

Which client requires immediate intervention by the RN?

- A. A child with cystic fibrosis who is constipated.
- B. A toddler with chicken pox who is scratching.
- C. **A child with acute renal failure and hyperkalemia.**
- D. An adolescent with a migraine and photophobia.

A 7 year old male is referred to the school clinic because he fainted on the playground. His height is 3 feet, 7 inches (107.5 cm), he weighs 55 pounds (25 kilograms), and his body mass index (BMI) is 20.9. Which assessment finding is most important for the RN to address?

- A. He consumed 2 bottles of water in 30 minutes prior to fainting.
- B. Since age 3 he has experienced exercise induced asthma.
- C. Reports drinking 3-4 high calorie, carbonated beverages daily.
- D. The child's father has a history of fainting when exercising.

The RN of a 6 year old girl is concerned about her child's obesity. The child's weight plots at the 75th percentile, and height at the 25th percentile. The child's body mass index (BMI) is at the 85th percentile for age and gender. Which interventions should the RN implement? (Select All That Apply)

- A. Explain that the child is likely to grow into her weight.
- B. **Determine the child's usual physical activity pattern.**
- C. **Obtain the child's 3- day diet history based on the mothers input.**
- D. **Inquire as to whether or not the school has a physical education program.**
- E. Tell the mother that girls hit their growth spurt before boys so eating more is expected.

(B, C, and D) are correct. The child's growth parameters, particularly her BMI, indicate that she is overweight. (B and D) assess for the child's level of activity, which should be evaluated and increased if possible. (C) Provides information about the quantity and quality of the child's dietary intake, which is information that is needed to create an individualized diet teaching plan. (A) Does not consider the serious health and psychological consequences associated with childhood obesity. Girls do not hit their growth spurt before boys in preadolescence, but this child is only 6 years of age and the child's obesity should not be negated because of this growth and development expectation. (e)

A toddler with hemophilia is being discharged from the hospital. Which teaching should the RN include in the discharge instructions to the mother?

- A. **Apply padding on the sharp corners of the furniture.**

- B. Prevent the client from running inside the house.
- C. Give an 81 mg tablet of aspirin for pain relief.
- D. Use a soft bristle toothbrush from frequent cleaning.

The RN is examining an infant for possible cryptorchidism. Which examine technique should be used?

- A. Place the infant in a side lying position to facilitate the exam.
- B. Hold the penis and extract the foreskin gently.
- C. Cleanse the penis with an antiseptic-soaked pad.
- D. Place the infant in a warm room and use a calm approach.

An infant who has been diagnosed with a tracheoesophageal fistula (TEF). What nursing intervention is indicated for this infant prior to surgical repair?

- A. Provide frequent sips of liquid.
- B. Give isotonic enemas as prescribed.
- C. Maintain nothing by mouth status.
- D. Prepare the infant for a barium enema.

An adolescent with non- Hodgkin's lymphoma (NHL) is complaining of a sore mouth two days after beginning chemotherapy. What activity should the RN implement?

- A. Encourage large meals during steroid and chemotherapy.
- B. Provide lemon glycerin swabs and dilute peroxide oral rinses.
- C. Recommend fluids using citrus juices and drinking with a straw.
- D. Frequent use of saline oral rinses and a soft sponge toothbrush.

A child with acute laryngotracheobronchitis (croup) received epinephrine 2 hours ago in the emergency room, and now is being prepared for discharge to go home. The RN should instruct the parents to take which action if the child's uncontrolled coughing reoccurs?

- A. Call for emergency transportation to the hospital.
- B. Increase the fluid intake to liquefy the secretions.
- C. Administer a dose of the prescribed cough medicine.
- D. Sit with the child in the bathroom with hot steam.

Moist, warm air (D) promotes bronchodilation, which helps relieve spasms that cause the coughing. If the symptoms continue or worsen, the child may need to be transported to the

hospital (A). Fluids will thin the secretions (B) and cough medicine (C) may decrease cough, but neither of these interventions decrease swelling or dilate the airway to improve breathing.

The RN is performing a routine examination of a 6-month old infant at the community health clinic. Records indicate that the child weighed 3 kg at birth. The clinic uses lbs to describe weight. When assessing this child, approximately what weight, in lbs, should the RN consider to be within normal range for this child?

- A. 15 to 18 lbs.
- B. **12 to 15 lbs.**
- C. 9 to 11.5 lbs.
- D. 6 to 7.5 lbs.

Birth weight should at least be double at this time.

When developing a teaching plan for an adolescent male who was recently diagnosed with Type 1 Diabetes Mellitus, the RN should instruct the client to eat a source of sugar if which symptom occurs?

- A. Excessive thirst.
- B. **Racing pulse.**
- C. Profuse perspiration.
- D. Seeing spots.

Tachycardia is one of the symptoms of hypoglycemia.

A breast feeding mother returns to work when her infant is 5 months old. She is having difficulty pumping enough milk to meet her infant's dietary requirements. Which suggestion should the RN provide to this mother?

- A. Mix infants formula with breast milk.
- B. **Supplement with an iron-rich formula.**
- C. Introduce baby food for one meal daily.
- D. Offer a follow-up transitional formula.

The RN is evaluating the effects of thyroid therapy used to treat a 5 month old with hypothyroidism. Which behavior indicates that the treatment has been effective?

- A. Keeps fists clenched, opens hands when grasping an object.
- B. Has strong Moro and tonic neck reflexes.
- C. Can lift head, but not chest when lying on abdomen.
- D. **Laughs readily, turns from back to side.**

The RN is assessing an infant with aortic stenosis and identifies bilateral fine crackles in both lung fields. Which additional finding should the RN expect to obtain?

- A. Vigorous feeding and sanitation.
- B. Hemiplegia.
- C. Fever.
- D. Hypotension and tachycardia.

A child with possible Duchenne muscular dystrophy (MD) undergoes an electro-myelogram (EMG). Following the procedure, the child's parents tell the RN that the child is complaining of sore muscles. How should the RN respond?

- A. Explain that muscle aches and pain are commonly experienced by children with this form of muscular dystrophy.
- B. Advise the parents that children with chronic diseases may seek attention by reporting pain or other unpleasant symptoms.
- C. Encourage the parents to monitor the child's body temperature for the next 24 hours and report a rise above 101 degree F.
- D. Offer reassurance that muscle soreness following this procedure is temporary and does not indicate a problem.

During an EMG, small needles are placed in the muscles to record contractions. This can cause temporary muscle aches following the procedure (D). Muscle weakness and hypertrophy, followed by atrophy are associated with MD rather than pain (A). Muscle soreness is an expected finding following an EMG and does not indicate attention-seeking behavior (C). It is not necessary to monitor body temperature (C) following EMG.

The heart rate of a 3 year old with a congenital heart defect has steadily decreased over the last few hours, and is now at 76 beats/minutes; the previous reading 4 hours ago was 110 beats/minutes. Which additional clinical finding should be reported immediately to the healthcare provider?

- A. Respiratory rate of 25 bpm.
- B. Urine output of 20 mL/hr.
- C. Oxygen saturation of 94%.
- D. Blood pressure of 70/40

The HCP prescribes epinephrine 0.01 mg/kg IM for a child with asthma who weighs 55 lbs. The available medication is labeled, 1 mg/ml. based on the child's weight, how many mL should the RN administer?

After receiving a single fluid bolus of 20 mL/kg of NS, a child's heart rate is 140 bpm, blood pressure 70/50, and capillary refill is 6 seconds. The child is anxious and crying. Which intervention should the RN implement first?

- A. Repeat the NS bolus as prescribed.
- B. Allow the child to assist with caregiving.
- C. Recommend age appropriate activities.
- D. Encourage the caregiver to remain at bedside.

The RN should instruct the parents of an 8 year old child who has sickle cell anemia to be alert for which complaint from the child?

- A. "I'm shorter than everyone else."
- B. "I'm really hot and thirsty."
- C. "I don't want to eat any vegetables."
- D. "I have to urinate every few hours."

Parents needs to be alert to situations where dehydration may be a possibility. Symptoms such as decreased urinary output and increased thirst indicate dehydration, which precipitate a sickle cell crisis (B). (A) Is sometimes expected with children with sickle cell anemia, especially if the child experiences many crisis. Many children do not like vegetables (C). Needing to urinate every few hours is not a warning sign for a possible sickle cell crisis (D); in fact, it may indicate adequate hydration.

The RN is assessing an 8 month old who has a cough, axillary temperature of 100, and rhinorrhea. What information is most important for the RN to obtain from this child's mother?

- A. Living conditions.
- B. Labor and delivery history of the infant.
- C. Immunization status of the infant.
- D. Alcohol and drug intake of the mother.

A milder form of pertussis occurs in children who are partially immunized, so immunization status (C) Is important in planning care. In the catarrhal stage, the clinical manifestations resemble upper respiratory infection. Information on (A) is not an immediate concern, but discharge planning should include discussion of family health problems or environmental conditions that could affect the infant. (B and D) are more important in planning the care of a newborn infant, but are not significant for a child 8 months of age.

During a routine clinic visit, the RN determines the 5 year old girl's systolic blood pressure is greater than the 90th percentile. What action should the RN implement next?

- A. Take the blood pressure two more times during the visit and determine the average of the three readings.
- B. Measure the child's blood pressure three times during the visit and determine the highest of the readings.
- C. Conduct a head to toe assessment and omit repeated blood pressures during the examination.
- D. Refer the child to the HCP and schedule evaluation of blood pressure in two weeks.

A child with hemophilia arrives at the clinic with a swollen knee after falling off a bicycle. What action should the RN implement first?

- A. Initiate an IV site and begin infusing normal saline.
- B. Type and cross for possible transfusion.
- C. Monitor the child's vital signs frequently.
- D. Apply ice pack and compression dressing to knee.

Rest, Ice, Compression (D), and elevation are immediate treatments that should be implemented to reduce swelling and bleeding in the joint. Blood loss within the knee is not immediately life threatening, so further assessment is needed to determine if an infusion of normal saline (A), or a blood transfusion (B) are indicated. Baseline vitals should be obtained, but frequent vital signs (C) are not immediately indicated.

What snack is best to provide a 6 year old on prescribed bedrest while receiving treatment for osteomyelitis?

- A. Milkshakes.
- B. Soup broth.
- C. Apple sauce.
- D. Popsicle.

A young child with osteomyelitis needs high calorie/ high protein snacks to maintain adequate nutrition and promote healing, and a milkshake (A) is the best choice to meet this dietary objective. (B, C, and D) are low in protein and provide minimal calories.

An 8 year old is admitted to the emergency Department because of lower right quadrant pain, nausea, and vomiting. Which assessment of the abdomen should the RN conduct after all other assessments are complete?

- A. Percussion.

- B. Palpation.
- C. Inspection.
- D. Auscultation.

A one month old male infant is brought to the clinic by his mother who states that her son has been vomiting forcefully after each meal for the last three days. The infant is afebrile, dehydrated, and pyloric stenosis is suspected. What other findings should the RN identify that are consistent with pyloric stenosis?

- A. Perianal diaper rash from persistent diarrhea.
- B. Rooting, hunger, and irritability.
- C. Bile-stained emesis.
- D. An olive-shaped mass in the abdominal area.

A RN is evaluating a young child with atopic dermatitis. Which question should the RN ask the parent while obtaining the child's history?

- A. "Does the child have any nausea or vomiting?"
- B. "Has the child displayed any symptoms of asthma or hay fever?"
- C. "Can any particular stress be associated with onset of rash?"
- D. "What time of the day does the rash appear on the body?"

Atopic dermatitis is known to be associated with asthma and hay fever (B). There is no significant association between atopic dermatitis and gastrointestinal symptoms (A). There is no evidence that stress can cause atopic dermatitis, although stress is associated with the disease during exacerbations (C). The rash persists over a period of time, and is not associated with diurnal pattern (D).

A 3 month old with myelomeningocele and atonic bladder is catheterized every 4 hours to prevent urinary retention. The home health RN notes that the child developed episodes of sneezing, urticaria, watery eyes, and a rash in the diaper area. What action is most important for the RN to take?

- A. Auscultate the lungs for respiratory pneumonia.
- B. Draw blood to analyze for streptococcal infection.
- C. Change to latex free gloves when handling infant.
- D. Apply zinc oxide to perineum with each diaper change.

A rash with urticaria, sneezing, and watery eyes are classic symptoms of an allergic reaction. Latex allergy is a serious threat created by the repeated catheterizations using pre-packaged

gloves, so the RN should use latex free gloves (C). The skin rash and urticaria are not typical of (A or B). (D) is ineffective in treating an allergic reaction.

A 17 year old male student with cystic fibrosis talks with the school RN about his disease and wonders how it will affect getting married and having children. Which relevant information would the RN include in this discussion?

- A. He should undergo cystic fibrosis screening before having children.
- B. Impotence is a frequent problem for males with cystic fibrosis.
- C. If the father is a carrier, 50 % chance of the offspring will have cystic fibrosis.
- D. He is likely to have infertility problems and needs further evaluation.

A female of child bearing age receives a rubella vaccination. She has two children at home, age 13 months and 3 years. Which instruction is most important for the RN to provide to this client?

- A. Inquire if anyone in the family is allergic for eggs.
- B. Tell the mother to isolate the children for 3 days.
- C. Encourage the client to immunize the children.
- D. Assess the family history for incidence of rubella.

A child weighing 67 lbs receives a prescription for benzotropine (Cogentin) 0.61 mg IV q12 hours. This drug is available as 1 mg/ml ampoules. How many mL should the RN administer?

0.61 ml/ dose

$$D/H \times V = 0.61 \text{ ml}/1\text{mg} \times 1 \text{ mL} = 0.61 \text{ mL/dose.}$$

A 12 year old boy with leukemia is being discharged from the hospital with a white blood cell count (WBC) count of 4,000 / mm³. He is scheduled to receive antineoplastic chemotherapy as an outpatient. What instruction should the RN include in this child's discharge plan?

- A. Avoid eating at buffets, smorgasbords, and salad bars.
- B. Spend time resting with family pets, but only cats and dogs.
- C. Swim weekly at the neighborhood pool for neuromuscular integrity.
- D. Have all visitors wear protective masks when coming to the home.

Neutropenia (WBC below 5,000 mm³) in a pediatric client with leukemia increases the risk of infection, so it is important for the client to avoid large crowds and situations where there is an elevated risk of exposure to infection organisms, such as public eating places (A). This child should also avoid (b AND c. (D) is impractical and expensive; the child needs protection from the visitors, so it is better to have this child to wear a mask.

A 12 year old is admitted to the hospital with possible encephalitis, and a lumbar puncture is scheduled. Which information should the RN provide this child concerning the procedure?

- A. Explain that fluids can't be taken for 8 hours before the procedure and for 4 hours after the procedure.
- B. Tell the child to expect loud clicking noises during the procedure that may be slightly annoying.
- C. **Describe the side lying, knees to chest position that must be assumed during the procedure.**
- D. Reassure the child that there will be no restrictions on activity after the procedure is completed.

Lying still on one side with the knees to the chest (C) is the position required to conduct a lumbar puncture (LP). Encephalitis is diagnosed with LP and analysis of CSF cultures. Keeping the client NPO is not required prior to an LP, and fluids are encouraged, not restricted (A) following an LP to replace the CSF that was removed. (B) Happens when the MRI is done. Activity is restricted (D) following an LP because the child must lie flat to avoid having a spinal headache.

A 10 year old girl is diagnosed with inflammatory bowel disease (IBD). Her mother is concerned that she will experience developmental delays as the result of this disorder. How should the RN respond?

- A. She will only experience developmental delays if weight loss can't be controlled.
- B. Scheduling a private tutor can help to prevent developmental delays.
- C. She is at high risk for a number of different problems, including developmental delays.
- D. **Growth failure is a concern, but developmental delays are not likely to occur.**

Growth failure (D) is a unique and important problem associated with IBD in the pediatric population. Weight loss (A) is seen with IBD, but is not associated with developmental delays. (B and C) are not associated with IBD as the age of onset typically occurs in late childhood or early adolescent.

A hospitalized child stiffens and starts to seize as the RN enters the room. What actions should the RN take? (Select All That Apply)

- A. Instruct the parents to leave the room.
- B. **Pad side rails with available pillows and blankets.**
- C. Notify the emergency response team.
- D. **Monitor duration and progress of the seizure.**
- E. **Turn client to the side if possible.**

(B, D, and E) are correct. Prevention of injury is the top priority when the client seizes, and padding rails (B) helps prevent injuries during a seizure. (D) Provides valuable information about

the seizure, which can help with diagnoses and treatment. Maintaining an open airway is essential, and turning the client to the side (E) helps prevent aspiration. The parents should be allowed to stay with the child (A). Calling the emergency response team (C) is not indicated.

How should the RN respond to the concerned parents of a 15 month old who is not yet able to self-feed with a spoon?

- A. Tell parents to guide the child's hand when using a spoon.
- B. Suggest using foods that can be eaten with fingers.
- C. Discuss possible causes for delay with self-feeding.
- D. Encourage longer mealtimes to practice eating with a spoon.

By 18 months of age, most toddlers have achieved the developmental milestone of bringing a spoon to their mouth without turning it over. Finger food (B) are appropriate for a 15 month old child's motor skills and allow independence, a psychosocial developmental task of the toddler. Guiding the child's hand (A) does not help to improve this motor skill and usually frustrates the toddler who wants to do things for themselves. (C) Might be recommended if the child's developmentally delayed. Longer mealtimes only lengthen the time the child sits at the table (D) and do not contribute to development of this motor skill.

During a well child visit for their child, one of the parents who have an autosomal dominant disorder tells the RN, "We don't plan on having any more children, the next child is likely to inherit this disorder." How should the RN respond?

- A. Explain that the risk of inheriting the disorder decreases by 50% with each child the couple has.
- B. Encourage the couple to reconsider their decision since the inheritance pattern may be sex linked.
- C. Confirm that there is a 50% chance of their future child inheriting this disorder.
- D. Acknowledging that the next child will inherit the disorder since the first child did not.

A child who has been vomiting for the past 3 days is admitted for correction of fluid and electrolyte imbalances. What acid based imbalance is this child likely to exhibit?

- A. Respiratory acidosis.
- B. Metabolic alkalosis.
- C. Respiratory alkalosis.
- D. Metabolic acidosis.

Metabolic acidosis (B) results from repeated vomiting and loss of gastric hydrochloric acid, which depletes the concentration of H ions and raises the plasma ph. (A and C) are respiratory

pathophysiologic mechanisms. (D) Results from accumulation of metabolic acid products in the blood.

The RN administers digoxin (Lanoxin) to a 9 month old infant with an apical heart rate of 160 bpm. Which apical pulse rate indicates that the therapeutic effect of the medication has been achieved?

- A. 180 bpm.
- B. 120 bpm.
- C. 80 bpm.
- D. 60 bpm.

The desired effect of digoxin is to lower the heart rate. The normal heart rate for a 9 month old is 100- 160 bpm. The therapeutic effect on the digoxin is achieved when the heart rate is within this normal range (B). (A) indicates an increase in pulse, and (C and D) are too low for the infant.

When providing care for a child who is in a balanced suspension skeletal traction using a Thomas splint and Pearson attachment to the right femur, which intervention is most important for the RN to implement?

- A. Assess skin for redness and signs of tissue breakdown.
- B. Change position every 2 hours.
- C. Cleanse pin sites as prescribed.
- D. Monitor peripheral pulses and sensation in the right leg.

The RN is planning care for a newborn infant scheduled for a cardiac catheterization. Which occurrence poses the greatest risk for this child?

- A. Loss of pulses proximal to the entry site of the cardiac catheter.
- B. Allergic response to the plastics in the catheter used for catheterization.
- C. Acute hemorrhage from the entry site of the catheter after the procedure.
- D. Fever associated with nausea and vomiting after the procedure.

A HCP prescribes antipyrine and benzocaine (Auralgan Otic), an anesthetic ear drop, for a 2 year old child with otitis media in the right ear. After positioning the child with the affected ear up, what action should the RN take?

- A. Cleanse the ear canal with saline.
- B. Put upward traction on the ear lobe.
- C. Pull pinna of the ear down and back.
- D. Gently massage in front of ear.

The RN is palpating the lymph nodes of an 18 month old. Which finding should the RN call to the attention of the healthcare provider?

- A. Small, firm, mobile nodules in the axilla.
- B. Enlarged, warm, tender, pre-auricular node.
- C. Enlarged, non-tender, movable occipital node.
- D. Small, discrete, mobile, non-tender, inguinal node.

Enlargement of the pre-auricular node with associated warmth and tenderness (B) is not an expected finding in an 18 month old and requires further investigation. (A, C, and D) are common and expected findings in an 18 month old child.

A 3 year old boy was successfully toilet trained prior to his admission to the hospital for injuries sustained from a fall. His parents are very concerned about this regression in toileting. Which information should the RN provide to the parents?

- A. A retraining program will need to be initiated when the child returns home.
- B. Diapering will be provided since hospitalization is stressful to preschoolers.
- C. Children usually resume their toileting behaviors when they leave the hospital.
- D. A potty chair should be brought from home so he can maintain his toileting skills.

The parents should be reassured that once the child is back in his familiar environment, he is likely to resume using the toileting behaviors (C). Retraining (A) is unlikely to be needed and such information might be distressing to the parents. (B does not address the parents concern.

1. A mother brings her 8 mo. old baby boy to clinic because he has been vomiting and had diarrhea for last 3 days. Which assessment is most important for nurse to make?
 - a. Assess infant abdomen for tenderness
 - b. Determine if the infant was exposed to a virus
 - c. Measure the infant's pulse
 - d. Evaluate the infant's cry

It is essential to establish if the infant is dehydrated because the extent of dehydration, if severe it can lead to metabolic acidosis, seizures, and death. One of the first signs of dehydration is tachycardia, so measurement of the child's heart rate (A) is essential. The underlying cause of dehydration may be associated with abdominal tenderness (B) or viral exposure (D), but determining the etiology is not the most urgent assessment to obtain. A child who is severely dehydrated may have a weaker cry than normal, but this symptom is difficult to measure (C) and is usually a later symptom.

2. While obtaining the vital signs of a 10 year old who had a tonsillectomy this morning, the nurse observes the child swallowing every 2-3 minutes. Which assessment should the nurse implement?
- Inspect the posterior oropharynx**
 - Assess for teeth clenching or grinding
 - Touch the tonsillar pillars to stimulate the gag reflex
 - Ask the child to speak to evaluate change in voice tone
3. The parents of a 3-year old boy who has Duchenne muscular dystrophy ask, "How can our son have this disease? We are wondering if we should have any more children." What information should the nurse provide to parents?
- This is an inherited X-linked recessive disorder, which primarily affects male children in the family**
 - The striated muscle groups of males can be impacted by a lack of the protein dystrophin in their mothers
 - The male infant had a viral infection that went unnoticed and untreated so muscle damage was incurred
 - Birth trauma with a breech vaginal birth causes damage to the spinal cord, thus weakening the muscles

DMD is inherited from an X-linked recessive gene, and affects males most exclusively (A), and about one-third of all cases occur from new mutations. DMD is characterized by progressive weakness and muscle wasting of skeletal muscle, not striated muscle, and dystrophin is a protein found in skeletal muscle (B) that is absent in children with DMD. DMD does not occur as a result of (C or D).

4. A 2-week-old female infant is hospitalized for the surgical repair of an umbilical hernia. After returning to the postoperative neonatal unit, her RR and HR have increased during the last hour. Which intervention should the nurse implement?
- Notify the HCP of these findings
 - Administer a PRN analgesic prescription**
 - Record the findings in the child's record
 - Wrap the infant tightly and rock in rocking chair
5. A 2-year-old girl is brought to the clinic by her 17 year old mother. When the nurse observes that the child is drinking sweetened soda from her bottle, what information should the nurse discuss with this mother?
- A 2-year old should be speaking in 2 word phrases
 - Dental caries are associated with drinking soda**
 - Drinking soda is related to childhood obesity**
 - Toddlers should be sleeping 10 hours a night
 - Toddlers should be drinking from a cup by age 2**

6. A mother brings her 3 month old infant to the clinic because the baby does not sleep through the night. Which finding is most significant in planning care for this family?
- The mother is a single parent and lives with her parents
 - The mother states the baby is irritable during feedings
 - The infant's formula has been changed twice
 - The diaper area shows severe skin breakdown**
7. The nurse determines that an infant admitted for surgical repair of an inguinal hernia voids a urinary stream from the ventral surface of the penis. What action should the nurse take?
- Document the finding**
 - Palpate scrotum for testicular descent
 - Assess for bladder distension
 - Auscultate bowel sounds
8. A 16 year old with acute myelocytic leukemia is receiving chemotherapy (CT) via an implanted medication port at the out-patient oncology clinic. What action should the nurse implement when the infusion is complete?
- Administer Zofran
 - Obtain blood samples for RBCs, WBCs, and platelets
 - Flush mediport w/ saline and heparin solution**
 - Initiate an infusion of normal saline
9. A mother brings her 3-week old infant to the clinic because the baby vomits after eating and always seems hungry. Further assessment indicates that the infant's vomiting is projectile, and the child seems listless. Which additional assessment finding indicates the possibility of a life threatening complication?
- Irregular palpable pulse**
 - Hyperactive bowel sounds
 - Underweight for age
 - Crying without tears

An irregular pulse (B) can be the result of dehydration, which can cause life threatening cardiac arrhythmias in a neonate. Crying without tears (A) is a sign of dehydration. The projectile vomiting prevents the neonate's normal weight gain (C). Hyperactive bowel sounds (D) may indicate an obstruction.

10. The nurse is performing a routine assessment of a 3-year old at a community health center. Which behavior by the child should alert the nurse to request a follow-up for a possible autistic spectrum disorder?
- Performs odd repetitive behaviors**
 - Shows indifference to verbal stimulation

- c. Strokes the hair of a hand held doll
 - d. Has a history of temper tantrums
11. Following admission for cardiac catheterization, the nurse is providing discharge teaching to the parents of a 2-year-old toddler with Tetralogy of Fallot. What instruction should the nurse give the parents if their child becomes pale, cool, lethargic?
- a. Encourage oral electrolyte solution intake
 - b. Assess the child to a recumbent position
 - c. Contact their HCP immediately**
 - d. Provide a quiet time by holding or rocking the toddler

12. A mother brings her 2 year old son to the clinic because he has been crying and pulling on his earlobe for the past 12 hours. The child's oral temperature is 101.2 F. Which intervention should the nurse implement?
- a. Ask the mother if the child has had a runny nose**
 - b. Cleanse purulent exudate from the affected ear canal
 - c. Apply a topical antibiotic to the periauricle area
 - d. Provide parent education to prevent recurrence

Otitis media is manifested by fever and ear pain not elicited by pulling on the auricle. It is usually accompanied by an upper respiratory infection or runny nose (A). There is no evidence that the tympanic membrane is ruptured, which would allow for the drainage of purulent exudate (B). There is no indication of periauricle cutaneous involvement, so (C), is not warranted and (D) is not indicated at this time.

13. During a follow up clinical visit a mother tells the nurse that her 5 month old son who had surgical correction for tetralogy of fallot has rapid breathing, often takes a long time to eat, and requires frequent rest periods. The infant is not crying while being held and his growth is in the expected range. Which intervention should the nurse implement?
- a. Stimulate the infant to cry to produce cyanosis
 - b. Auscultate heart and lungs while infant is held**
 - c. Evaluate infant for failure to thrive
 - d. Obtain a 12-lead electrocardiogram

Complications following repair of TOF include rhythm disturbance and low cardiac output due to right ventricular outflow obstruction, which contributes to right-sided heart failure. A focused assessment should be conducted, including auscultating heart and lung sounds while the infant is quiet (B), to identify findings that might be contributing to the infants fatigue and tachypnea. Stimulating the infant is unnecessary (A). (C) Is not indicated. (D) Should be obtained after auscultations.

14. The mother of an 11-year old boy who has juvenile arthritis tells the nurse, "I really don't want my son to become dependent on pain medication, so I only allow him to take it when he is really hurting." Which information is most important for the nurse to provide this mother?
- a. The child should be encouraged to rest when he experiences pain

- b. Encourage quiet activities such as watching television as a pain distracter
 - c. The use of hot baths can be used as an alternative for pain medication
 - d. Giving pain medication around the clock helps control the pain**
- 15. The mother of a 4-month-old baby girl asks the nurse when she should introduce solid foods to her infant. The mother states, "My mother says I should put rice cereal in the baby's bottle now." The nurse should instruct the mother to introduce solid foods when her child exhibits which behavior?
 - a. Stops rooting when hungry
 - b. Opens mouth when food comes her way**
 - c. Awakens once for nighttime feedings
 - d. Gives up a bottle for a cup
- 16. A 6-year-old boy with bronchial asthma takes the beta-adrenergic agonist agent albuterol (Proventil). The child's mother tells the nurse that she uses this medication to open her son's airway when he is having trouble breathing. What is the nurse's best response?
 - a. Recommend that the mother bring the child in for immediate evaluation
 - b. Advise the mother that over-use of the drug may cause chronic bronchitis
 - c. Assure the mother that she is using the medication correctly**
 - d. Confirm that the medication helps to reduce airway inflammation
- 17. A mother brings her school-aged daughter to the pediatric clinic for evaluation of her anti-epileptic medication regimen. What information should the nurse provide to the mother?
 - a. The medication dose will be tapered over a period of 2 weeks when being discontinued**
 - b. If seizures return, multiple medications will be prescribed for another 2 years
 - c. A dose of valproic acid (Depakote) should be available in the event of status epilepticus
 - d. Phenytoin (Dilantin) and phenobarbital (Luminal) should be taken for life
- 18. A child receives a prescription for amantadine 42 mg PO BID. Amantadine is available as a 50 mg/5 mL syrup. Using a supplied calibrated measuring device, how many mL should the nurse administer per dose? (round to nearest tenth)
0.5 mL
- 19. A male toddler is brought to the emergency center approximately three hours after swallowing tablets from his grandmother's bottle of digoxin (Lanoxin). What prescription should the nurse implement first?
Administer activated charcoal orally
 - a. Administer activated charcoal
 - b. Prepare gastric lavage
 - c. Obtain a 12-lead electrocardiogram

d. Give IV digoxin immune fab (Digibind)

20. An 8-year-old male client with nephrotic syndrome is receiving salt-poor human albumin IV. Which findings indicate to the nurse that the child is manifesting a therapeutic response?
- a. Decreased urinary output
 - b. Decreased periorbital edema**
 - c. Increased periods of rest
 - d. Weight gain 0.5 kg/day
21. A mother of a 3-year old boy has just given birth to a new baby girl. The little boy asks the nurse, "why is my baby sister eating my mommy's breast?" how should the nurse respond? Select all that apply
- a. Remind him that his mother breastfed him too**
 - b. Clarify that breastfeeding is the mother's choice
 - c. Reassure the older brother that it does not hurt his mother**
 - d. Explain that newborns get milk from their mothers in this way**
 - e. Suggest that the baby can also drink from a bottle
22. A middle school male student was recently diagnosed with attention-deficit hyperactivity disorder (ADHD) and is having trouble with his grades. He is referred to the school nurse by the teacher because he continues to have learning problems. Which action should the school nurse take?
- a. Ask the parents to have the child seen by a clinical psychologist**
 - b. Ask the parents to become involved in helping the child with his homework
 - c. Refer the child to the school counselor for educational testing
 - d. Seek the advice of the school principle regarding the child's learning needs
23. A child diagnosed with Kawasaki disease is brought to the clinic. The mother reports that her child is irritable, refuses to eat, and has skin peeling on both his hands and feet. Which intervention should the nurse instruct the mother to implement first? *
- a. Place the child in a quiet environment**
 - b. Make a list of foods that the child likes
 - c. Encourage the parents to rest when possible
 - d. Apply lotion to hands and feet
- Kawasaki disease is an autoimmune disease that causes the blood vessels to become inflamed. Placing the child in a quiet environment (A) at this time provides low stimulus environment that can help quiet the child and reduce stress on the child's body. Once the child is consoled, treating the peeling skin (D) and encouraging the child to eat food preferences (B) should be addressed. The parents need rest (C) to adequately care for the child.
24. The nurse is preparing a teaching plan for the parents of a 6 month-old infant with GERD. What instruction should the nurse include when teaching the parents measures to promote adequate nutrition?

- a. Alternate glucose water with formula
 - b. Mix the formula with rice cereal**
 - c. Add multivitamins with iron to the formula
 - d. Use water to dilute the formula
25. A child with pertussis is receiving azithromycin (Zithromax Injection) IV. Which intervention is most important for the nurse to include in the child's plan of care?
- a. Obtain vital signs at onset of fluid overload
 - b. Change IV site dressing q3 days and PRN
 - c. Monitor for signs of facial swelling or urticaria
 - d. Assess for abdominal pain and vomiting**
26. The nurse is conducting an admission assessment of an 11-month old infant with CHF who is scheduled for repair of restenosis of coarctation of the aorta that was repaired 4 days after birth. Findings include blood pressure higher in the arms than the lower extremities, pounding brachial pulses, and slightly palpable femoral pulses. What pathophysiologic mechanisms support these findings?
- a. The aortic semilunar valve obstructs blood flow into the systemic circulation
 - b. The lumen of the aorta reduces the volume of the blood flow to the lower extremities**
 - c. The pulmonic valve prevents adequate blood volume into the pulmonary circulation
 - d. An opening in the atrial septum causes a murmur due to a turbulent left to right shunt
27. A child who is admitted to the hospital with anemia is anxious, fearful, and hyperventilating. The nurse anticipates the child developing which acid base imbalance?
- a. Metabolic acidosis
 - b. Respiratory acidosis
 - c. Respiratory alkalosis**
 - d. Metabolic alkalosis
28. The mother of a toddler reports to the nurse working in the pediatric clinic that her child has had a fever and sore throat for the past two days. The nurse observes several swollen red spots in the child's body, a few of which are fluid filled blisters. Which action should the nurse implement?
- a. Obtain fluid culture from blisters
 - b. Administer a fever reducing salicylate
 - c. Cover drainage vesicles with a dressing
 - d. Implement transmission precautions**
29. The mother of a 14-year old who had a below-the-knee amputation for osteosarcoma tells the nurse that her child is angry and blaming her for allowing the amputation to occur. Which response is best for the nurse to provide?
- a. "I will ask the HCP for a psychiatric consult for your child"**

- b. "This type of acting out behavior is normal for adolescents"
 - c. "It is important to focus on your child's needs at this difficult time"
 - d. "A reaction of anger is your child's attempt to cope with this loss"**
30. The nurse provides information about the human papilloma virus (HPV) vaccine to the mother of a 14-year-old adolescent who came to the clinic this morning complaining of menstrual cramping. Which explanation should the nurse provide to support administering the HPV vaccine to the adolescent who came to the clinic this morning complaining of menstrual cramping.
- a. Use of protective barriers during sexual activity prevents most strains of HPV infection**
 - b. Most adolescents are not honest about being sexually active
 - c. Not all strains of HPV will be covered if given at a later date
 - d. Immunity must be established to prevent future HPV infection and risk for cervical cancer
31. An adolescent's mother calls the primary HCP's office to inquire about the results of her daughter's serum test results that were drawn last week. Since it is the teenager's 18th birthday, how should the nurse respond to this mother's inquiry?
- a. Ask when the adolescent was last seen in the clinic
 - b. Tell the mother to have the teenager call the clinic
 - c. Since the serum samples were drawn last week provide the mother with the findings
 - d. Explain that the information cannot be released without the 18-year olds permission**
32. The parents of 15-month old boy tell the nurse that they are concerned because their son brings his spoon to his mouth but does not turn it over. What action should the nurse implement first?
- a. Discuss referral to an occupational therapist
 - b. Question the parents about their concern**
 - c. Tell the parents to hold the spoon correctly in the child's hand
 - d. Suggest longer mealtimes so the child can finish eating
33. A child with Grave's disease who is taking propranolol (Inderal) is seen in the clinic. The nurse should monitor the child for which therapeutic response?
- a. Increased weight gain
 - b. Decreased heart rate**
 - c. Reduce headaches
 - d. Diminished fatigue
34. A 10-year-old girl who has had type 1 diabetes mellitus (DM) for the past two years tells the nurse that she would like to use a pump instead of insulin injections to manage her diabetes. Which assessment of the girl is most important for the nurse to obtain?
- a. Understanding of quality control process used to troubleshoot the pump**

- b. Interpretation of fingerstick glucose levels that influence diet selections
 - c. Knowledge of her glycosylated hemoglobin A1c levels for past year
 - d. Ability to perform the pump for basal insulin with mealtime boluses**
35. In developing a behavior modification program for an extremely aggressive 10 year old boy, what should the nurse do first?
- a. Determine what activities, foods, and toys the child enjoys**
 - b. Evaluate the child's previous reactions to punishment
 - c. Provide the child with positive feedback
 - d. Encourage other children on the unit to describe the token system
36. In assessing a 10-year old newly diagnosed with osteomyelitis, which information is most important for the nurse to obtain?
- a. Family history of bone disorders
 - b. Recent occurrence of infection**
 - c. Cultural heritage and beliefs
 - d. Occurrence of increased fluid intake
37. A 6-year-old child is diagnosed with rheumatic fever and demonstrates associated chorea (sudden aimless movements of the arms and legs). Which information should the nurse provide to the parents?
- a. Permanent life style changes need to be made to promote safety in the home
 - b. The chorea or movements are temporary and will eventually disappear**
 - c. Muscle tension is decreased with fine motor project skills, so these activities should be encouraged
 - d. Consistent discipline is needed to help the child control the movements
38. A 3 year-old boy is receiving a weekly chemotherapy treatment. Which toy is best for the nurse to provide for this child?
- a. Bouncy ball
 - b. Coloring book with crayons**
 - c. Duck that squeaks
 - d. Remote-controlled car

Chemotherapy treatment requires the client to stay still, which is difficult for a child that age. (B) Provides an activity that promotes creativity while maintaining safety. (A) Is not appropriate for this setting. (C) is too noisy and is more appropriate for a younger child, whereas (D) would entertain school aged children.

39. A 9-week-old infant is scheduled for cleft lip repair. Which information is most important for the nurse to convey to the surgeon before transporting the infant to the surgical suite?
- a. Red blood cell count of 2.3 million/mm³**
 - b. White blood cell count of 10,000/mm³
 - c. Weight gain of 2 pounds since birth
 - d. Urine specific gravity is 1.011

The norm for erythrocytes for an infant at 2 months of age is 2.7 to 4.9 million / mm³, so an erythrocyte count below normal (A) places the infant at risk for poor oxygenation in the event of preoperative bleeding, so this value should be brought to the surgeon's attention prior to surgery. (B) Is at highest level of normal (5- 10,000 mm³). (C) Indicates the infant is gaining weight considering the average birth weight generally doubles by 4 to 7 months of age. (D) is a characteristic of an infant's inability to concentrate urine, but not preoperative priority is (A).

40. The nurse is caring for a 3-year old child who has been recently diagnosed with cystic fibrosis, which discharge instruction by the nurse is most important to promote pulmonary function?

- a. Chest physiotherapy should be performed before meals and at bedtime
- b. Cough suppressants can be used up to four times a day for relief
- c. Oxygen should be given through a nasal cannula between 4-6 L/min
- d. Exercise is discouraged in order to preserve pulmonary vital capacity

Chest physiotherapy (A) should be performed one hour before meals, and at least early morning and before bedtime. Cystic fibrosis causes thick mucus secretions in the respiratory system.

Goals of the therapy include minimizing respiratory complications. (B) Should be avoided because they inhibit expectoration, which would contribute to developing pulmonary infections. Oxygen should be administered at no more than 2 lpm (C) to avoid depression of the respiratory drive. Aerobic exercise (D) should be encouraged to help mobilize secretions.

41. An adolescent who is taking antiretroviral therapy for HIV infection arrives at the clinic for a follow up visit. Which information is most important for the nurse to obtain?

- a. Missed medication doses
- b. A 24-hour dietary recall
- c. Barrier contraceptive use
- d. Ingestion of illicit drugs

42. A 5-year-old boy with leukemia is receiving chemotherapy through a peripherally inserted central catheter (PICC). Twenty minutes after the infusion is begun, the child feels dizzy and complains of itching. Which intervention should the nurse implement first?

- a. Discontinue the medication infusion
- b. Flush IV line with saline
- c. Obtain emergency resuscitation equipment
- d. Measure current blood pressure and pulse

If a reaction is suspected, the drug should be discontinued and immediately (A), followed by clearing the line with a saline flush (B). Emergency equipment and drugs should already be on hand (C). Vital signs and other subsequent measurements should be monitored after the drug is discontinued.

43. A nurse is teaching a class for mothers of premature infants, and is asked about "a shot for respiratory virus." What information about palivizumab (Synagis) is correct?

- a. It is required immunization for all infants under the age of 3 months

- b. It must be repeated every two months to be effective
- c. **It is recommended for infants who meet established high-risk criteria**
- d. It provides protection for one year with a single injection

44. MISSING 45

45. When assessing a 5-year-old, which ability should the nurse expect the child to be developing at this age?

- a. Learning to ride a tricycle
- b. **Tying shoelaces**
- c. Buttoning clothes
- d. Cutting with scissors

Tying shoe (B) laces is a skilled achieved by a 5 year old. (A) Is usually mastered at three. (C and D) Are usually mastered at age 4.

46. A mother brings her 2-month old son to the clinic for a well-baby exam. During the assessment the nurse finds that the right testicle is not distended into the scrotum but the left is palpable. Which action should the nurse take?

- a. **Ask if the right testis has been seen in the scrotum before**
- b. Address possible concerns about the child's future fertility
- c. Schedule an IV pyelogram to validate presence of the testicle
- d. Prepare to obtain a catheterized urine specimen for culture

47. MISSING 48

48. An 8-year-old girl with precocious sexual development is being treated medically with injections of luteinizing hormone-releasing hormone (LRHR) to regulate the pituitary gland. Which statement by the parents indicates that they understand the treatment?

- a. "We should be sure to start our daughter on birth control pills"
- b. "Our daughter will be on this hormone treatment the rest of her life"
- c. "We should encourage her to dress in clothing that suits her sexual maturity level"
- d. **"Sexual maturity differences between my daughter and her peers will disappear within a few years"**

The hormone treatment will cease at a chronologically appropriate time, thus allowing pubertal changes to resume. For example, when the child becomes the appropriate age to develop sexually (D). (B) Is incorrect. (A) is only appropriate if the child is sexually active, and no 8 year old should be sexually active. The child should be dressed appropriately for her chronological age (C).

49. MISSING 50

50. While auscultating the lung sounds of a 5 year-old Chinese boy who recently completed antibiotic therapy for pneumonia, the nurse notices symmetrical, round, bruise-like blemishes on his chest. Which action is best for the nurse to take?

- a. Identify the antibiotic used to treat the pneumonia
- b. Report suspected child abuse to the proper authorities
- c. **Inquire about the use of alternative methods of treatment**
- d. Ask the parents if the child has been in a recent accident

Cupping is an ancient folk-healing practice used in many Asian cultures for the purpose of “drawing out the poisons”. Cupping often results in bruise-like blemishes that occur when suction is created and steam cools inside a hollow container pressed against the skin. The RN should first inquire if this practice was used as alternative method of treatment (B). This skin pattern is not typical of (A and C). (D) is not indicated based on these findings.

51. Which instructions should the nurse include in the discharge teaching plan of 7 year old girl with history of frequent urinary tract infections?
- a. Take frequent bubble baths
 - b. Perform intermittent catheterization
 - c. Check oral temperature daily
 - d. **Monitor for changes in urinary odor**

Lower urinary tract infections (UTI) cause frequency, urgency, pain, and subtle changes in the odor of the urine (D) may be the first and only sign of infection. (A) May cause further irritation and swelling of the urethra. (B) is not necessary since the bladder function is intact. (C) is not needed since temperature evaluation of > 100 F is unusual with UTI's.

52. A male infant with bronchiolitis is brought to the clinic by his mother. The infant is congested and febrile with a capillary refill of 2 seconds. Which information should the nurse discuss with the mother?
- a. Encourage infant to play
 - b. Limit the amount of oral intake
 - c. **Keep infant isolated from others**
 - d. Lay infant on back for naps

Bronchiolitis is contagious, and the infant should be isolated from others ©. The infant is unlikely to want to play (A), and rest and sleep should be promoted to minimize oxygen consumption. Fluid intake should be encouraged to thin pulmonary secretions (B). To facilitate respiratory ease, the infant should be positioned in an infant seat, not flat on their backs.

- a. During a routine physical exam, a male adolescent client tells the nurse, “sometimes, my mother gets angry because I want to be with my own friends.” What is the best initial response by the nurse?
- b. Offer reassurance that his mother's concern is normal
- c. Determine if his friends are engaged in unsafe behaviors
- d. **Ask about the client's response to his mother's anger**
- e. Offer to discuss his concerns together with his mother

The RN should first gather more information about the interactions between the mother and the adolescent ©. (A, B, and D) are premature until more information is available.

1. The nurse is caring for a 3-year old child who is 2 hours postop from a cardiac

catheterization via the right femoral artery. Which assessment finding is an indication of arterial obstruction?

- A. Blood pressure trend is downward and pulse is rapid and irregular.
- B. Right foot is cool to the touch and appears pale and blanched.**
- C. Pulse distal to the femoral artery is weaker on the left foot than right foot.
- D. The pressure dressing at right femoral area is moist and oozing blood.

2. Following a motor vehicle collision, a 3-year old girl has a spica cast applied. Which toy is best for the nurse for this 3 year old child?

- A. Duck that squeaks.
- B. Fashion doll and clothes.
- C. Set of cloth and hand puppets.**
- D. Hand held video game.

3. An infant with tetralogy of Fallot becomes acutely cyanotic and hyperpneic. Which action should the nurse implement first?

- A. Administer morphine sulphate.
- B. Start IV fluids.
- C. Place the infant in a knee-chest position.**
- D. Provide 100% oxygen by face mask.

4. A child admitted with diabetic ketoacidosis is demonstrating Kussmaul respirations. The nurse determines that the increased respiratory rate is a compensatory mechanism for which acid base alteration?

- A. Metabolic alkalosis.**
- B. Respiratory acidosis.
- C. Respiratory alkalosis.
- D. Metabolic acidosis.

5. A 7-year-old is admitted to the hospital with persistent vomiting, and a nasogastric tube attached to low intermittent suction is applied. Which finding is most important for the nurse to report to the healthcare provider?

- A. Gastric output of 100 mL in the last 8 hours.
- B. Shift intake of 640 mL IV fluids plus 30 mL PO ice chips.
- C. Serum potassium of 3.0 mg/dL.
- D. Serum pH of 7.45.

6. The nurse is evaluating diet teaching for a client who has nontropical sprue (celiac disease). Choosing which food indicates that the teaching has been effective?

- A. Creamed corn.
- B. Pancakes.
- C. Rye crackers.
- D. Cooked oatmeal.

7. During a well-baby check, the nurse hides a block under the baby's blanket, and the baby looks for the block. Which normal growth and development milestone is the baby developing?

- A. Separation anxiety.
- B. Associative play.
- C. Object prehension.
- D. Object permanence.

8. The nurse is measuring the frontal occipital circumference (FOC) of a 3-month-old infant, and notes that the FOC has increased 5 inches since birth and the child's head appears large in relation to body size. Which action is most important for the nurse to take next?

- A. Measure the infant's head-to-toe length.
- B. Palpate the anterior fontanel for tension and bulging.
- C. Observe the infant for sunken eyes.
- D. Plot the measurement on the infant's growth chart.
9. The nurse is preparing a 10 year old with a lacerated forehead for suturing. Both Parents and 12 year old sibling are at the child's bedside. Which instruction best Supports family?
- A. While waiting for the healthcare provider, only one visitor may stay with the child.
- B. All of you should leave while the healthcare provider sutures the child's forehead.
- C. It is best if the sibling goes to the waiting room until the suturing is completed.
- D. Please decide who will stay when the healthcare provider begins suturing.
10. The nurse is planning for a 5-month old with gastroesophageal reflux disease whose weight has decreased by 3 ounces since the last clinic visit one month ago. To increase caloric intake and decrease vomiting, what instructions should the nurse provide this mother?
- A. Give small amounts of baby food with each feeding.
- B. Thicken formula with cereal for each feeding.
- C. Dilute the child's formula with equal parts of water.
- D. Offer 10 % dextrose in water between most feedings.
11. While teaching a parenting class to new parents the nurse describes the needs of infants and toddlers regarding discipline and limit setting. What is the most important reason for implementing such parenting behaviors?
- A. Children need help in developing social skills.
- B. This age child fears loss of self control.
- C. They provide the child with a sense of security.

D. Children must to learn to deal with authority.

12. The parents of a newborn infant with hypospadias are concerned about when the surgical correction should occur. What information should the nurse provide?

- A. Repair should be done by one month to prevent bladder infection.
- B. To form a proper urethra repair, it should be done after sexual maturity.
- C. Repairs typically should be done before the child is potty trained.**
- D. Delaying the repair until school age reduces castration fears.

13. Which drink choice on a hot day indicates to the nurse that a teenager with sickle cell anemia understands dietary consideration related to the disease?

- A. Milkshake.
- B. Iced tea.
- C. Diet cola.
- D. Lemonade.**

14. The nurse is assessing an infant with diarrhea and lethargy. Which finding should the nurse identify that is consistent with early dehydration?

- A. Tachycardia.**
- B. Bradycardia.
- C. Dry mucous membrane.
- D. Increased skin turgor.

15. While auscultating the lung sounds of a 5 year old Chinese boy who recently completed antibiotic therapy for pneumonia, the nurse notices symmetrical, round, bruise-like blemishes on his chest. What action is best for the nurse to take?

- A. Identify the antibiotic used to treat the pneumonia.
- B. Inquire about the use of alternative methods of treatment.**
- C. Ask the parents if the child has been in a recent accident.

D. Report suspected child abuse to the authorities.

16. A child with acute lymphocytic leukemia (ALL) who is receiving chemotherapy via a subclavian IV infusion, has an oral temperature of 103 degrees. In assessing the IV site, the nurse determines that there are no signs of infection at the site. Which intervention is the most important for the nurse to implement?

- A. Obtain specimen for blood cultures.
- B. Assess the CBC.
- C. Monitor the oral temperature every hour.
- D. Administer acetaminophen as prescribed.

17. A child who weights 25 kg is receiving IV ampicillin 300 mg/kg/24 hours in equally divided doses every 4 hours. How many mg should the nurse administer to the child for each dose?

1875mg

18. The nurse is caring for an infant scheduled for reduction of intussusceptions. The day before the scheduled procedure the infant passes a soft-formed brown stool. Which intervention should the nurse implement?

- A. Instruct the parents that the infant needs to be NPO.
- B. Notify the healthcare provider of the passage of brown stool.
- C. Obtain a stool specimen for laboratory analysis.
- D. Ask the parents about recent changes in the infant's diet.

19. The mother of a 4-month old asks the nurse for advice in preventing diaper rash. What suggestion should the nurse provide?

- A. At diaper change generously powder the baby's diaper area with talcum powder to promote dryness.

- B. Wash the diaper area every 2 hours with soap and water to help prevent skin breakdown.
- C. Use a barrier cream, such as zinc oxide, which does not have to be completely removed with each diaper change.
- D. Place a cloth diaper inside the disposable diaper for overnight periods when increased wearing time is likely.
20. Which statement by a school aged client going to summer camp indicates the best understanding of the mode of transmission of Lyme disease?
- A. I'll cover my mouth with a wet cloth if there's too much dust blowing.
- B. Cuts and scrapes need to be washed out and covered right away.
- C. I'm not going to swim where the water is standing still or feels too hot.
- D. I have to wear long sleeves and pants when we're hiking around the pond.
21. The nurse is evaluating the effects of thyroid therapy used to treat a 5 months old with hypothyroidism. Which behavior indicates that the treatment has been effective?
- A. Laughs readily, turns from back to side.
- B. Has strong Moro and tonic neck reflexes.
- C. Keeps fists clenched, opens hands when grasping an object.
- D. Can lift head, but not chest when lying on abdomen.
22. The HR for a 3 year old with a congenital heart defect has steadily decreased over the last few hours, now it's 76 bpm, the previous reading 4 hours ago was 110 bpm. Which additional finding should be reported immediately to a healthcare provider?
- A. Oxygen saturation 94%.
- B. RR of 25 breaths/minute.
- C. Urine output 20 mL/hr.
- D. BP 70/40.

23. A 2 year old is admitted to the hospital with possible encephalitis, and a lumbar puncture is scheduled. Which information should the nurse provide this child concerning the procedure?

- A. Describe the side-lying, knees to chest position that must be assumed during the procedure.
- B. Tell the child to expect loud clicking noises during the procedure that may be slightly annoying.
- C. Reassure the child that there will be no restrictions on activity after the procedure is completed.
- D. Explain that fluids cannot be taken for 8 hours before the procedure and for 4 hours after the procedure.

24. The parents of a 3 y/o boy who has Duchenne muscular dystrophy (DMD) ask “how can our son have this disease? We are wondering if we should have any more children” What information should the nurse provide these parents?

- A. This is an inherited X-linked recessive disorder, which primarily affects male children in the family
- B. The male infant had a viral infection that went unnoticed and untreated, so muscle damage was incurred
- C. The XXXX muscle groups of males can be impacted by a lack of the protein dystrophin in the mother
- D. Birth trauma with a breech vaginal birth causes damage to the spinal cord, thus weakening the muscles

25. The nurse finds a 6 month old infant unresponsive and calls for help. After opening the airway and finding the XXXX the infant is still not breathing. Which action should the nurse take?

- A. Palpate femoral pulse and check for regularity
- B. Deliver cycles of 30 chest compressions and 2 breaths
- C. Give two breaths that make the chest rise
- D. Feel the carotid pulse and check for adequate breathing.

26. A 3 year old with HIV infection is staying with a foster family who is caring for 3 other foster children in their home. When one of the children acquires pertussis, the foster mother calls the clinic and asks the nurse what she should do. Which action should the nurse take first?

- A. Remove the child who has HIV from the foster home
- B. Report the exposure of the child with HIV to the health department
- C. Place the child who has HIV in reverse isolation
- D. Review the immunization documentation of the child who has HIV

27. A 16 y/o female student with a history of asthma controlled with both an oral antihistamine and an albuterol (Proventil) metered-dose inhaler (MDI) comes to the school nurse. The student complains that she cannot sleep at night, feels shaky and her heart feels like it is “beating a mile per minute” Which information is most important for the nurse to obtain?

- a. When she last took the antihistamine
- b. When her last Asthma attack occurred
- c. Duration of most asthma attacks
- d. How often the MDI is used daily

28. The nurse is assessing a child for neurological soft signs, which finding is most likely demonstrated in the child’s behavior?

- a. Inability to move tongue in a direction
- b. Presence of vertigo

c. Poor coordination and sense of position

d. Loss of visual acuity

29. The nurse is assessing an infant with pyloric stenosis. Which pathophysiological mechanism is the most likely consequence of this infant's clinical picture?

a. Metabolic alkalosis

b. Respiratory acidosis

c. Metabolic acidosis

d. Respiratory Alkalosis

30. A 4 month-old girl is brought to the clinic by her mother because she has had a cold for 2 o 3 days and woke up this morning with a hacking cough and difficulty breathing. Which additional assessment finding should alert the nurse that the child is in acute respiratory distress?

a. Bilateral bronchial breath sounds

b. Diaphragmatic respiration

c. A resting respiratory rate of 35 breathe per minute

d. flaring of the nares

31. a two year old boy begins to cry when the mother starts to leave. What is the nurse's best response in this situation?

a. Let me read this book to you

b. Two years old usually stop crying the minute the parent leaves

c. Now be a big boy. Mommy will be back soon

d. Let's wave bye-bye to mommy

32. A two year old child with a heart failure (HF) is admitted for replacement of a graft for coarctation of the aorta. Prior to administering the next dose of digoxin (Lanoxin) the

nurse obtains an apical heart rate of 128 bpm. What action should the nurse implement?

- a. Determine the pulse deficit
- b. Administer the scheduled dose**
- c. calculate the safe dose range
- d. review the serum digoxin level

33. A child with leukemia is admitted for Chemotherapy and the nursing diagnosis “altered nutrition, less those body requirements related to anorexia, nausea and vomiting” is identified. Which intervention the nurse included in this child plan of care?

- a. Encourage a variety of large portions of food at every meal
- b. Allow the child to eat any food desired and tolerated**
- c. Recommended eating the food as sibling eat at home
- d. Restrict food brought from fast food restaurants

34. a 6 year old who has asthma is demonstrating a prolonged expiratory phase and wheezing and has a 35% of personal best peak expiratory flow rate (PEFR) based on these finding, actions should the nurse take first?

- a. Administer a prescribed bronchodilator**
- b. Encourage the child to cough and deep breath
- c. Report findings to the health care provider
- d. determine what triggers precipitated this attack

35. The nurse plans to administer 10 mcg/kg of digoxin elixir as a loading dose to a child who weights 55 pounds. Digoxin is available as elixir of 50 mcg/ml. How many ml of the digoxin elixir should the nurse administer to this child?

5 ml

36. the nurse observes a mother giving her 11 month-old ferrous sulfate, followed by two

onces of orange juice. What should the nurse do next?

- a. suggest placing the iron drops in the orange juice and feed the infant
- b. Tell the mother to follow the iron drops with formula instead of orange juice
- c. instruct the mother to feed the infant nothing in the next 30 minutes after the iron
- d. Give positive feedback about the way she administered the sulfate**

37. Which nursing intervention is most important to include in the plan of care for a child with acute glomerulonephritis

- A. encourage fluid intake
- b. promote complete bed rest
- c. weight the child daily**
- d. administer vitamin supplements

38. During a well baby visit the parents explain that a soft bulge appears in the groin of their 4 month old son when he cries or strain stooling. The infant is scheduled for surgical repair of the inguinal hernia in two weeks. The parent should be instructed to take which measure if the hernia becomes incarcerated prior to the surgery?

- a. Use rectal thermometer for straining on stool
- b. Gently manipulate the hernia for reduction**
- c. Offer oral electrolyte fluids for comfort
- d. Give acetaminophen or aspirin for crying

39. A 16 year old male client who has been treated in the past for a seizure disorder is admitted to the hospital. Immediately after admission he begins to have a grand mal seizure. Which action should the nurse take?

- a. Obtain assistance in holding him to prevent injury
- b. Observe him carefully**
- c. Call a CODE

d. Place a padded tongue blade between the teeth

40. The mother of a 9 month old who was diagnosed with respiratory syncytial virus yesterday calls the clinic to inquire if it will be all right to take her infant to the first b-day party of a friend's child the following day. What response should the nurse provide this mother?

- a. The child will no longer be contagious, no need to take any further precaution
- b. Make sure there are not children under the age of 6 months around the infected child
- c. The child can be around other children but should wear mask at all times
- d. Do not expose other children to RSV. It is very contagious even without direct contact**

41. When screening a 5 year old for strabism, what action should the nurse take

- A. Have the child identify colored patterns on polychromatic cards
- B. Direct the child through the six cardinal position of gaze**
- C. Inspect the child for the setting sun sign
- D. Observe the child for blank, sunken eyes

42. The nurse is assessing a 6 month old infant. Which response requires further evaluation by the nurse?

- A. Has doubled birth weight
- B. Turn head to locate sound
- C. Plays peek a boo
- D. Demonstrate startle reflex**

43. A child is brought to the clinic complaining of fever and joint pain, and is DX with rheumatic fever. When planning care for this child what is the goal of nursing care?

- A. Reduce fever

- B. Maintain fluid and electrolytes
- C. Prevent cardiac damage
- D. Maintain joint mobility and function

44. The nurse working on the pediatric unit takes two 8-year old girls to the playroom.

Which activity is best for the nurse to plan for these girls?

- A. Selecting a board game
- B. Playing Doctor and nurse
- C. Watching cartoon on TV
- D. Coloring, cutting and pasting

45. The nurse is developing the plan of care for a hospitalized child with von Willebrand disease. What priority nursing intervention should be included in this child plan of care

- A. Reduce exposure to infection
- B. Eliminate contact with cold grafts (crafts? Is not legible)
- C. Guard against bleeding injuries
- D. Reduce contact with other children

46. How should the nurse instruct the parents of a 4 month old with seborrheic dermatitis (cradle cap) to shampoo the child's hair?

- A. Use a soft brush and gently scrub the area
- B. Avoid scrubbing the scalp until the scales disappear
- C. Avoid washing the child's hair more than once a week
- D. Use soap and water and avoid shampoos

47. Prior to discharge, the parents of a child with cystic fibrosis are demonstrating chest physiotherapy (CPT) that they will perform for their child at home. Which action requires intervention by the nurse?

- A. Plan to perform CPT when the child awakens in the morning

- B. A Copped hand is used when percussing the lung field
- C. A bronchodilator is administered before starting CPT
- D. The child is placed in a supine position to begin percussion**

48. When assessing the breath sounds of an 18 month old child who is crying, what action should the nurse take?

- A. Document that the assessment is not available because the child is crying
- B. Ask the parents to quiet the child so breath sounds can be auscultated
- C. Allow the child to initially play with stethoscope, and distract during auscultation**
- D. Auscultate and document breath sounds, noting that the child was crying at the time

49. The mother of a one month old calls the clinic to report that the back of her infant is flat. How should the nurse respond

- A. Turn the infant on the left side braced against the crib when sleeping
- B. Prop the infant in a sitting position with a cushion when no sleeping
- C. Place a small pillow under the infant's head while lying on the back
- D. Position the infant on the stomach occasionally when awake and active**

50. Which nursing intervention is most important to assist in detecting hypopituitarism and hyperpituitarism in children

- A. Carefully recording the height and weight of children to detect inappropriate growth**
- B. Performing head circumference measurements on infants under one year of age
- C. Assessing for behavioral problems at home and school by interviewing the parents
- D. Noting a tracked weight gain without a gain in height on a growth chart

51. A 7 year old child is admitted to the hospital with acute glomerulonephritis (AGN). When obtaining the nursing history which finding should the nurse expect to obtain?

- A. High blood cholesterol level on routine screening
- B. Increased thirst and urination
- C. A recent strep throat infection
- D. A recent DPT immunization

52. The nurse plans to screen only the highest risk children for scoliosis. Which group of children should the nurse screen first

- A. Girls between ages 10 and 14
- B. Boys between ages 10 and 14
- C. Boys and girls between 12 and 14
- D. Boys and girls between 8 and 12

53. In assessing a 10 year old newly diagnosed with osteomyelitis, which information is most for the nurse to obtain

- A. Recent recurrence of infections
- B. Cultural heritage and belief
- C. Family history of bone disorder
- D. Occurrence of increased fluid intake

54. A 3 year old boy in a daycare facility scratches his head frequently and the nurse confirms the presence if head lice. The nurse washes the child's hair with permethrin (Nix) shampoo and call his parents. What instructions should the nurse provide to the parents about treatment of head lice?

- A. Wash the child's bed linens and clothing In hot soapy water
- B. Dispose of the child's brushes, comb's and other hair accessories
- C. Rewash the child's hair following a 24 hour isolation period
- D. Take the child to a hair salon for a shampoo and shorter haircut

55. The nurse on a pediatric unit observes a distraught mother in the hallway scolding her 3 year old son for wetting his pants. What initial action should the nurse take?

- A. Suggest that the mother consult a pediatric nephrologists
- B. Provide disposable training pants while calming the mother
- C. Refer the mother to a community parent education program
- D. Inform the mother that toilet training is slower for boys**

1: Kawasaki: priority is to prevent irritability/provide quiet environment

2. Pinworms: assess stool

3. Calculation (with too much information): 10mL xxxxxxx

4. Blind child in spica cast: provide familiar toys from home xxxx

5. Outpatient chemotherapy: Flush with NS and Heparin xxxxx

6. Calculation (kg): 0.3mL xxxxxxx

7. Child with Lyme Disease/Rickettsia: assess skin xxxxxxxx

8. Croup: suggest humidifier/steam from shower xxxxx

9. ADHD: increasing structure of child

10. High Blood Pressure: Take BP 3 times and then record lowest BP

11. Calculation (Regular): 4.3 mgxxxxxx

12. Concerning vital sign: BP 90/70

13. Child with Pertussis: cover mouth and send back to room xxxxxxxx

14. Allergies: wait 7 days before introducing new foods to child

15. Hip Dysplasia of infant: presence of gluteal folds

16. OCD: Repetitive Movements

17. Physical Assessment: place tongue depressor on side (NOT CENTER)

18. Intersusception: Currant Jelly Stools

19. Unable to eat: check diaper rash

20. Answer: check fluorinated water
21. Ingestion of Digoxin/Lanoxin: Administer Digibind
22. Mist Tent: allow mother to hold child
23. Wilms Tumor: Don't palpate the abdomen xxxxxxxxxxxx
24. Steroid use: rinse mouth to prevent thrush
25. Sickle Cell Crisis: administration of medication
26. Child inability to walk: **inform child's parents first**
27. Immunocompromised: Don't eat fresh fruits
28. Adolescent hospitalized: **provide computer to connect with friends**
29. Herniated Hernia: answer will include incarcerated
30. 4 year old boy playing with dolls: imaginary play
31. Administration of ear medication: pull ear up and backwards xxxxxxxx
32. Child with cough brought to **clinic: give finger foods**
33. Answer: irritable bowel syndrome
34. Asthma Attack: Administer Albuterol
35. Hunger sign: rooting reflex
36. Implementation of cereals: 4-6 months
- 37: Diabetes Mellitus: Reinforce teaching about external pump
38. Cleft Palate Repair: 6-24 months
- 39. Which patient should be assessed first? Infant/child with renal issues**
- 40. Irritable / crying child who just received fluids...priority intervention = another fluid bolus
xxxxx**

The healthcare provider prescribes midazolam 0.08 mg/kg IM times one dose during conscious sedation for a 2 year old who weighs 29 pounds. How many mg per dose should this child received. (Enter numeric value only. If rounding is required round to the nearest whole number)

Breastfeeding infant screened for congenital hypothyroidism is found to have low levels of thyroxine and high levels of thyroid stimulating hormone. What is the explanation for this finding?

The TSH is high because of the low production of T4 by the thyroid gland.

The healthcare provider prescribes antipyrine and benzocaine for a 2 year old child with otitis media in the right ear. After positing the affected ear up what action should the nurse take?

Pull pinna of the ear down and back

A 4 month old boy has an inguinal hernia that is visible when he cries, but it does not cause him discomfort. His parents ask if the hernia should be repaired now. The nurse's response should be based on what information?

Surgical correction is indicated if the inguinal hernia is incarcerated.