

Hesi Critical Thinking

1. The nurse is working in the emergency department (ED) of a children's medical center. Which client should the nurse assess first?

Correct - 3-The child hit by a car should be assessed first because he or she may have life-threatening injuries that must be assessed and treated promptly.

2. The 8-year-old client diagnosed with a vaso-occlusive sickle cell crisis is complaining of a severe headache. Which intervention should the nurse implement first?

Correct - 2-Because the client is complaining of a headache, the nurse should first rule out cerebrovascular accident (CVA) by assessing the client's neurological status and then determine whether it is a headache that can be treated with medication.

3. The 6-year-old client who has undergone abdominal surgery is attempting to make a pinwheel spin by blowing on it with the nurse's assistance. The child starts crying because the pinwheel won't spin. Which action should the nurse implement first?

Correct -1. The nurse should always praise the child for attempts at cooperation even if the child did not accomplish what the nurse asked.

4. The nurse is caring for clients on the pediatric medical unit. Which client should the nurse assess first?

Correct - 4. A pulse oximeter reading of less than 93% is significant and indicates hypoxia, which is life threatening; therefore, this child should be assessed first.

5. The nurse has received the a.m. shift report for clients on a pediatric unit. Which medication should the nurse administer first?

Correct - 3-Sliding scale insulin is ordered ac, which is before meals; therefore, this medication must be administered first after receiving the a.m. shift report.

4-Routine medications have a 1-hour leeway before and after the scheduled time; therefore, this medication does not have to be administered first.

6. A 5-year-old boy is being admitted to the hospital to have his tonsils removed. Which information should the nurse collect before this procedure?

D. Reactions to previous hospitalizations

Rationale

Assess how the child reacted to hospitalization and any complications. If the child reacted poorly, he or she may be afraid now and will need special preparation for the examination that is to follow. The other items are not significant for the procedure

7. A 6-month-old infant has been brought to the well-child clinic for a check-up. She is currently sleeping. What should the nurse do first when beginning the examination?

) Auscultate the lungs and heart while the infant is still sleeping.

Rationale

When the infant is quiet or sleeping is an ideal time to assess the cardiac, respiratory, and abdominal systems. Assessment of the eye, ear, nose, and throat are invasive procedures and should be performed at the end of the examination.

6. The nurse enters the client's room and realizes the 9-month-old infant is not breathing. Which interventions should the nurse implement? Prioritize the nurse's actions from first (1) to last (5).

Rationale

Correct Answer: 4, 5, 3, 2, 1

4. The nurse must first determine the infant's responsiveness by thumping the

baby's feet.

5. The nurse should then open the child's airway using the head-tilt chin-lift technique, with care taken not to hyperextend the neck. Then the nurse should look, listen, and feel for respirations.

3. The nurse then administers quick puffs of air while covering the child's mouth and nose, preferably with a rescue mask.

2. The nurse should determine whether the infant has a pulse by checking the brachial artery.

1. If the infant has no pulse, the nurse should begin chest compressions using two fingers at a rate of 30:2.

7. The 3-year-old client has been admitted to the pediatric unit. Which task should the nurse instruct the unlicensed assistive personnel (UAP) to perform first?

Correct - 1. The first intervention after the child is admitted to the unit is to orient the parents and child to the room, the call system, and the hospital rules, such as not leaving the child alone in the room.

8. The clinic nurse is preparing to administer an intramuscular (IM) injection to the 2-year-old toddler. Which intervention should the nurse implement first?

Correct - 2- The nurse must explain any procedure in words the child can understand. It does not matter how old the child is.

. The nurse is writing a care plan for the 5-year-old child diagnosed with gastroenteritis. Which client problem is priority?

Correct - 2- The child diagnosed with gastroenteritis is at high risk for hypovolemic shock resulting from vomiting and diarrhea; therefore, maintaining fluid and electrolyte homeostasis is priority.

10. Which data would warrant immediate intervention from the pediatric nurse? 1. Proteinuria for the child diagnosed with nephrotic syndrome.

Correct - 3- Drooling indicates the child is having trouble swallowing, and the epiglottis is at risk of completely occluding the airway. This warrants immediate intervention. The nurse should notify the HCP and obtain an emergency tracheostomy tray for the bedside.

11. Which client should the pediatric nurse assess first after receiving the a.m. shift report? 4. The 13-month-old child diagnosed with diarrhea who has sunken eyeballs and

decreased urine output.

Rationale

Correct - 4. Sunken eyeballs and decreased urine output are signs of dehydration, which is a life-threatening complication of diarrhea; therefore, this child should be assessed first.

12. The pediatric clinic nurse is triaging telephone calls. Which client's parent should the nurse call first?

1. The 4-month-old child who had immunizations yesterday and the parent is reporting a high-pitched cry and a 103°F fever.

Correct 1- A high fever and high-pitched crying may indicate a reaction to the immunizations; therefore, this parent needs to be called first to bring the child to the clinic.

13. The parent of a 12-year-old male child with a left below-the-knee cast calls the pediatric clinic nurse and tells the nurse, "My son's foot is cold and he told me it feels like his foot is asleep." Which action should the nurse implement first?

3. Instruct the parent to elevate the left leg on two pillows.

Correct - 3. The nurse should first take care of the client's body by having the parent elevate the left leg.

14. Which child requires the nurse to notify the healthcare provider?

1. The 1-year-old child with iron deficiency anemia who has dark-colored stool.

2. The 3-year-old child with phenylketonuria (PKU) whose parent does not feed the child any meat or milk products.

3. The 5-year-old child with rheumatic heart fever who is having difficulty breathing.

4. The 7-year-old child diagnosed with acute glomerulonephritis who has dark "tea"-colored urine.

Rationale

Correct - 3-A complication of rheumatic heart disease is valvular disorders that may be manifested by respiratory problems; therefore, the nurse should notify the child's health-care provider.

15. The pediatric nurse on the surgical unit has just received a.m. shift report. Which client should the nurse assess first?

1. The 3-week-old child 1 day postoperative with surgical repair of a myelomeningocele who has bulging fontanel.

Correct - 1-Bulging fontanel is a sign of increased intracranial pressure, which is a complication of neurological surgery; therefore, this child should be assessed first.

16. The charge nurse has assigned a staff nurse to care for an 8-year-old client diagnosed with cerebral palsy. Which nursing action by the staff nurse would warrant immediate intervention by the charge nurse?

4. The staff nurse places the child in semi-Fowler's position to eat lunch.

Rationale

Correct - 4-The child should be positioned upright to prevent aspiration during meals; therefore, this action would require the charge nurse to intervene.

17. The nurse and the unlicensed assistive personnel (UAP) are caring for clients on the pediatric unit. Which action by the nurse indicates appropriate delegation?

4. The nurse checks to make sure the UAP's delegated tasks have been completed.

Rationale

Correct - 4. The last step of delegating to a UAP is for the nurse to evaluate and determine whether the delegated tasks have been completed and performed correctly. This indicates the nurse has delegated appropriately.

18. The nurse on a pediatric unit has received the a.m. shift report and tells the unlicensed assistive personnel (UAP) to keep the 2-year-old child NPO for a procedure. At 0830, the nurse observes the mother feeding the child. Which action should the nurse implement first?

1. Determine what the UAP did not understand about the instruction.

Rationale

Correct - 1.Communication to the UAP must be clear, concise, correct, and complete. The nurse must determine why there was a lack of communication, which resulted in the child receiving food; therefore, this action should be implemented first.

19. The charge nurse on the six-bed pediatric burn unit is making shift assignments and has one registered nurse (RN), one scrub technician, one unlicensed assistive personnel (UAP), and a unit secretary. Which client care assignment indicates the best use of the hospital personnel?

1. The RN performs daily whirlpool dressing changes.

2. The unit secretary transcribes the HCP's orders.

3. The scrub technician medicates the client prior to dressing changes. 4. The UAP places the current laboratory results on the chart.

1-The scrub technician is assigned to perform daily whirlpool dressing changes, which is a lengthy procedure. Therefore, assigning the one RN to this task would be inappropriate because he or she cannot be unavailable for an extended period of time.

**2-One of the responsibilities of the unit secretary is to transcribe the HCP's orders, but the licensed nurse retains total responsibility for the correctness and accuracy of the transcribed orders.

3-The scrub technician cannot administer medications.

4-The unit secretary and laboratory personnel are responsible for posting laboratory data into the client's charts. The UAP should be on the unit taking care of the clients.

20. The RN and the UAP are caring for clients on a pediatric surgical unit. Which tasks would be most appropriate to delegate to the UAP? Select all that apply.

1. Pass dietary trays to the clients.

2. Obtain routine vital signs on the clients.

3. Complete the preoperative checklist.

4. Change linens on the clients' beds.

5. Document the clients' intake and output.

1, 2, 4, and 5 are correct.

1. The UAP can pass the dietary trays to the clients because it does not require judgment.

2. One of the responsibilities of the UAP is taking routine vital signs on clients.

3. The nurse must complete the preoperative checklist because it requires nursing judgment to determine whether the client is ready for surgery.

4. One of the responsibilities of the UAP is changing bed linens.

5. The UAP can document the client's intake and output, but the UAP cannot evaluate the numbers.

21. Which client should the charge nurse on the pediatric unit assign to the most experienced nurse?

1. The 4-year-old child diagnosed with hemophilia receiving factor VIII.

2. The 8-year-old child with headaches who is scheduled for a CT scan.

3. The 6-year-old child recovering from a sickle cell crisis.

4. The 11-year-old child newly diagnosed with rheumatoid arthritis.

1-The administration of blood products does not require the most experienced nurse.

2-Preparing a child for a routine procedure does not require the most experienced nurse.

3-The child recovering from a sickle cell crisis would not require the most experienced nurse.

****4-The child newly diagnosed with a chronic disease, which will have acute exacerbations, requires extensive teaching; therefore, the most experienced nurse should be assigned to this child and family.**

22. The charge nurse is making shift assignments on a pediatric oncology unit. Which delegation/assignment would be most appropriate?

1. Delegate the unlicensed assistive personnel (UAP) to obtain routine blood work from the central line.

2. Instruct the licensed practical nurse (LPN) to contact the leukemia support group.

3. Assign the chemotherapy-certified RN to administer chemotherapeutic medication.

4. Have the dietitian check the meal trays for the amount eaten.

1-Only an RN can withdraw blood from a central line.

2. The social worker or case manager is responsible for referring clients to support groups. This is not an expected responsibility of a floor nurse/LPN.

****3. Only chemotherapy-certified RNs can administer antineoplastic, chemotherapeutic medications. This is a national minimal standard of care according to the Oncology Nursing Society.**

4. The dietitian is responsible for ensuring that the proper food is provided along with evaluating the child's nutritional intake, not checking the amount of food eaten—this is the responsibility of the nursing staff.

23. The nurse observes the unlicensed assistive personnel (UAP) bringing a cartoon video to a 6-year-old female child on bed rest so that she can watch it on the television. Which action should the nurse take?

1. Tell the UAP that the child should not be watching videos.

2. Explain that this is the responsibility of the child life therapist.

3. Praise the UAP for providing the child with an appropriate activity. 4. Notify the charge nurse that the UAP gave the child videos to watch.

1. A 6 year old child on bed rest needs an appropriate activity to help with distraction; a cartoon video would be an age appropriate activity.

2. The child life therapist is responsible for recreational and developmental activity for the hospitalized child, but any staff member should address the child's psychosocial needs.

****3. Part of the delegation process is to evaluate the UAP's performance of duties, and the nurse should praise any initiative on the part of the UAP in being a client advocate.**

4. Videos are one of the few age-appropriate activities to occupy a 6-year-old on bed rest; therefore, there is no reason to notify the charge nurse.

24. Which newborn should the nurse in the neonatal intensive care unit (NICU) assign to a new graduate who has just completed an NICU internship?

1. The 1-day-old infant diagnosed with a myelomeningocele.

2. The 2-week-old infant who was born 6 weeks premature.

3. The 3-hour-old infant who is being evaluated for esophageal atresia. 4. The 1-week-old infant diagnosed with tetralogy of Fallot.

1-The newborn with the myelomeningocele has a portion of the spinal cord and membranes protruding through the back and is at risk for hydrocephalus and meningitis; this client should be assigned to a more experienced nurse.

****2-The new graduate who has completed the NICU internship should be able to care for a premature infant because care is primarily supportive.**

3-Esophageal atresia, a congenital anomaly in which the esophagus does not completely develop, is a clinical and surgical emergency. It puts the newborn at risk for aspiration because the upper esophagus ends in a blind pouch with the lower part of the esophagus connected to the trachea. This newborn should be assigned to a more experienced nurse.

4-Tetralogy of Fallot is a cyanotic, congenital anomaly. It includes a combination of four defects of the heart, all of which result in unoxygenated blood being pumped into the systemic circulation. This newborn must be assigned to an experienced nurse.

25. The newly hired nurse is working on a pediatric unit and needs the unlicensed assistive personnel (UAP) to obtain a urine specimen on an 11-month-old infant. Which statement made to the UAP indicates the nurse understands the delegation process?

1. "Be sure to weigh the diaper when obtaining the urine specimen."

2. "Do you know how to apply the urine collection bag?"

3. "Use a small indwelling catheter when obtaining the urine specimen." 4. "I need for you to get a urine specimen on the infant."

1-Weighing the diaper is the procedure for determining the infant's urinary output and is not part of the procedure for obtaining a urine specimen.

****2-The NCSBN position paper in 1995 defined delegation as transferring to a competent individual the authority to perform a selected nursing task in a selected situation. The nurse retains the accountability for the delegation. The nurse must determine whether the UAP has the ability and knowledge to perform a task. This question clarifies whether the UAP has the ability to obtain a urine specimen.**

3-Obtaining a urine specimen with an indwelling catheter on an 11-month-old infant would require more expertise than a UAP would have on the pediatric unit.

Furthermore, it does not determine whether the UAP understands how to do the procedure.

4. This statement does not determine whether the UAP understands how to perform the procedure of obtaining a urine specimen from an 11-month-old infant.

26. Which task is most appropriate for the pediatric nurse to delegate to the unlicensed assistive personnel (UAP)?

1. Ask the UAP to orient the parents and child to the room.

2. Tell the UAP to prepare the child for an endoscopy.

3. Request the UAP to log roll the client who had a spinal surgery. 4. Instruct the UAP to assess the child's developmental level.

****1-The UAP can orient the parents and child to the room, and demonstrate how to use the call light, how the bed works, or how the television works.**

2-The UAP cannot prepare a child for endoscopy; this requires assessment and evaluation to determine if the child is ready for the procedure.

3-There must be at least two people to log roll a child, and the UAP cannot do this procedure alone.

4-The nurse cannot delegate assessment to the UAP.

27. Which behavior by the unlicensed assistive personnel (UAP) warrants intervention by the nurse?

1. The UAP weighs the child's diaper on a scale and records the urine output on the intake & output (I&O) sheet.
2. The UAP sits with the child while the parent goes down to the cafeteria to get something to eat.
3. The UAP bathes the child with congenital dislocated hip with the Pavlik harness on the child.

4. The UAP applies wrist restraints on the 7-month-old who is 1 day postoperative cleft palate repair.

1-The UAP can weigh the diapers and obtain urine output. The nurse must evaluate the output.

2-A child under 12 years of age cannot be left alone in the room, and the UAP could stay with the child while the parent gets something to eat.

3-The Pavlik harness should not be removed, so bathing the child in the harness is appropriate and does not warrant intervention.

**4- The 7-month-old should have elbow restraints, not wrist restraints. Elbow restraints prevent the child from putting fingers into the mouth, but allow the child to move the arms.

28. The nurse is caring for pediatric clients. Which tasks are most appropriate to assign to an unlicensed assistive personnel (UAP) and/or a licensed vocational nurse (LPN)? Select all that apply.

1. Instruct the LPN to teach the parent of a child new diagnosed with type 1 diabetes.

2. Tell the UAP to apply an ice collar to the child who is 1 day postoperative tonsillectomy.

3. Ask the UAP to place ointment on a child's diaper rash around the anal area.

4. Request the LPN to double-check the medication dose for the child receiving an antibiotic.

5. Tell the LPN to transcribe the healthcare provider's orders for the child with cystic fibrosis.

2, 3, 4, and 5 are correct.

1. The nurse cannot assign teaching to the LPN.

2. The UAP can apply an ice collar since the client is stable.

3. The UAP can apply ointment to a diaper rash—it is a medication but it can be applied by the UAP.

4. The LPN can double-check a dose of medication. The nurse can assign medication administration to an LPN.

5. The LPN can transcribe a healthcare provider's orders.

29. The nurse is discharging a 4-month-old child with a temporary colostomy. Which intervention should the nurse implement?

1. Request the UAP to complete the discharge written documentation.

2. Tell the LPN to show the parent how to irrigate the colostomy.

3. Ask the UAP to remove the child's intravenous catheter.

4. Request the UAP to escort the parent and child to the car.

1-The nurse cannot delegate teaching to the UAP.

2-The LPN could teach a client how to irrigate a colostomy, but a 4-month-old is incontinent of stool; therefore, irrigating the colostomy is not done.

3-The LPN or nurse should remove the IV catheter of a 4-month-old child, not the UAP.

****4-The UAP can escort the child and parents to the car.**

30. The unlicensed assistive personnel (UAP) tells the nurse the child with Down syndrome who is 2 days postoperative appendectomy is having pain. Which intervention should the nurse implement first?

1. Tell the UAP to check the child's vital signs.

2. Assess the child's abdominal dressing and pain immediately.

3. Notify the healthcare provider.

4. Check the MAR for last time pain medication was administered.

1-The UAP can take vital signs but the nurse should assess the child to determine whether this is routine postoperative pain (expected), or whether a complication is occurring.

****2. A rule of thumb—if anyone else gives the nurse information about a client, the nurse should first assess the client before taking any further action.**

3. The nurse may need to notify the HCP, but not before assessing the child.

4. The nurse may need to administer pain medication but not prior to assessing the child.

31. The 8-year-old male child in the pediatric unit is refusing to ambulate postoperatively. Which intervention would be most appropriate?

1. Give the child the option to ambulate now or after lunch.

2. Ask the parents to insist the child ambulate in the hall.

3. Refer the child to the child developmental therapist.

4. Tell the child he can watch a video game if he cooperates.

****1.The nurse should offer the child choices that ensure cooperation with the therapeutic regimen. The choices are when the child will ambulate, not whether the child will ambulate.**

2. The nurse could ask the parents for help in making sure the client ambulates, but this may cause a rift in the nurse/parent/child relationship. This is not the most appropriate intervention.

3. The child development therapist could assist with activities that would encourage the client to ambulate, but the nurse should take control of the situation and ensure the client ambulates. This is not the most appropriate intervention.

4. This is bribery, and the nurse should not use this technique to ensure cooperation with the therapeutic regimen.

32. The clinic nurse overhears a mother in the waiting room tell her 6-year-old son, "If you don't sit down and be quiet, I am going to get the nurse to give you a shot." Which action should the nurse implement?

1. Do not take any action because the mother is attempting to discipline her son. 2. Tell the child the nurse would not give him a shot because the mother said to.

3. Report this verbally abusive behavior to Child Protective Services.

4. Tell the mother this behavior will cause her son to be afraid of the nurses.

1. The nurse must take action or the child will be afraid of the nurse.
2. The nurse should discuss the inappropriate comment with the mother, not with the child.
3. If every nurse who overheard this type of comment reported it to Child Protective Services, it would only unnecessarily increase the workload in an already overloaded system. Furthermore, reporting perceived potential abuse to Child Protective Services is a very serious accusation.

****4. The nurse should explain to the mother that threatening the child with a shot will cause the child to be frightened of healthcare professionals. This type of comment is inappropriate and should not be used to discipline a child.**

33. The parents of an infant born with Down syndrome are holding their infant and crying. The father asks, "I have heard children like this are hard to take care of at home." Which referral would be most appropriate for the parents?

1. The Web site for the National Association for Down Syndrome.
2. The hospital chaplain.

3. A Down syndrome support group. 4. A geneticist.

1. There is a Web site to obtain information about Down syndrome, but this type of referral would not be the most appropriate for parents who need to deal with emotional aspects of having a child with special needs.
2. The hospital chaplain is an important part of the multidisciplinary healthcare team but would not have specialized knowledge regarding caring for a special needs child.

****3. According to the NCLEX-RN® test plan, referrals are included in management of care. The most appropriate referral would be to a support group where other parents who have special needs children can share their feelings and provide advice on how to care for their child in the home.**

4. Although Down syndrome results from a trisomy chromosome 21, it is primarily associated with maternal age over 35 years. Furthermore, a geneticist would not have specialized knowledge regarding caring for a special needs child.

34. The charge nurse on the pediatric unit hears the overhead announcement of Code Pink (infant abduction), newborn nursery. Which action should the charge nurse implement?

1. Send a staff member to the newborn nursery.
2. Explain the situation to the clients and visitors.
3. Continue with the charge nurse's responsibilities.

4. Station a staff member at all the unit exits.

1. The newborn nursery does not need any more people in the area. Personnel are needed to monitor any and all exits.
2. The purpose of using code names to alert hospital personnel of emergency situations is to avoid panic among the clients and visitors; therefore, the nurse should not explain the situation to the clients and visitors.
3. Any time there is an overhead emergency announcement, the charge nurse is responsible for following the hospital emergency plan.

****4. Code Pink means an infant has been abducted from the newborn nursery. The priority intervention is to prevent the abductor from taking the child from the hospital, which can be prevented by placing a staff member at all of the unit exits.**

35. The mother of a 4-year-old child diagnosed with Duchenne's muscular dystrophy is overwhelmed and asks the nurse, "I have been told a case manager will come and talk to me. What will they do for me?" Which statement indicates the nurse understands the role of the case manager?

1. "You will have a case manager so that the hospital can save money."
2. "She will make sure your child gets the right medication for muscular dystrophy."
3. "She will help you find the resources you need to care for your child."
4. "The case manager helps your child to have a normal life expectancy."

1. Even though case management is a strategy to ensure coordination of care while reducing costs, the nurse should not share this with the mother.

2. The case manager is not responsible for ensuring that the client receives the correct medication; it is the responsibility of the HCP.

****3. According to the NCLEX-RN® test blueprint, questions on case management are included. The case manager will coordinate the care for a client with a chronic illness with other members of the multidisciplinary healthcare team. This attempts to prevent duplication of services and allows the mother to have a specific individual to coordinate services to meet the child's needs.**

4. The life expectancy of a child with Duchenne's muscular dystrophy is approximately 25 years. The case manager is not responsible for helping the child have a normal life expectancy.

36. The nurse is assigned to the pediatric unit performance improvement committee. The unit is concerned with IV infection rates. Which action should the nurse implement first when investigating the problem?

1. Contact central supply for samples of IV start kits.
2. Obtain research to determine the best length for IV dwell time.

3. Identify how many IV infections have occurred in the last year. 4. Audit the charts to determine if hospital policy is being followed.

1. Although this would not be the first step in investigating a problem, this action may be initiated if it is determined to be the cause for the increase in infection rates.

2. The nurse should utilize evidenced-based practice research when proposing changes because it is part of the performance improvement process, but it is not the first intervention when investigating the problem.

****3. The first intervention is to determine the extent of the problem and who owns the problem. The NCLEX-RN® test blueprint includes performance improvement (quality improvement) in the management of care content.**

4. This action may need to be implemented once it is determined whether there is a problem with IV infection rates. However, this would be the second step in the process.

37. The clinic nurse is discussing a tubal ligation with a 17-year-old adolescent with Down syndrome. The adolescent does not want the surgery, but her parents (who are also in the room) are telling her she must have it. Which statement by the nurse would be an example of the ethical principle of justice?

1. "I think this requires further discussion before scheduling this procedure."

2. "You will not be able to have children after you have this procedure."

3. "You should have this procedure because you could not care for a child." 4. "You can refuse this procedure and your parents can't make you have it."

****1.** The ethical principle of justice is to treat all clients fairly, without regard to age, socioeconomic status, or any other variable, including clients with special needs. This statement supports the adolescent's right to her opinion even though she has Down syndrome.

2.If the adolescent needs clarification of the procedure, this would be an appropriate response, which is an example of the ethical principle of veracity or truth telling.

3.This statement is an example of the ethical principle of paternalism, in which the nurse knows what is best for the client.

4.This is an example of autonomy, in which the client has the right to self-determination. The Nuremburg Code of ethics specifically supports the rights of individuals with special needs against being forced to participate in procedures they do not want.

38. The school nurse has referred an 8-year-old student for further evaluation of vision. The single mother has told the school nurse she does not have the money for the evaluation or glasses. Which action by the nurse would be an example of client advocacy?

1. Tell the mother the child cannot read the board.

2. Refer the mother to a local service organization. 3. Ask the mother if the family is on Medicaid.

4. Loan the mother money for the examination.

1.Although this may be the case, this is not client advocacy, and doing so may make the mother feel guilty about not being able to afford glasses for her child.

****2.**This is an example of client advocacy because many local service organizations, such as the Lions Club or the Rotary Club, will subsidize the cost of the vision test and glasses.

3.Medicaid does not pay for glasses, and it is not the school nurse's business whether the family is on Medicaid.

4.The nurse should not loan the mother money because this crosses professional boundaries.

39. The emergency department (ED) nurse is scheduling the 16-year-old client for an emergency appendectomy. Which intervention should the nurse implement when obtaining permission for the surgery?

1. Withhold the narcotic pain medication until the client signs the permit.

2. Have the client's parent sign the operative permit.

3. Explain the procedure to the client and let the parent or legal guardian sign and have the parents in simple terms.

4. Get a visitor from the ED waiting area to witness the parent's signature.

1. The 16-year-old client is not old enough to sign the permit; therefore, pain medication would not be withheld.

****2.** Legally, a child under the age of 18 must have a parent or legal guardian sign for informed consent. The nurse should determine whether the child is aware of the situation and assents to the procedure.

3. The surgeon is responsible for explaining the procedure; the nurse is responsible for witnessing the signature on the operative permit.

4. The nurse is responsible for witnessing the signature. Having a visitor sign the operative permit is a violation of HIPAA.

40. The unit manager has been notified by central supply that many client items are missing from stock and have not been charged to the client. Which action should the nurse manager implement regarding the lost charges?

1. Send out a memo telling the staff to follow the charge procedures.
2. Form a performance improvement committee to study the problem.
3. Determine whether the items in question are being restocked daily.
4. Schedule a staff meeting to discuss how to prevent further lost charges.

1. A written memo does not allow the staff to have input into how to correct the problem. This memo might lead to blaming and arguments among the staff.

2. The performance improvement committee is designed to improve client care, not to address management issues.

3. This is implying that the unit manager does not believe the central supply lost charges. If the unit manager has this concern, it should be addressed directly with the central supply supervisor.

****4. Because the staff is responsible for following the hospital procedure for charging for items used in client care, the unit manager should discuss this with staff to determine what should be done to correct the problem.**

41. Which child's behavior warrants notifying the child developmental specialist?

1. The 1-year-old child who cries when the parent leaves the room.
2. The 2-year-old child who can talk in two- or three-word sentences.
3. The 3-year-old child who is toilet trained for bowel and bladder.
4. The 4-year-old child who throws frequent temper tantrums.

1. A 1 yr old child who cries when the parent leaves the room is developmentally on target

2. The 2-year-old who can speak in two- or three-word sentences is developmentally on target.

3. The 3-year-old should be toilet trained by this age.

****4. The toddler (age 1-3) is expected to throw temper tantrums, but a 4-year-old child should not be doing this; therefore, the child is not developmentally on target and the child developmental specialist should be notified.**

42. Which child should the nurse assign to the new graduate who has just completed orientation to the pediatric unit?

1. The 5-year-old child admitted in a sickle cell crisis whose patient-controlled analgesia (PCA) pump is not controlling the child's pain.
2. The 6-year-old child in Russell's traction for a fractured femur who has insertion pin sites that are inflamed and infected.
3. The 12-year-old child who is newly diagnosed with type 1 diabetes who needs medication teaching.
4. The 16-year-old female diagnosed with scoliosis who is being admitted for insertion of a spinal rod in the morning.

1. The child with uncontrolled pain would require a more experienced nurse.

2. Infected skeletal pin sites can lead to osteomyelitis, which would require a more experienced nurse.

3. This child and parents require extensive teaching and should be assigned to a more experienced nurse.

****4. The new graduate should be able to complete preoperative teaching and prepare the young client for surgery. This client is stable.**

43. Which action by the emergency department (ED) nurse warrants intervention by the charge nurse?

1. The nurse is elevating the right arm of a child who appears to have fractured the wrist.

2. The nurse is notifying Child Protective Services for a child who is suspected of being sexually abused.

3. The nurse is assessing the tonsils on a 4-year-old child who has a sore throat and is drooling.

4. The nurse is obtaining a midstream urine specimen for the child who is complaining of burning upon urination.

1. Elevating the arm to help decrease edema is an appropriate intervention and does not warrant intervention.

2. The nurse is legally obligated to notify CPS for any suspected child abuse.

****3. A child who is drooling may have epiglottitis and opening the mouth may lead to respiratory distress. This action warrants intervention by the charge nurse.**

4. The nurse needs to confirm a urinary tract infection by obtaining a urine specimen.

45. Which interventions should the nurse implement to help establish a nurse/parent relationship? Select all that apply.

1. Include the parents when developing the plan of care for their child.

2. Encourage the parents to hold their child as much as possible.

3. Allow the parents to verbalize their feelings of fear and anxiety.

4. Tell the parents to never leave while the child is hospitalized.

5. Request the parents to bring toys from home the child will enjoy.

1 and 3 are correct.

1. Including the parents in developing the plan of care will help establish a positive relationship.

2. Holding their child will help with the child/parent relationship, but not with the nurse/parent relationship.

3. Allowing the parents to vent their feelings will help form a positive nurse/parent relationship.

4. The nurse must not make the parents feel guilty if they have to work while the child is hospitalized. A relative can stay with the child if parents have to work.

5. This will help the child/parent relationship not the nurse/parent relationship.

46. The nurse is caring for clients on the pediatric unit. Which child would warrant a referral to the early childhood development specialist?

1. The 9-month-old child who says only "mama" or "dada."

2. The 11-month-old child who walks hanging onto furniture.

3. The 8-month-old child who sits by leaning forward on both hands. 4. The 4-month-old infant who turns from the abdomen to the back.

1. The 9-month-old infant's language and cognitive skills include imitating sounds, saying single syllables, and beginning to put syllables together. Using "mama" and "dada" indicates this child is developmentally on target.

2. The 10- to 12-month-old infant can walk with one hand held or cruise the furniture, but will usually crawl to get places more rapidly. This behavior indicates the child is developmentally on target.

****3. The 8-month-old infant should be able to sit steadily unsupported; therefore, this child is developmentally delayed and warrants a referral to the early childhood development specialist. Leaning forward on both hands to sit is normal for a 6-month-old.**

4. The 4-month-old infant should be able to turn from the abdomen to back; therefore, this child is developmentally on target.

47. The 10-year-old child diagnosed with leukemia is scheduled for a bone marrow aspiration. Which intervention is most important when obtaining informed consent for the procedure?

1. Obtain assent from the child.

2. Have the parent sign the permit.

3. Refer any questions to the HCP.

4. Witness the signature on the permit.

****1. The most important intervention for this child is to make sure the child has some control and input into the decision making. It is customary to obtain assent from children 7 years of age and older. Assent means the child has been fully informed about the procedure and concurs with those giving the informed consent.**

2. The parents must sign the permit because the child is under age 18, but the most important intervention is to make sure the child is included and aware of decisions being made about his or her body.

3. The nurse may be able to clarify some of the child's or parent's questions and does not need to refer all questions to the HCP.

4. Witnessing the signature on the permit is required prior to the child's having surgery, but it is not the most important intervention.

48. The 13-year-old client has just delivered a 4-pound baby boy. The stepfather of the client becomes verbally abusive to the nurse when he is asked to leave the room. The client is withdrawn and silent. Which legal action should the nurse implement?

1. Call hospital security to come to the room.

2. Contact Child Protective Services.

3. Refer the child to the social worker.

4. Ask the client whether she feels safe at home.

1. The nurse should call hospital security when a client or visitor is being abusive, but this is not a legal action.

****2. Legally, the nurse is required to report any suspected child abuse. A 13-year-old child who is having a baby and is withdrawn and silent along with a potential abuser who is trying to control access to the child should make the nurse suspect child abuse.**

3. Referring the client to a social worker is not a legal action.

4. Asking the client whether she feels safe at home is an appropriate assessment question, but it is not a legal action.

49. The fire alarm on the pediatric unit has just started sounding. Which action should the charge nurse implement first?

1. Call the hospital operator to find out the location of the fire.

2. Ensure that all visitors and clients are in the room with the door closed.

3. Prepare to evacuate the clients and visitors down the stairs. 4. Make a list of which clients are not currently on the unit.

1. The charge nurse must first make sure that clients and visitors are safe. Someone will notify the charge nurse about the location of the fire.

****2. Safety of the clients and visitors is priority; therefore, ensuring that they are in a room with the door closed is the first intervention.**

3. The charge nurse may need to prepare for evacuation, but it is not the first intervention.

4. Although making a list of clients not currently on the unit is an appropriate intervention, the charge nurse must first ensure the safety of the clients and visitors who are on the pediatric unit.

50. A nurse overhears two other nurses talking about a client in the hospital dining room. Which action should the nurse implement first?

1. Notify the HIPAA officer about the breach of confidentiality.

2. Immediately report the two nurses to their clinical manager.

3. Document the situation in writing and submit to the Chief Nursing Officer (CNO).

4. Tell the two nurses they are violating the client's confidentiality.

1. The HIPAA officer can be notified of the breach of confidentiality, but the nurse must first confront the two nurses and correct the behavior.

2. The nurses can be reported to their clinical manager, but the nurse must first confront the two nurses and correct the behavior.

3. The situation can be documented in writing and turned into the HIPAA officer (not the CNO), but the nurse must first confront the two nurses and correct the behavior.

****4. This is a violation of HIPAA; therefore, the nurse must first confront the two nurses and correct the behavior.**

51. The nurse is caring for newborns in the nursery. Which newborn warrants immediate intervention by the nurse?

1. The 8-hour-old newborn who has not passed meconium.

2. The 15-hour-old newborn who is slightly jaundiced.

3. The 4-hour-old newborn who is jittery and irritable. 4. The 10-hour-old newborn who will not stop crying.

1. The nurse would not be concerned about not passing meconium until at least 24 hours after delivery.

2. The nurse would not be concerned about a newborn who is slightly jaundiced until after 24 hours after delivery, at which point the HCP would investigate to determine whether the jaundice is pathological.

****3. A newborn who is jittery and irritable needs to be assessed first for possible hypoglycemia. The nurse could feed the newborn glucose water or provide more frequent, regular feedings.**

4. Although the nurse should determine why the newborn will not stop crying, the newborn who is showing signs of hypoglycemia warrants immediate intervention.

53. The nurse who has never worked on the maternity ward has been pulled from the surgical unit to work in the newborn nursery. Which assignment would be most appropriate for the nurse to accept?

1. Perform an assessment on the newborn.
2. Assist the pediatrician with a circumcision.
3. Gavage feed a newborn who is 8 hours old.

4. Transport newborns to the mothers' room.

1. The nurse should not accept any assignment for which he or she is unqualified.

A newborn assessment requires specialized knowledge and skills to detect potential complications.

2. The nurse who is not familiar with the procedure or the unit should not be assigned to assist a pediatrician to perform a procedure.

3. This is a dangerous procedure because the nurse must insert a tube into the newborn's stomach. A nurse who is not familiar with this procedure should refuse the assignment.

****4. Any nurse can take an infant to the mother's room and check the bands to ensure the right infant is with the right mother. This is an appropriate task for a nurse who has never worked in the nursery.**

54. The nurse is instructing the unlicensed assistive personnel (UAP) on gross motor skill activity that is appropriate for a developmentally delayed 9-month-old infant. Which activity should the nurse delegate to the UAP?

1. Help the child to sit without support.

2. Teach the child to catch the beach ball. 3. Reward the child with food for sitting up. 4. Teach the child to blow a kiss.

****1. The 9-month-old infant should be able to sit without support. Therefore, the nurse should instruct the UAP to perform the developmental task of helping the child sit without support.**

2. Teaching a child to catch a beach ball would be appropriate for a 15- to 18-month-old child, so the nurse should not instruct the UAP to perform this task.

3. The UAP should not use food as a reward or comfort measure because it may lead to childhood obesity.

4. Teaching a child how to blow a kiss is a language/cognitive activity and will not help the child's gross motor development.

55. Which incident should the primary nurse report to the clinical manager concerning a violation of information technology guidelines?

1. The nurse keeps the computer screen turned away from public view.

2. The nurse researches medications using the online formulary.

3. The nurse shares the computer access code with another nurse.

4. The nurse logs off the computer when leaving the terminal.

1. Making sure no one can view the screen is an appropriate information technology guideline.

2. Researching medication online is ensuring safe and effective nursing care and shows that the nurse is keeping abreast of new medications.

****3. According to the NCLEX-RN® test blueprint, the nurse must be knowledgeable of information technology. Giving another nurse his or her access code is a very serious violation of information technology guidelines and should be reported.**

4. Logging off the computer is an appropriate information technology guideline.

56. The nurse is caring for clients in a pediatric emergency department (ED). Which client should the nurse assess first?

1. The child with a dog bite on the left hand who is bleeding.
2. The child who has a laceration on the right side of the forehead.
3. The child with a fractured tibia who will not move the foot.

4. The child who has ingested a bottle of prenatal vitamins.

1. A dog bite is an emergency, but it is not life threatening; therefore, this child would not be assessed first.

2. The child with a head laceration must be assessed, but not before a child who might die of medication poisoning.

3. The child with a fractured tibia would not be expected to move the foot.

****4. A child who ingested a bottle of prenatal vitamins presents a medication poisoning that is a potentially life-threatening situation. This child must be assessed first to determine how many vitamins were taken, how long ago they were taken, and whether or not the vitamins contained iron. The child's neurological status must also be assessed.**

57. The nurse is caring for a client in a children's medical center. Which behavior indicates the nurse understands the pediatric client's rights?

1. The nurse administers an injection without talking to the child.

2. The nurse covers the 5-year-old child's genitalia during a code.

3. The nurse discusses the child's condition with the grandparents. 4. The nurse leaves an uncapped needle at the client's bedside.

1. The pediatric client has the right to an explanation of procedures being done to his or her body.

****2. The pediatric client has a right to be treated with dignity and respect. Just because the child is being coded does not mean the nurse should allow the child's body to be exposed to everyone in the room.**

3. The pediatric client has a right to confidentiality, and the parents/legal guardians are the only individuals who have a right to the child's health information. Talking to the grandparents is a violation of HIPAA unless the parents have approved.

4. The nurse is responsible and accountable to protect the health, safety, and rights of the pediatric client. Leaving an uncapped needle at the bedside could cause serious harm to the child.

58. The home health nurse is planning the care of a 14-year-old client diagnosed with leukemia who is receiving chemotherapy. Which psychosocial problem is priority for this client?

1. Diversional activity deficit.

2. High risk for infection.

3. Social isolation.

4. Hopelessness.

1. Diversional activity deficit would be appropriate if the client did not have sufficient activities to keep him or her occupied. Most children of this age will watch television, play video games, or read books.

2. The client has leukemia and is receiving chemotherapy, which leads to an increased risk of infection; however, this is a physiological problem, not a psychosocial problem.

****3.** The client will be isolated from peers and schools because of the high risk of infection resulting from the immunosuppression secondary to chemotherapy and the disease process. At this stage, the child needs to be developing peer relationships and independence from parents. Therefore, social isolation is the priority psychosocial problem for this client.

4. The nurse should not identify hopelessness because childhood leukemia has a good prognosis.

59. The nurse is administering IV fluids to a 3-year-old client. Which action by the nurse would warrant intervention by the charge nurse?

1. The nurse places the IV on an infusion pump.

2. The nurse does not use a volume-controlled chamber.

3. The nurse checks the child's IV site every hour.

4. The nurse labels the IV tubing with date and time.

1. Placing the IV line on an infusion pump helps to make sure the client does not receive an overload of IV fluid. Most facilities require an IV pump and volume-controlled chamber when administering fluids in a pediatric clinic.

****2.** A volume-controlled chamber (Buretrol) is a device that is used with children when administering IV fluids. The chamber is filled with 1 hour's amount of fluid so that the child will not inadvertently receive an overload of fluid. Fluid volume overload is a potentially life-threatening situation in children.

3. The site should be checked frequently to ensure that the IV does not infiltrate; therefore, this does not warrant intervention.

4. The IV tubing should not be used longer than 72 hours; therefore, labeling the tubing with the date and time would not warrant intervention.

60. The nurse is caring for clients on a psychiatric pediatric unit. Which action by the nurse is reportable to the state board of nursing?

1. The nurse leaves for lunch and does not return to complete the shift.

2. The nurse fails to check the ID band when administering medications.

3. The nurse has had three documented medication errors in the last 3 months. 4. The nurse has admitted to having an affair with another staff member.

****1.** Abandonment is a reportable offense to the state board of nursing in every state. Reportable offenses could result in stipulations made to the nurse's license.

2. This is failure to follow the five rights of medication administration, but it is not a reportable offense.

3. Multiple medication errors are a management issue, not a reportable offense.

4. Having an affair with a fellow employee is not a reportable offense.

61. The nurse is working in a free healthcare clinic. Which client situation warrants further investigation?

1. The child diagnosed with rheumatoid arthritis who is wearing a copper bracelet.

2. The mother of a child with a sunburn who is using juice from an aloe vera plant on the burn.

3. The grandmother who reports rubbing Vick's Vapo-Rub on the child's chest for a cold.

4. The father who tells the nurse that the child receives a variety of herbs every day.

1. A copper bracelet may or may not help the child with rheumatoid arthritis, but because it will not hurt the child, it does not warrant further investigation.

2. Aloe vera is used in many topical burn preparations; therefore, this practice would not warrant further investigation.

3. Vick's VapoRub may or may not help the child's cold, but, because it will not hurt the child, it does not warrant further investigation.

****4. Herbal products are not regulated by the Food and Drug Administration, and there is very little (if any) research on herbal use with children. The nurse should at least investigate which herbs the child is receiving before taking further action.**

62. The unlicensed assistive personnel (UAP) tells the primary nurse that the 4-year-old child is alone in the room because the mother went to the cafeteria to get something to eat. Which action should the nurse implement first?

1. Arrange for the mother to have a tray sent to the room.

2. Go to the cafeteria and ask the mother to return to the room.

3. Tell the UAP to stay with the child until the mother returns.

4. Notify social services that the mother left the child alone.

1. This is an appropriate nursing intervention so that the mother will not have to leave her child, but it is not the first intervention. The child's safety is priority.

2. The nurse could go to the cafeteria and tell the mother to return to the room, but during this time the UAP should stay with the child.

****3. The child's safety is priority; therefore, the nurse should have the UAP stay with the child until the mother returns.**

4. Social services would not need to be notified at this time. If the mother continually leaves the child alone, then this would be an appropriate action.

63. The nurse is evaluating an 18-month-old child in the pediatric clinic. Which data would indicate to the nurse that the child is not meeting tasks according to Erikson's Stages of Psychosocial Development?

1. The child stamps his or her foot and says "no" frequently.

2. The child does not interact with the mother.

3. The child cries when the mother leaves the room. 4. The child responds when called by name.

1. An 18-month-old child should be throwing temper tantrums. This indicates the child is developing a sense of autonomy.

****2. An 18-month-old child should cling to the mother and interact continuously with the primary caregiver. A child not interacting with the mother is not meeting the task of developing a sense of autonomy.**

3. The child has met the task of trust when he or she cries if the mother leaves the room.

4. When a child responds to his or her name, it indicates a sense of identity; therefore, the task is met.

64. Which statement by the female charge nurse indicates she has an autocratic leadership style?

1. "You must complete all the a.m. care before you take your morning break." 2. "I don't care how the work is done as long as it is completed on time."

3. "I would like to talk to you about your ideas on a new staffing mix."

4. "I think we should have a pot luck lunch tomorrow because it is Saturday."

****1. An autocratic manager uses an authoritarian approach to direct the activities of others. This individual makes most of the decisions alone without input from other staff members.**

2. A laissez-faire manager maintains a permissive climate with little direction or control.

3. A democratic manager is people oriented and emphasizes efficient group functioning. The environment is open, and communication flows both ways.

4. A democratic manager is people oriented and emphasizes efficient group functioning.

65. The nurse is evaluating the care of a 5-year-old client with a cyanotic congenital heart defect. Which client outcome would support that discharge teaching has been effective?

1. The mother makes the child get up when squatting.

2. The child is playing in the dayroom without oxygen.

3. The father buys the child a baseball and a bat.

4. The nurse finds unopened packs of salt on the meal tray.

1. Squatting relieves the hypoxic episodes, and the child should be able to remain in the squatting position.

2. The child with a cyanotic, congenital heart defect should have oxygen when being active.

3. This indicates the father does not understand that the child will not be able to participate in active sports because of the stress that is placed on the heart.

****4. This behavior indicates the child understands the importance of salt restriction because of potential congestive heart failure.**

69. The unconscious 4-year-old child is brought to the emergency department by paramedics; the child has bruises covering the torso in varying stages of healing. The nurse notes small burn marks on the child's genitalia. Which actions should the nurse implement? Select all that apply.

1. Notify Child Protective Services.

2. Ask the parent how the child was injured.

3. Perform a thorough examination for more injuries.

4. Tell the parents that the police have been called.

5. Prepare the child for skull x-rays and a CT scan.

1, 3, and 5 are correct.

1. This child has injuries consistent with child abuse. Child Protective Services and the police should be notified.

2. This could result in not being able to prosecute the perpetrator if the nurse is not trained in forensic medicine.

3. The nurse should determine the full extent of the child's injuries.

4. The nurse should not notify the parent of the potential involvement. The police are fully capable of doing this for themselves. The nurse could instigate an inflammatory situation with this action.

5. The child needs x-ray studies to determine the extent of internal injuries.

70. The 24-month-old toddler is admitted to the pediatric unit with vomiting and diarrhea. Which interventions should the nurse implement? Rank in order of performance.

1. Teach the parent about weighing diapers to determine output status.
2. Show the parent the call light and explain safety regimens.
3. Assess the toddler's tissue turgor.
4. Place the appropriate size diapers in the room.
5. Take the toddler's vital signs.

Rationale

Correct Answer: 5, 3, 2, 4, 1

5. Taking the vital signs is part of the assessment and a beginning point for the nurse.
3. Since the child has been losing fluids, the nurse should assess tissue turgor to try and determine whether fluid replacement by the parents has been effective.
2. The nurse should make sure that the parents do not leave the child alone in the room and make sure the parents are aware of any safety measures used to protect the toddler from abduction and how to call the nurse in case of need.
4. The parents will need to change diapers so the child will not develop skin irritation problems.
1. When the nurse provides diapers it is a good opportunity to teach the parents about weighing the diapers before and after the child soils them.

During a mental status assessment, which question by the nurse would best assess a person's judgment?

- A) "Do you feel that you are being watched, followed, or controlled?"
- B) "Tell me about what you plan to do once you are discharged from the hospital."
- C) "What does the statement, 'People in glass houses shouldn't throw stones,' mean to you?"
- D) "What would you do if you found a stamped, addressed envelope lying on the sidewalk?"

Rationale

A person exercises judgment when he or she can compare and evaluate the alternatives in a situation and reach an appropriate course of action. Rather than testing the person's response to a hypothetical situation (as illustrated in the option with the envelope), the nurse should be more interested in the person's judgment about daily or long-term goals, the likelihood of acting in response to delusions or hallucinations and the capacity for violent or suicidal behavior.

During a mental status examination, the nurse wants to assess a patient's affect. The nurse should ask the patient which question?

- A) "How do you feel today?"
- B) "Would you please repeat the following words?"
- C) "Have these medications had any effect on your pain?"
- D) "Has this pain affected your ability to get dressed by yourself?"

Rationale

Judge mood and affect by body language and facial expression and by asking directly, "How do you feel today?" or "How do you usually feel?" The mood should be

appropriate to the person's place and condition and should change appropriately with topics.

During an assessment, the nurse notices that a patient is handling a small charm that is tied to a leather strip around his neck. Which action by the nurse is appropriate?

- A) Ask the patient about the item and its significance.
- B) Ask the patient to lock the item with other valuables in the hospital's safe.
- C) Tell the patient that a family member should take valuables home.
- D) No action is necessary.
- A) Ask the patient about the item and its significance.

Page: 21 Rationale

amulet's meaning. Amulets, such as charms, are often seen as an important means of protection from "evil spirits" by some cultures.

During an interview, a parent of a hospitalized child is sitting in an open position. As the interviewer begins to discuss his son's treatment, however, he suddenly crosses his arms against his chest and crosses his legs. This would suggest that the parent is:

- A) just changing positions.
- B) more comfortable in this position.
- C) tired and needs a break from the interview.
- D) uncomfortable talking about his son's treatment.
- D) uncomfortable talking about his son's treatment.

Rationale

Note the person's position. An open position with the extension of large muscle groups shows relaxation, physical comfort, and a willingness to share information. A closed position with the arms and legs crossed tends to look defensive and anxious. Note any change in posture. If a person in a relaxed position suddenly tenses, it suggests possible discomfort with the new topic.

During an interview, the nurse states, "You mentioned shortness of breath. Tell me more about that." Which verbal skill is used with this statement?

- A) Reflection
- B) Facilitation
- C) Direct question
- D) Open-ended question
- D) Open-ended question

Rationale

The open-ended question asks for narrative information. It states the topic to be discussed but only in general terms. The nurse should use it to begin the interview, to introduce a new section of questions, and whenever the person introduces a new topic.

An elderly Mexican-American woman with traditional beliefs has been admitted to an inpatient care unit. A culturally-sensitive nurse would:

- A) contact the hospital administrator about the best course of action.
- B) automatically get a curandero for her because it is not culturally appropriate for her to request one.
- C) further assess the patient's cultural beliefs and offer the patient assistance in contacting a curandero or priest if she desires.
- D) ask the family what they would like to do because Mexican-Americans traditionally give control of decisions to their families.

C) further assess the patient's cultural beliefs and offer the patient assistance in contacting a curandero or priest if she desires.

Rationale

In addition to seeking help from the biomedical/scientific health care provider, patients may also seek help from folk or religious healers. Some people, such as those of Mexican-American or American Indian origins, may believe that the cure is incomplete unless the body, mind, and spirit are also healed (although the division of the person into parts is a Western concept).

A female patient does not speak English well, and the nurse needs to choose an interpreter. Which of the following would be the most appropriate choice?

- A) A trained interpreter
 - B) A male family member
 - C) A female family member
 - D) A volunteer college student from the foreign language studies department
- A) A trained interpreter

Rationale

whenever possible, the nurse should use a trained interpreter, preferably one who knows medical terminology. In general, an older, more mature interpreter is preferred to a younger, less experienced one, and the same gender is preferred when possible. In an interview, the nurse may find it necessary to take notes to aid his or her memory later. Which statement is true regarding note-taking?

- A) Note-taking may impede the nurse's observation of the patient's nonverbal behaviors.
 - B) Note-taking allows the patient to continue at his or her own pace as the nurse records what is said.
 - C) Note-taking allows the nurse to shift attention away from the patient, resulting in an increased comfort level.
 - D) Note-taking allows the nurse to break eye contact with the patient, which may increase his or her level of comfort.
- A) Note-taking may impede the nurse's observation of the patient's nonverbal behaviors.

Rationale

Some use of history forms and note-taking may be unavoidable. But be aware that note-taking during the interview has disadvantages. It breaks eye contact too often, and it shifts attention away from the patient, which diminishes his or her sense of importance. It also may interrupt the patient's narrative flow, and it impedes the observation of the patient's nonverbal behavior.

The mother of a 16-month-old toddler tells the nurse that her daughter has an earache. What would be an appropriate response?

- A. "Maybe she is just teething."
- B. "I will check her ear for an ear infection."
- C. "Are you sure she is really having pain?"
- D. "Please describe what she is doing to indicate she is having pain."
- D. "Please describe what she is doing to indicate she is having pain."

Rationale

With a very young child, ask the parent, "How do you know the child is in pain?" Pulling at ears alerts parent to ear pain. The statements about teething and questioning whether the child is really having pain do not explore the symptoms, which should be done before a physical examination.

The nurse is conducting a developmental history on a 5-year-old child. Which questions are appropriate to ask the parents for this part of the assessment? Select all that apply.

- A. "How much junk food does your child eat?"
- B. "How many teeth has he lost, and when did he lose them?"
- C. "Is he able to tie his shoelaces?"
- D. "Does he take a children's vitamin?"
- E. "Can he tell time?"
- F. "Does he have any food allergies?"
- B. "How many teeth has he lost, and when did he lose them?"
- C. "Is he able to tie his shoelaces?"
- E. "Can he tell time?"

Rationale

Questions about tooth loss, ability to tell time, and ability to tie shoelaces are appropriate questions for a developmental assessment. Questions about junk food intake and vitamins are part of a nutritional history. Questions about food allergies are not part of a developmental history.

The nurse is conducting an interview in an outpatient clinic and is using a computer to record data. Which is the best use of the computer in this situation? Select all that apply.

- A) Collect the patient's data in a direct, face-to-face manner.
- B) Enter all the data as the patient states it.
- C) Ask the patient to wait as the nurse enters data.
- D) Type the data into the computer after the narrative is fully explored.
- E) Allow the patient to see the monitor during typing.
- A) Collect the patient's data in a direct, face-to-face manner.
- D) Type the data into the computer after the narrative is fully explored.
- E) Allow the patient to see the monitor during typing.

Rationale

The use of a computer can become a barrier. The nurse should begin the interview as usual by greeting the patient, establishing rapport, and collecting the patient's narrative story in a direct face-to-face manner. Only after the narrative is fully explored should the nurse type data into the computer. When typing, the nurse should position the monitor so that the patient can see it.

The nurse is conducting an interview. Which of these statements is true regarding open-ended questions? Select all that apply.

- A) They elicit cold facts.
- B) They allow for self-expression.
- C) They build and enhance rapport.
- D) They leave interactions neutral.
- E) They call for short one- to two-word answers.
- F) They are used when narrative information is needed.
- B) They allow for self-expression.
- C) They build and enhance rapport.

F) They are used when narrative information

Rationale

Open-ended questions allow for self-expression, build rapport, and obtain narrative information. These features enhance communication during an interview. The other statements are appropriate for closed or direct questions.

The nurse is interviewing a patient who has a hearing impairment. What techniques would be most beneficial in communicating with this patient?

A) Determine the communication method he prefers.

B) Avoid using facial and hand gestures because most hearing-impaired people find this degrading.

C) Request a sign language interpreter before meeting with him to help facilitate the communication.

D) Speak loudly and with exaggerated facial movement when talking with him because this helps with lip reading.

A) Determine the communication method he prefers.

Rationale

The nurse should ask the deaf person the preferred way to communicate—by signing, lip reading, or writing. If the person prefers lip reading, then the nurse should be sure to face him or her squarely and have good lighting on the nurse's face. The nurse should not exaggerate lip movements because this distorts words. Similarly, shouting distorts the reception of a hearing aid the person may wear. The nurse should speak slowly and should supplement his or her voice with appropriate hand gestures or pantomime.

The nurse is performing a functional assessment on an 82-year-old patient who recently had a stroke. Which of these questions would be most important to ask?

A. "Do you wear glasses?"

B. "Are you able to dress yourself?"

C. "Do you have any thyroid problems?"

D. "How many times a day do you have a bowel movement?"

B. "Are you able to dress yourself?"

Rationale

Functional assessment measures how a person manages day-to-day activities. For the older person, the meaning of health becomes those activities that they can or cannot do. The other responses do not relate to functional assessment.

The nurse is performing a health interview on a patient who has a language barrier, and no interpreter is available. Which is the best example of an appropriate question for the nurse to ask in this situation?

A) "Do you take medicine?"

B) "Do you sterilize the bottles?"

C) "Do you have nausea and vomiting?"

D) "You have been taking your medicine, haven't you?"

A) "Do you take medicine?"

Rationale

In a situation where there is a language barrier and no interpreter available, use simple words avoiding medical jargon. Avoid using contractions and pronouns. Use nouns repeatedly and discuss one topic at a time.

The nurse is preparing to assess a patient's abdomen by palpation. How should the nurse proceed?

- A) Avoid palpation of reported "tender" areas because this may cause the patient pain.
- B) Quickly palpate a tender area to avoid any discomfort that the patient may experience.
- C) Begin the assessment with deep palpation, encouraging the patient to relax and take deep breaths.
- D) Start with light palpation to detect surface characteristics and to accustom the patient to being touched.
- D) Start with light palpation to detect surface characteristics and to accustom the patient to being touched.

Rationale

Light palpation is performed initially to detect any surface characteristics and to accustom the person to being touched. Tender areas should be palpated last, not first. The nurse is preparing to do a functional assessment. Which statement best describes the purpose of a functional assessment?

- A. It assesses how the individual is coping with life at home.
- B. It determines how children are meeting developmental milestones.
- C. It can identify any problems with memory the individual may be experiencing.
- D. It helps to determine how a person is managing day-to-day activities.
- D. It helps to determine how a person is managing day-to-day activities.

Rationale

The functional assessment measures how a person manages day-to-day activities. The other answers do not reflect the purpose of a functional assessment.

The nurse is preparing to do a mental status examination. Which statement is true regarding the mental status examination?

- A) A patient's family is the best resource for information about the patient's coping skills.
- B) It is usually sufficient to gather mental status information during the health history interview.
- C) It takes an enormous amount of extra time to integrate the mental status examination into the health history interview.
- D) It is usually necessary to perform a complete mental status examination to get a good idea of the patient's level of functioning.

B) It is usually sufficient to gather mental status information during the health history interview.

Rationale

The full mental status examination is a systematic check of emotional and cognitive functioning. The steps described here, though, rarely need to be taken in their entirety. Usually, one can assess mental status through the context of the health history interview.

The nurse is reviewing concepts of cultural aspects of pain. Which statement is true regarding pain?

- A) All patients will behave the same way when in pain.
- B) Just as patients vary in their perceptions of pain, so will they vary in their expressions of pain.

C) Cultural norms have very little to do with pain tolerance, because pain tolerance is always biologically determined.

D) A patient's expression of pain is largely dependent on the amount of tissue injury associated with the pain.

B) Just as patients vary in their perceptions of pain, so will they vary in their expressions of pain.

Rationale

In addition to expecting variations in pain perception and tolerance, the nurse should expect variations in the expression of pain. It is well known that individuals turn to their social environment for validation and comparison. The other statements are incorrect.

A nurse is taking complete health histories on all of the patients attending a wellness workshop. On the history form, one of the written questions asks, "You don't smoke, drink, or take drugs, do you?" This question is an example of:

A) talking too much.

B) using confrontation.

C) using biased or leading questions.

D) using blunt language to deal with distasteful topics.

C) using biased or leading questions.

Rationale

This is an example of using leading or biased questions. Asking, "You don't smoke, do you?" implies that one answer is "better" than another. If the person wants to please someone, he or she is either forced to answer in a way corresponding to their implied values or is made to feel guilty when admitting the other answer.

The nurse recognizes that working with children with a different cultural perspective may be especially difficult because:

A) children have spiritual needs that are influenced by their stages of development.

B) children have spiritual needs that are direct reflections of what is occurring in their homes.

C) religious beliefs rarely affect the parents' perceptions of the illness.

D) parents are often the decision makers, and they have no knowledge of their children's spiritual needs.

A) children have spiritual needs that are influenced by their stages of development.

Rationale

Illness during childhood may be an especially difficult clinical situation. Children, as well as adults, have spiritual needs that vary according to the child's developmental level and the religious climate that exists in the family. The other statements are not correct.

When assessing the quality of a patient's pain, the nurse should ask which question?

A) "When did the pain start?"

B) "Is the pain a stabbing pain?"

C) "Is it a sharp pain or dull pain?"

D) "What does your pain feel like?"

D) "What does your pain feel like?"

Rationale

To assess the quality of a person's pain, have the patient describe the pain in his or her own words.

When performing a physical assessment, the technique the nurse will always use first is:

- A) palpation.
- B) inspection.
- C) percussion.
- D) auscultation.
- B) inspection.

Rationale

The skills requisite for the physical examination are inspection, palpation, percussion, and auscultation. The skills are performed one at a time and in this order (with the exception of the abdominal assessment, where auscultation takes place before palpation and percussion). The assessment of each body system begins with inspection. A focused inspection takes time and yields a surprising amount of information.

When performing a physical examination, safety must be considered to protect the examiner and the patient against the spread of infection. Which of these statements describes the most appropriate action the nurse should take when performing a physical examination?

- A) There is no need to wash one's hands after removing gloves, as long as the gloves are still intact.
- B) Wash hands before and after every physical patient encounter.
- C) Wash hands between the examination of each body system to prevent the spread of bacteria from one part of the body to another.
- D) Wear gloves throughout the entire examination to demonstrate to the patient concern regarding the spread of infectious diseases.
- B) Wash hands before and after every physical patient encounter.

Rationale

The nurse should wash his or her hands before and after every physical patient encounter; after contact with blood, body fluids, secretions, and excretions; after contact with any equipment contaminated with body fluids; and after removing gloves. Hands should be washed after gloves have been removed, even if the gloves appear to be intact. Gloves should be worn when there is potential contact with any body fluids.

When planning a cultural assessment, the nurse should include which component?

- A) Family history
- B) Chief complaint
- C) Medical history
- D) Health-related beliefs
- D) Health-related beliefs

Rationale

Health-related beliefs and practices are one component of a cultural assessment. The other items reflect other aspects of the patient's history.

When providing culturally competent care, nurses must incorporate cultural assessments into their health assessments. Which statement is most appropriate to use when initiating an assessment of cultural beliefs with an elderly American Indian patient?

- A) "Are you of the Christian faith?"

- B) "Do you want to see a medicine man?"
- C) "How often do you seek help from medical providers?"
- D) "What cultural or spiritual beliefs are important to you?"
- D) "What cultural or spiritual beliefs are important to you?"

Rationale

The nurse needs to assess the cultural beliefs and practices of the patient. American Indians may seek assistance from a medicine man or shaman, but the nurse should not assume this. An open-ended question regarding cultural and spiritual beliefs is best used initially when performing a cultural assessment.

When the nurse is evaluating the reliability of a patient's responses, which of these statements would be correct? The patient:

- A. has a history of drug abuse and therefore is not reliable.
- B. provided consistent information and therefore is reliable.
- C. smiled throughout interview and therefore is assumed reliable.
- D. would not answer questions concerning stress and therefore is not reliable.
- B. provided consistent information and therefore is reliable.

Rationale

A reliable person always gives the same answers, even when questions are rephrased or are repeated later in the interview. The other statements are not correct.

When the nurse is evaluating the reliability of a patient's responses, which of these statements would be correct? The patient:

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Rationale

A reliable person always gives the same answers, even when questions are rephrased or are repeated later in the interview. The other statements are not correct.

Why is it important for the nurse to ask a patient what medications he or she is taking?

- A) Certain drugs can affect the metabolism of nutrients.
- B) The nurse needs to assess the patient for allergic reactions.
- C) Medications need to be documented on the record for the physician's review.
- D) Medications can affect one's memory and ability to identify food eaten in the last 24 hours.
- A) Certain drugs can affect the metabolism of nutrients.

Rationale

Analgesics, antacids, anticonvulsants, antibiotics, diuretics, laxatives, antineoplastic drugs, steroids, and oral contraceptives are drugs that can interact with nutrients, impairing their digestion, absorption, metabolism, or use. The other responses are not correct.