment? Begin with the first technique and end with the last. Provide answer using lowercase letters separated by commas (e.g., a, b, c, d).

   a. Auscultation
   b. Palpation
   c. Inspection
   d. Percussion

   ANS:
   c, a, d, b

   The correct order of abdominal examination is inspection, auscultation, percussion, and palpation. Palpation is always performed last because it may distort the normal abdominal sounds.

   DIF: Cognitive Level: Apply REF: p. 104
   TOP: Integrated Process: Nursing Process: Assessment
   MSC: Area of Client Needs: Health Promotion and Maintenance