MULTIPLE CHOICE

1. Which factor significantly contributed to the shift from home births to hospital births in the early 20th century?
   a. Puerperal sepsis was identified as a risk factor in labor and delivery.
   b. Forceps were developed to facilitate difficult births.
   c. The importance of early parental-infant contact was identified.
   d. Technologic developments became available to physicians.

   ANS: D
   Technologic developments were available to physicians, not lay midwives. So in-hospital births increased in order to take advantage of these advancements. Puerperal sepsis has been a known problem for generations. In the late 19th century, Semmelweis discovered how it could be prevented with improved hygienic practices. The development of forceps is an example of a technology advance made in the early 20th century but is not the only reason birthplaces moved. Unlike home births, early hospital births hindered bonding between parents and their infants.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Safe and Effective Care Environment

2. Family-centered maternity care developed in response to
   a. demands by physicians for family involvement in childbirth.
   b. the Sheppard-Towner Act of 1921.
   c. parental requests that infants be allowed to remain with them rather than in a nursery.
   d. changes in pharmacologic management of labor.

   ANS: C
   As research began to identify the benefits of early extended parent-infant contact, parents began to insist that the infant remain with them. This gradually developed into the practice of rooming-in and finally to family-centered maternity care. Family-centered care was a request by parents, not physicians. The Sheppard-Towner Act of 1921 provided funds for state-managed programs for mothers and children. The changes in pharmacologic management of labor were not a factor in family-centered maternity care.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 2 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Psychosocial Integrity

3. Which setting for childbirth allows the least amount of parent-infant contact?
   a. Labor/delivery/recovery/postpartum room
   b. Birth center
   c. Traditional hospital birth
   d. Home birth

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ANS: C
In the traditional hospital setting, the mother may see the infant for only short feeding periods, and the infant is cared for in a separate nursery. The labor/delivery/recovery/postpartum room setting allows increased parent-infant contact. Birth centers are set up to allow an increase in parent-infant contact. Home births allow an increase in parent-infant contact.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 2 OBJ: Nursing Process: Planning
MSC: Client Needs: Health Promotion and Maintenance

4. As a result of changes in health care delivery and funding, a current trend seen in the pediatric setting is
   a. increased hospitalization of children.
   b. decreased number of children living in poverty.
   c. an increase in ambulatory care.
   d. decreased use of managed care.

ANS: C
One effect of managed care has been that pediatric health care delivery has shifted dramatically from the acute care setting to the ambulatory setting in order to provide more cost-efficient care. The number of hospital beds being used has decreased as more care is given in outpatient settings and in the home. The number of children living in poverty has increased over the past decade. One of the biggest changes in health care has been the growth of managed care.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 5 OBJ: Nursing Process: Planning
MSC: Client Needs: Safe and Effective Care Environment

5. The Women, Infants, and Children (WIC) program provides
   a. well-child examinations for infants and children living at the poverty level.
   b. immunizations for high-risk infants and children.
   c. screening for infants with developmental disorders.
   d. supplemental food supplies to low-income pregnant or breastfeeding women.

ANS: D
WIC is a federal program that provides supplemental food supplies to low-income women who are pregnant or breastfeeding and to their children until age 5 years. Medicaid's Early and Periodic Screening, Diagnosis, and Treatment Program provides for well-child examinations and for treatment of any medical problems diagnosed during such checkups. Children in the WIC program are often referred for immunizations, but that is not the primary focus of the program. Public Law 99-457 is part of the Individuals with Disabilities Education Act that provides financial incentives to states to establish comprehensive early intervention services for infants and toddlers with, or at risk for, developmental disabilities.

PTS: 1 DIF: Cognitive Level: Comprehension REF: p. 8
OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

6. In most states, adolescents who are not emancipated minors must have the permission of their parents before

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a. treatment for drug abuse.
b. treatment for sexually transmitted diseases (STDs).
c. accessing birth control.
d. surgery.

ANS: D
Minors are not considered capable of giving informed consent, so a surgical procedure would require consent of the parent or guardian. Exceptions exist for obtaining treatment for drug abuse or STDs or for getting birth control in most states.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 17 OBJ: Nursing Process: Planning
MSC: Client Needs: Safe and Effective Care Environment

7. The maternity nurse should have a clear understanding of the correct use of a clinical pathway. One characteristic of clinical pathways is that they
a. are developed and implemented by nurses.
b. are used primarily in the pediatric setting.
c. set specific time lines for sequencing interventions.
d. are part of the nursing process.

ANS: C
Clinical pathways are standardized, interdisciplinary plans of care devised for patients with a particular health problem. They are used to identify patient outcomes, specify time lines to achieve those outcomes, direct appropriate interventions and sequencing of interventions, include interventions from a variety of disciplines, promote collaboration, and involve a comprehensive approach to care. They are developed by multiple health care professionals and reflect interdisciplinary care. They can be used in multiple settings and for patients throughout the life span. They are not part of the nursing process but can be used in conjunction with the nursing process to provide care to patients.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 7 OBJ: Nursing Process: Planning
MSC: Client Needs: Safe and Effective Care Environment

8. The fastest growing group of homeless people is
a. men and women preparing for retirement.
b. migrant workers.
c. single women and their children.
d. intravenous (IV) substance abusers.

ANS: C
Pregnancy and birth, especially for a teenager, are important contributing factors for becoming homeless. People preparing for retirement, migrant workers, and IV substance abusers are not among the fastest growing groups of homeless people.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 14 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

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9. A nurse wishes to work to reduce infant mortality in the United States. Which activity would this nurse most likely participate in?
   a. Creating pamphlets in several different languages using an interpreter.
   b. Assisting women to enroll in Medicaid by their third trimester.
   c. Volunteering to provide prenatal care at community centers.
   d. Working as an intake counselor at a women's shelter.

   ANS: C
   Prenatal care is vital to reducing infant mortality and medical costs. This nurse would most likely participate in community service providing prenatal care outreach activities in community centers, particularly in low-income areas. Pamphlets in other languages, enrolling in Medicaid, and working at a women's shelter all might impact infant mortality, but the greatest effect would be from assisting women to get consistent prenatal care.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 14 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

10. The intrapartum woman sees no need for a routine admission fetal monitoring strip. If she continues to refuse, what is the first action the nurse should take?
   a. Consult the family of the woman.
   b. Notify the provider of the situation.
   c. Document the woman's refusal in the nurse's notes.
   d. Make a referral to the hospital ethics committee.

   ANS: B
   Patients must be allowed to make choices voluntarily without undue influence or coercion from others. The physician, especially if unaware of the patient's decision, should be notified immediately. Both professionals can work to ensure the mother understands the rationale for the action and the possible consequences of refusal. The woman herself is the decision maker, unless incapacitated. Documentation should occur but is not the first action. This situation does not rise to the level of an ethical issue so there is no reason to call the ethics committee.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 18 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Safe and Effective Care Environment

11. Which statement is true regarding the "quality assurance" or "incident" report?
   a. The report assures the legal department that no problem exists.
   b. Reports are a permanent part of the patient's chart.
   c. The nurse's notes should contain, "Incident report filed, and copy placed in chart."
   d. This report is a form of documentation of an event that may result in legal action.

   ANS: D
   An incident report is used when something occurs that might result in legal action, such as a patient fall or medication error. It warns the legal department that there may be a problem in a particular patient's care. Incident reports are not part of the patient's chart; thus the nurses' notes should not contain any reference to them.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 18 OBJ: Integrated Process: Communication and Documentation

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MSC: Client Needs: Safe and Effective Care Environment

12. Elective abortion is considered an ethical issue because
    a. abortion law is unclear about a woman's constitutional rights.
    b. the Supreme Court ruled that life begins at conception.
    c. a conflict exists between the rights of the woman and the rights of the fetus.
    d. it requires third-party consent.

    ANS: C
    Elective abortion is an ethical dilemma because two opposing courses of action are available. The belief that induced abortion is a private choice is in conflict with the belief that elective pregnancy termination is taking a life. Abortion laws are clear concerning a woman's constitutional rights. The Supreme Court has not ruled on when life begins. Abortion does not require third-party consent.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 11 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Safe and Effective Care Environment

13. Which woman would be most likely to seek prenatal care?
    a. A 15-year-old who tells her friends, "I don't believe I'm pregnant."
    b. A 20-year-old who is in her first pregnancy and has access to a free prenatal clinic.
    c. A 28-year-old who is in her second pregnancy and abuses drugs and alcohol.
    d. A 30-year-old who is in her fifth pregnancy and delivered her last infant at home.

    ANS: B
    The patient who acknowledges the pregnancy early, has access to health care, and has no reason to avoid health care is most likely to seek prenatal care. Being in denial about the pregnancy increases the risk of not seeking care. This patient is also 15, and other social factors may discourage her from seeking care as well. Women who abuse substances are less likely to receive prenatal care. Some women see pregnancy and delivery as a natural occurrence and do not seek health care.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 14 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

14. A woman who delivered her baby 6 hours ago complains of headache and dizziness. The nurse administers an analgesic but does not perform any assessments. The woman then has a tonic-clonic seizure, falls out of bed, and fractures her femur. How would the actions of the nurse be interpreted in relation to standards of care?
    a. Negligent: the nurse failed to assess the woman for possible complications
    b. Negligent: because the nurse medicated the woman
    c. Not negligent: the woman had signed a waiver concerning the use of side rails
    d. Not negligent: the woman did not inform the nurse of her symptoms as soon as they occurred

    ANS: A

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There are four elements to malpractice, which is negligence in the performance of professional duties: duty, breach of duty, damage, and proximate cause. The nurse was negligent because she or he did not perform any assessments, which is the first step of the nursing process and is a standard of care. By not assessing the patient, the nurse did not meet established standards of care, and thus is guilty of professional negligence, or malpractice.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 16 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Safe and Effective Care Environment

15. Which patient situation fails to meet the first requirement of informed consent?
    a. The patient does not understand the physician's explanations.
    b. The physician gives the patient only a partial list of possible side effects and complications.
    c. The patient is confused and disoriented.
    d. The patient signs a consent form because her husband tells her to.

ANS: C
The first requirement of informed consent is that the patient must be competent to make decisions about health care. Full disclosure of information is an important element of the consent, but first the patient has to be competent to sign. Understanding is an important element of the consent, but first the patient has to be competent to sign. Voluntary consent is an important element of the consent, but first the patient has to be competent to sign.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 17 OBJ: Nursing Process: Assessment
MSC: Client Needs: Safe and Effective Care Environment

16. Which situation reflects a potential ethical dilemma for the nurse?
    a. A nurse administers analgesics to a patient with cancer as often as the provider's order allows.
    b. A neonatal nurse provides nourishment and care to a newborn who has a defect that is incompatible with life.
    c. A labor nurse, whose religion opposes abortion, is asked to assist with an elective abortion.
    d. A postpartum nurse provides information about adoption to a new mother who feels she cannot adequately care for her infant.

ANS: C
A dilemma exists in this situation because the nurse is being asked to assist with a procedure that she or he believes is morally wrong. The other situations do not contain elements of conflict for the nurse.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 11 OBJ: Nursing Process: Assessment
MSC: Client Needs: Safe and Effective Care Environment

17. When planning a parenting class, the nurse should explain that the leading cause of death in children 1 to 4 years of age in the United States is
    a. premature birth.
    b. congenital anomalies.

.

c. accidental death.
d. respiratory tract illness.

ANS: C
Although the rates have dropped, unintentional injury (accidents) are still the leading cause of death for children aged 1 to 19. The other options contribute to morbidity and mortality in children but are not the leading cause.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 10 | Table 1.3 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Safe and Effective Care Environment

18. A nurse is floated to a different unit. The nurse does not know how to perform a treatment that has been prescribed for one of his or her assigned patients. What should the nurse's first action be?
a. Delay the treatment until another nurse can do it.
b. Make the child's parents aware of the situation.
c. Inform the nursing supervisor of the problem.
d. Arrange to have the child transferred to another unit.

ANS: C
Nurses who work outside their usual areas of expertise must assess their own skills and avoid performing tasks or taking on responsibilities in areas in which they are not competent. This nurse should inform the supervisor of the situation. The nurse could endanger the child by delaying the intervention until another nurse is available. Telling the child's parents would most likely increase their anxiety and will not resolve the difficulty. Transfer to another unit delays needed treatment and would create unnecessary disruption for the child and family.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 19 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

19. The mother of a 5-year-old female inpatient on the pediatric unit asks the nurse if she could provide information regarding the recommended amount of television viewing time for her daughter. The nurse responds that the appropriate amount of time a child should be watching television is
a. 1 to 2 hours per day.
b. 2 to 3 hours per day.
c. 3 to 4 hours per day.
d. 4 hours or more.

ANS: A
The American Academy of Pediatrics (2013) encourages parents to monitor their children's media exposure and limit their children's screen time (TV, computer, video games) to no more than 1 to 2 hours per day. The other options all contain more screen time than is recommended.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 15 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

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20. Family-centered care (FCC) describes safe, quality care that recognizes and adapts to both the physical and psychosocial needs of the family. Which nursing practice coincides with the principles of FCC?
    a. The newborn is returned to the nursery at night so that the mother can receive adequate rest before discharge.
    b. The father is encouraged to go home after the baby is delivered.
    c. All patients are routinely placed on the fetal monitor.
    d. The nurse's assignment includes both mom and baby and increases the nurse's responsibility for education.

    ANS: D
    Family-centered care increases the responsibilities of nurses. In addition to the physical care provided, nurses assume a major role in teaching, counseling, and supporting families. The other options do not provide family-centered care because they increase family separation or use technology routinely, which may not be needed.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 2 OBJ: Integrated Process: Caring
    MSC: Client Needs: Health Promotion and Maintenance

21. Which statement related to nursing care of the child at home is most correct?
    a. The technology-dependent infant can safely be cared for at home.
    b. Home care increases readmissions to the hospital for a child with chronic conditions.
    c. There is increased stress for the family when a sick child is being cared for at home.
    d. The family of the child with a chronic condition is likely to be separated from their support system if the child is cared for at home.

    ANS: A
    Greater numbers of technology-dependent infants and children are now cared for at home. The numbers include those needing ventilator assistance, total parenteral nutrition, IV medications, apnea monitoring, and other device-assisted nursing care. Optimal home care can reduce the rate of readmission to the hospital for children with chronic conditions. Consumers often prefer home care because of the decreased stress on the family when the patient is able to remain at home. When the child is cared for at home the family is less likely to be separated from their support system because of the need for hospitalization.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 7 OBJ: Nursing Process: Planning
    MSC: Client Needs: Safe and Effective Care Environment

22. Maternity nursing care that is based on knowledge gained through research is known as
    a. nurse-sensitive indicators.
    b. evidence-based practice.
    c. case management.
    d. outcomes management.

    ANS: B

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Evidence-based practice is based on knowledge gained from research and clinical trials. Nurse-sensitive indicators are patient care outcomes particularly dependent on the quality and quantity of nursing care provided. Case management is a practice model that uses a systematic approach to identify specific patients, determine eligibility for care, and arrange access to services. The determination to lower health care costs while maintaining the quality of care has led to a clinical practice model known as outcomes management.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 6 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Safe and Effective Care Environment

23. The level of practice a reasonably prudent nurse provides is called
    a. the standard of care.
    b. risk management.
    c. a sentinel event.
    d. failure to rescue.

ANS: A
Guidelines for standards of care are published by various professional nursing organizations. The standard of care for neonatal nurses is set by the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) . The Society of Pediatric Nurses is the primary specialty organization that sets standards for the pediatric nurse. Risk management identifies risks and establishes preventive practices, but it does not define the standard of care. Sentinel events and failure to rescue can be caused by not practicing up to standards of care, but they do not define it.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 16 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

MULTIPLE RESPONSE

1. When counseling the newly pregnant woman regarding the option of using a free-standing birth center for care, the nurse should be aware that this type of care setting includes which advantages? (*Select all that apply.*)
    a. Less expensive than acute-care hospitals
    b. Access to follow-up care for 6 weeks postpartum
    c. Equipped for obstetric emergencies
    d. Safe, home-like births in a familiar setting
    e. Staffing by lay midwives

ANS: A, B, D

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Women who are at low risk and desire a safe, home-like birth are very satisfied with this type of care setting. The new mother may return to the birth center for postpartum follow-up care, breastfeeding assistance, and family planning information for 6 weeks postpartum. Because birth centers do not incorporate advanced technologies into their services, costs are significantly less than those for a hospital setting. The major disadvantage of this care setting is that these facilities are not equipped to handle obstetric emergencies. Should unforeseen difficulties occur, the woman must be transported by ambulance to the nearest hospital. Birth centers are usually staffed by certified nurse-midwives (CNMs); however, in some states lay midwives may provide this service.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 3 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Safe and Effective Care Environment

2. A school nurse is working with unlicensed assistive personnel (UAPs). What aspects of delegation should the nurse incorporate into his or her practice in this setting?
   a. The registered nurse is always responsible for assessment.
   b. Uncomplicated medication administration can be performed by the UAP.
   c. The nurse does not need to supervise UAPs in this setting.
   d. The nurse must work within school district policies when delegating.
   e. Understanding the complexity of the child's needs is a consideration when delegating.

   ANS: A, B, D, E
   Delegation to UAPs is very common in all health care settings, including schools. When delegating to a UAP in the school setting, factors for the nurse to consider include that the RN is always responsible for assessment, supervision is necessary, the complexity of the child's needs must be considered, and policies must be followed. Medication administration by the UAP may be allowed.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 19 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Safe and Effective Care Environment

3. A student nurse has been studying *Healthy People 2020.* What information about this initiative does the student understand? (*Select all that apply.*)
   a. It is a new agenda for health care and research priorities.
   b. None of the priorities in this document pertains to pregnant women or children.
   c. Objectives are aimed at keeping people healthy with a good quality of life.
   d. Ensuring that 77.9% of women receive prenatal care in the first trimester is one goal.
   e. Increasing to 100% the proportion of people with health insurance.

   ANS: C, D, E
   The *Healthy People 2020* initiative is an update of previous versions and is the nation's blueprint for health care and research priorities. Many of its objectives pertain to pregnant women and children. The objectives include improving health and quality of life, ensuring that 77.9% of pregnant women receive prenatal care in the first trimester, and increasing the number of people with health insurance to 100%.

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PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 5 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

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MULTIPLE CHOICE

1. Which principle of teaching should the nurse use to ensure learning in a family situation?
   a. Motivate the family with praise and positive reinforcement.
   b. Present complex subject material first, while the family is alert and ready to learn.
   c. Families should be taught using medical jargon so they will be able to understand the technical language used by physicians.
   d. Learning is best accomplished using the lecture format.

   ANS: A
   Praise and positive reinforcement are particularly important when a family is trying to master a frustrating task, such as breastfeeding. Learning is enhanced when the teaching is structured to present the simple tasks before the complex material. Even though a family may understand English fairly well, they may not understand the medical terminology or slang terms. A lively discussion stimulates more learning than a straight lecture, which tends to inhibit questions.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 25 OBJ: Nursing Process: Planning
   MSC: Client Needs: Health Promotion and Maintenance

2. When addressing the questions of a newly pregnant woman, the nurse can explain that the certified nurse-midwife is qualified to perform
   a. regional anesthesia.
   b. cesarean deliveries.
   c. vaginal deliveries.
   d. internal versions.

   ANS: C
   The nurse-midwife is qualified to deliver infants vaginally in uncomplicated pregnancies. The other procedures must be performed by a physician or other medical provider.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 26 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Safe and Effective Care Environment

3. Which nursing intervention is an independent (nurse-driven) function of the nurse?
   a. Administering oral analgesics
   b. Teaching the woman perineal care
   c. Requesting diagnostic studies
   d. Providing wound care to a surgical incision

   ANS: B

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Nurses are responsible for various independent functions, including teaching, counseling, and intervening in nonmedical problems. Interventions initiated by the physician and carried out by the nurse are called dependent functions. Administering oral analgesics is a dependent function; it is initiated by a physician or other provider and carried out by the nurse. Requesting diagnostic studies is a dependent function. Providing wound care is a dependent function; it is usually initiated by the physician or other provider through direct orders or protocol.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: Box 2.3 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

4. Which response by the nurse to the woman's statement, "I'm afraid to have a cesarean birth," would be the most therapeutic?
   a. "What concerns you most about a cesarean birth?"
   b. "Everything will be OK."
   c. "Don't worry about it. It will be over soon."
   d. "The doctor will be in later, and you can talk to him."

   ANS: A
   Focusing on what the woman is saying and asking for clarification are the most therapeutic responses. Stating that "everything will be ok" or "don't worry about it" belittles the woman's feelings and might be providing false hope. Telling the patient to talk to the doctor does not allow the woman to verbalize her feelings when she desires.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: Box 2.2 OBJ: Integrated Process: Communication and Documentation
   MSC: Client Needs: Psychosocial Integrity

5. To evaluate the woman's learning about performing infant care, the nurse should
   a. demonstrate infant care procedures.
   b. allow the woman to verbalize the procedure.
   c. observe the woman as she performs the procedure.
   d. routinely assess the infant for cleanliness.

   ANS: C
   The woman's ability to perform the procedure correctly under the nurse's supervision is the best method of evaluation. Demonstration is an excellent teaching method but not an evaluation method. During verbalization of the procedure, the nurse may not pick up on techniques that are incorrect. It is not the best tool for evaluation. Observing the infant for cleanliness does not ensure the proper procedure is carried out. The nurse may miss seeing unsafe techniques being used.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: p. 31 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Health Promotion and Maintenance

6. What situation is most conducive to learning?
   a. A teacher who speaks very little Spanish is teaching a class of Latino students.
   b. A class is composed of students of various ages and educational backgrounds.
   c. An auditorium is being used as a classroom for 300 students.

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d. An Asian nurse provides nutritional information to a group of pregnant Asian women.

ANS: D
Teaching is a vital function of the professional nurse. A patient's language and culture influence the learning process; thus a situation that is most conducive to learning is one in which the teacher has knowledge and understanding of the patient's language and cultural beliefs. The ability to understand the language in which teaching is done determines how much the patient learns. Patients for whom English is not their primary language may not understand idioms, nuances, slang terms, informal usage of words, or medical words. The teacher should be fluent in the language of the student. Developmental levels and educational levels influence how a person learns best. In order for the teacher to best present information, the class should be composed of the same levels. A large class is not conducive to learning. It does not allow for questions, and the teacher is not able to see the nonverbal cues from the students to ensure understanding.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 25 OBJ: Nursing Process: Planning
MSC: Client Needs: Psychosocial Integrity

7. What is the primary role of practicing nurses in the research process?
   a. Designing research studies
   b. Collecting data for other researchers
   c. Identifying researchable problems
   d. Seeking funding to support research studies

ANS: C
Nursing generates and answers its own questions based on evidence within its unique subject area. Nurses of all educational levels are in a position to find researchable questions based on problems seen in their practice area. Designing research studies is generally left to nurses with advanced degrees. Collecting data may be part of a nurse's daily activity, but not all nurses will have this opportunity. Seeking funding goes along with designing and implementing research studies.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 25 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Safe and Effective Care Environment

8. The step of the nursing process in which the nurse determines the appropriate interventions for the identified nursing diagnosis is called
   a. assessment.
   b. planning.
   c. intervention.
   d. evaluation.

ANS: B
The third step in the nursing process involves planning care for problems that were identified during assessment. The first step of the nursing process is assessment, during which data are collected. The intervention phase is when the plan of care is carried out. The evaluation phase is determining whether the goals have been met.

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PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: pp. 30-31 OBJ: Nursing Process: Planning
MSC: Client Needs: Safe and Effective Care Environment

9. Which goal is most appropriate for demonstrating effective parenting?
   a. The parents will demonstrate correct bathing by discharge.
   b. The mother will make an appointment with the lactation specialist prior to discharge.
   c. The parents will place the baby in the proper position for sleeping and napping by 2300 on postpartum day 1.
   d. The parents will demonstrate effective parenting by discharge.

   ANS: D
   Outcomes and goals are not the same. Goals are broad and not measurable and so must be linked to more measurable outcome criteria. Demonstrating effective parenting is one such goal. The other options are measurable outcome indicators that help determine if the goal has been met.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: p. 31 OBJ: Nursing Process: Planning
   MSC: Client Needs: Safe and Effective Care Environment

10. Which nursing intervention is correctly written?
    a. Encourage turning, coughing, and deep breathing.
    b. Force fluids as necessary.
    c. Assist to ambulate for 10 minutes at 8 AM, 2 PM, and 6 PM.
    d. Observe interaction with infant.

    ANS: C
    This intervention is the most specific and details what should be done, for how long, and when. The other interventions are too vague.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 31 OBJ: Nursing Process: Planning
    MSC: Client Needs: Safe and Effective Care Environment

11. What part of the nursing process includes the collection of data on vital signs, allergies, sleep patterns, and feeding behaviors?
    a. Assessment
    b. Planning
    c. Intervention
    d. Evaluation

    ANS: A
    Assessment includes gathering baseline data. Planning is based on baseline data and physical assessment. Implementation is the initiation and completion of nursing interventions. Evaluation is the last step in the nursing process and involves determining whether the goals were met.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 29 OBJ: Nursing Process: Assessment

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MSC: Client Needs: Safe and Effective Care Environment

12. The nurse who coordinates and manages a patient's care with other members of the health care team is functioning in which role?
    a. Teacher
    b. Collaborator
    c. Researcher
    d. Advocate

    ANS: B
    The nurse collaborates with other members of the health care team, often coordinating and managing the patient's care. Care is improved by this interdisciplinary approach as nurses work together with dietitians, social workers, physicians, and others. Education is an essential role of today's nurse. The nurse functions as a teacher during prenatal care, during maternity care, and when teaching parents of children regarding normal growth and development. Nurses contribute to their profession's knowledge base by systematically investigating theoretic for practice issues and nursing. A nursing advocate is one who speaks on behalf of another. As the health professional who is closest to the patient, the nurse is in an ideal position to humanize care and to intercede on the patient's behalf.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 25 OBJ: Nursing Process: Planning
    MSC: Client Needs: Safe and Effective Care Environment

13. Which statement about alternative and complementary therapies is true?
    a. Replace conventional Western modalities of treatment
    b. Are used by only a small number of American adults
    c. Allow for more patient autonomy but also may carry risks
    d. Focus primarily on the disease an individual is experiencing

    ANS: C
    Being able to choose alternative and complementary health products and practices does allow for patient autonomy, but the major concern is risk as patients may not disclose their use or substances may interact with other medications the patient is taking. Alternative and complementary therapies are part of an integrative approach to health care for most people, although some may choose only these types of therapies. An increasing number of American adults are seeking alternative and complementary health care options. Alternative healing modalities offer a holistic approach to health, focusing on the whole person and not just the disease.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 31 OBJ: Integrated Process: Culture and Spirituality
    MSC: Client Needs: Physiologic Integrity

14. Which step in the nursing process identifies the basis or cause of the patient's problem?
    a. Intervention
    b. Expected outcome
    c. Nursing diagnosis
    d. Evaluation

    ANS: C

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A nursing diagnosis states the problem and its cause (“related to”). Interventions are actions taken to meet the problem. Expected outcome is a statement of how the goal will be measured. Evaluation determines whether the goal has been met.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: pp. 30-31 OBJ: Nursing Process: Planning
MSC: Client Needs: Safe and Effective Care Environment

MULTIPLE RESPONSE

1. Today’s nurse often assumes the role of teacher or educator. Which strategies would be best to use for a nurse working with a new mother? (*Select all that apply.*)
   a. Computer-based learning
   b. Videos
   c. Printed material
   d. Group discussion
   e. Lecture

   ANS: A, B, C, D
   To be effective as a teacher, the nurse must tailor teaching to specific needs and characteristics of the patient. Computer-based learning, videos, printed material, and group discussions have all be shown to be effective teaching strategies. Lecture is probably the least effective method as it does not allow for participation.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 24 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

2. The nurse who uses critical thinking understands that the steps of critical thinking include (*Select all that apply.*)
   a. therapeutic communication.
   b. examining biases.
   c. setting priorities.
   d. managing data.
   e. evaluating other factors.

   ANS: B, D, E
   The five steps of critical thinking include *recognizing assumptions, examining biases, analyzing the need for closure, managing data,* and *evaluating other factors such as emotions and environmental factors.* Therapeutic communication is a skill that nurses must have to carry out the many roles expected in the profession; however, it is not one of the steps of critical thinking. Setting priorities is part of the planning phase of the nursing process.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 27 OBJ: Nursing Process: Planning |Nursing Process: Implementation
   MSC: Client Needs: Safe and Effective Care Environment

3. A nurse wishes to incorporate the American Nurses Association Code of Ethics for Nurses in daily practice. Which of the following actions best demonstrates successful integration of the code into daily routines?

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a. Strives to treat all patients equally and with caring kindness
b. Calls the provider when the patient's pain is not controlled with prescribed medications
c. Reads current literature related to practice area and brings ideas to unit management
d. Routinely stays overtime in order to visit and bond with new families
e. Decides to "play nicely" and not get involved in disputes about patient care

ANS: A, B, C

The ANAs Code of Ethics includes statements about practicing with compassion and respect for the inherent dignity, worth, and unique attributes of every person, advocating for the patient, and advancing the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy. Staying overtime may contribute to burn out and does not advance the Code of Ethics. Nurses are responsible for making decisions and taking action consistent with the obligation to promote health and to provide optimal care; not getting involved in patient care disputes does not uphold this standard.

PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
REF: Box 2.1 OBJ: Integrated Process: Caring
MSC: Client Needs: Safe and Effective Care Environment

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MULTIPLE CHOICE

1. The nurse teaches parents that the formula used to guide time-out as a disciplinary method is
   a. 1 minute per each year of the child's age.
   b. to relate the length of the time-out to the severity of the behavior.
   c. never to use time-out for a child younger than 4 years.
   d. to follow the time-out with a treat.

   ANS: A
   It is important to structure time-out in a time frame that allows the child to understand why he or she has been removed from the environment. The current guideline is 1 minute per age in years. Relating time to a behavior is subjective and is inappropriate when the child is very young. Time-out can be used with the toddler. Negative behavior should not be reinforced with a positive action.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 44 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

2. The nurse observes that when an 8-year-old enters the playroom, the child often causes disruption by taking toys from other children. The nurse's best approach for this behavior is to
   a. ban the child from the playroom until the child learns to control behavior.
   b. explain to the children in the playroom that this child is very ill and should be allowed to have the toys.
   c. approach the child in his or her room and ask, "Would you like it if the other children took your toys from you?"
   d. approach the child in his room and state, "I am concerned that you are taking the other children's toys. It upsets them and me."

   ANS: D
   By the nurse's using "I" rather than the "you" message, the child can focus on the behavior. The child and the nurse can begin to explore why the behavior occurs. Banning the child from the playroom will not solve the problem. The problem is his behavior, not the place where he exhibits it. Illness is not a reason for a child to be undisciplined. When the child recovers, the parents will have to deal with a child who is undisciplined and unruly. Children should not be made to feel guilty and to have their self-esteem attacked.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 44 OBJ: Integrated Process: Communication and Documentation
   MSC: Client Needs: Health Promotion and Maintenance

3. Families who deal effectively with stress exhibit which behavior pattern?
   a. Focus on family problems
   b. Feel weakened by stress
   c. Expect that some stress is normal
   d. Feel guilty when stress exists

.

ANS: C
Healthy families recognize that some stress is normal in all families. Healthy families focus on family strengths rather than on the problems and know that stress is temporary and may be positive. If families are dealing effectively with stress, then weakening of the family unit should not occur. Because some stress is normal in all families, feeling guilty is not reasonable. Guilt only immobilizes the family and does not lead to resolution of the stress.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 38 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

4. Which family will most likely have the most difficulty coping with a seriously ill child?
   a. A single-parent mother who has the support of her parents and siblings
   b. Parents who have just moved to the area and have not yet found health care providers
   c. The family of a child who has had multiple hospitalizations related to asthma and has adequate relationships with the nursing staff
   d. A family in which there is a young child and four older married children who live in the area

ANS: B
Parents in a new environment will have increased stress related to their lack of a support system. They have no previous experiences in the setting from which to draw confidence. Not only does this family not have friends or relatives to help them, they must find a provider when their child is seriously ill. Although only one parent is available, she has the support of her extended family, which will assist her in adjusting to the crisis. Because this family has had positive experiences in the past, family members can draw from those experiences and feel confident about the setting. This family has an extensive support system that will assist the parents in adjusting to the crisis.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 38 | Box 3.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

5. A nurse determines that a child consistently displays predictable behavior and is regular in performing daily habits. Which temperament is the child displaying?
   a. Easy
   b. Slow-to-warm-up
   c. Difficult
   d. Shy

ANS: A
Children with an easy temperament are even tempered, predictable, and regular in their habits. They react positively to new stimuli. The slow-to-warm-up temperament type prefers to be inactive and moody. A high activity level and adapting slowly to new stimuli are characteristics of a difficult temperament. Shyness is a personality type and not a characteristic of temperament.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 43 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

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6. The parent of a child who has had numerous hospitalizations asks the nurse for advice because the child has been having behavior problems at home and in school. In discussing effective discipline, what is an essential component?
   a. All children display some degree of acting out, and this behavior is normal.
   b. The child is manipulative and should have firmer limits set on her behavior.
   c. Positive reinforcement and encouragement should be used to promote cooperation and the desired behaviors.
   d. Underlying reasons for rules should be given, and the child should be allowed to decide which rules should be followed.

   ANS: C
   Using positive reinforcement and encouragement to promote cooperation and desired behaviors is one of the three essential components of effective discipline. Behavior problems should not be disregarded as normal. It would be incorrect to assume the child is being manipulative and should have firmer limits set on her behaviors. Providing the underlying reasons for rules and giving the child a choice concerning which rules to follow constitute a component of permissive parenting and are not considered an essential component of effective discipline.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 44 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Psychosocial Integrity

7. What characteristic would most likely be found in a Mexican-American family?
   a. Stoicism
   b. Close extended family
   c. Considering docile children weak
   d. Very interested in health-promoting lifestyles

   ANS: B
   Most Mexican-American families are very close, and it is not unusual for children to be surrounded by parents, siblings, grandparents, and godparents. It is important to respect this cultural characteristic and to see it as a strength, not a weakness. Although stoicism may be present in any family, Mexican-American families tend to be more expressive. Considering docile children weak is a characteristic of Native Americans. Although everyone tends now to embrace more health-promoting lifestyles, they are more prominent in Anglo-Americans.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 41 OBJ: Integrated Process: Culture and Spirituality
   MSC: Client Needs: Psychosocial Integrity

8. While reviewing the dietary-intake documentation of a 7-year-old Asian patient with a fractured femur, the nurse notes that the patient consistently refuses to eat the food on his tray. What assumption is most likely accurate?
   a. The child is a picky eater.
   b. The child needs less food because of bed rest.
   c. The child may have culturally related food preferences.
   d. The child is probably eating between meals and spoiling his appetite.

   ANS: C

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When cultural differences are noted, food preferences should always be obtained. A child will often refuse to eat unfamiliar foods. Although the child may be a picky eater, the key point is that there are cultural differences that need to be considered. The foods he is being served may seem strange to a child. Nutrition plays an important role in healing. Although the energy the child expends has decreased while on bed rest, he or she has increased needs for good nutrition. Although the nurse should determine whether the child is eating food the family has brought from home, the more important point is to determine whether there are culturally related food preferences.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 38 OBJ: Integrated Process: Culture and Spirituality
MSC: Client Needs: Psychosocial Integrity

9. A nurse is caring for a child who is a Christian Scientist. What intervention should the nurse include in the care plan for this child?
   a. Offer iced tea to the child who is experiencing deficient fluid volume.
   b. Offer to inform a Christian Science practitioner of the child's admission.
   c. Allow parents to sign a form opting out of routine immunizations.
   d. Ask parents whether the child has been baptized.

   ANS: B
   When a Christian Science believer is hospitalized, a parent or patient may request that a Christian Science practitioner be notified as opposed to the hospital-assigned clergy. Coffee and tea are declined as a drink. Christian Science believers seek exemption from immunizations but obey legal requirements. Baptism is not a ceremony for the Christian Science religion.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: Table 3.1 OBJ: Integrated Process: Culture and Spirituality
   MSC: Client Needs: Psychosocial Integrity

10. To resolve family conflict, it is necessary to have open communication, accurate perception of the problem, and a(n)
    a. intact family structure.
    b. arbitrator.
    c. willingness to consider the view of others.
    d. balance in personality types.

    ANS: C
    Without constructive efforts to resolve the conflict, such as the willingness of the members of a group to consider the views of others, conflict resolution cannot take place. The structure of a family may affect family dynamics, but it is still possible to resolve conflict without an intact family structure if all of the ingredients of conflict resolution are present. Conflicts can be resolved without the assistance of an arbitrator. Most families have diverse personality types among their members. This diversity may make conflict resolution more difficult but should not impede it as long as the ingredients of conflict resolution are present.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 37 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

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11. Which statement is true about the characteristics of a healthy family?
    a. The parents and children have rigid assignments for all the family tasks.
    b. Young families assume the total responsibility for the parenting tasks, refusing any assistance.
    c. The family is overwhelmed by the significant changes that occur as a result of childbirth.
    d. Adults agree on the majority of basic parenting principles.

    ANS: D
    Adults in a healthy family communicate with each other so that minimal discord occurs in parenting principles, such as discipline and sleep schedules. Healthy families remain flexible in their role assignments. Members of a healthy family accept assistance without feeling guilty. Healthy families can adapt to the significant changes that are common during the months after childbirth.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 37 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

12. A nurse observes that parents discuss rules with their children when the children do not agree with the rules. Which style of parenting is being displayed?
    a. Autocratic
    b. Authoritative
    c. Permissive
    d. Disciplinarian

    ANS: B
    A parent who discusses the rules with which children do not agree is using an authoritative parenting style. A parent who expects children to follow rules without questioning is using an authoritarian parenting style. A parent who does not consistently enforce rules and allows the child to decide whether he or she wishes to follow rules is using a permissive parenting style. A disciplinarian style would be similar to the authoritarian style.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 43 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

13. What should the nurse expect to be problematic for a family whose religious affiliation is Jehovah's Witness?
    a. Birth control
    b. Autopsy
    c. Plasma expanders
    d. Blood transfusion

    ANS: D
    Jehovah's Witnesses do not accept blood transfusions but may accept alternatives such as plasma expanders. Birth control and autopsy are also allowed.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: Table 3.1 OBJ: Integrated Process: Culture and Spirituality
    MSC: Client Needs: Psychosocial Integrity

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14. A traditional family structure in which married male and female partners and their children live as an independent unit is known as a(n) _____ family.
    a. extended
    b. binuclear
    c. nuclear
    d. blended

    ANS: C
    A nuclear family is one in which two opposite-sex parents and their children live together. This is also known as a traditional family. Extended or multigenerational families include other blood relatives in addition to the parents. Binuclear is not a listed family type according to U.S. Census Bureau data but would include two nuclear families living together. A blended family is reconstructed after divorce and involves the merger of two families.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 34 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

15. A pictorial tool that can assist the nurse in assessing aspects of family life related to health care is the
    a. genogram.
    b. ecomap.
    c. life cycle model.
    d. human development wheel.

    ANS: A
    A genogram (also known as a pedigree) is a diagram that depicts the relationships and health issues of family members over generations, usually three. An ecomap is a pictorial representation of the family structures and their relationships with the external environment. The life cycle model in no way illustrates a family genogram. This model focuses on stages that a person reaches throughout his or her life. The human development wheel describes various stages of growth and development rather than a family's relationships to each other.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 45 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

16. According to Friedman's classifications, providing such physical necessities as food, clothing, and shelter is the _____ family function.
    a. economic
    b. socialization
    c. reproductive
    d. health care

    ANS: D
    Physical necessities such as food, clothing, and shelter are considered part of health care. The economic function provides resources but is not concerned with health care and other basic necessities. The socialization function teaches the child cultural values. The reproductive function is concerned with ensuring family continuity.

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PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 45 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

17. The nurse is in a unique position to assess children for symptoms of neglect. Which high-risk family situation places the child at the greatest risk for being neglected?
    a. Marital conflict and divorce
    b. Adolescent parenting
    c. Substance abuse
    d. A child with special needs

    ANS: C
    Parents who abuse drugs or alcohol may neglect their children because obtaining and using the substance(s) may have a stronger pull on the parents than the care of their children. Although divorce is traumatic to children, research has shown that living in a home filled with conflict is also detrimental. In this situation conflict may arise and young children may be unable to verbalize their distress; however, the child is not likely to be neglected. Teenage parenting often has a negative effect on the health and social outcomes of the entire family. Adolescent girls are at risk for a number of pregnancy complications, are unlikely to attain a high level of education, and are more likely to be poor. But this does not equate with a higher risk of neglect. When a child is born with a birth defect or has an illness that requires special care, the family is under additional stress. These families often suffer financial hardship as health insurance benefits quickly reach their maximum. But again, this does not lead to neglect as a frequent problem.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 37 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

18. A nurse is caring for the seriously ill child of a single parent. The parent reports being overwhelmed with the situation and not being able to make decisions. What action by the nurse is best?
    a. Refer the patient to the hospital's social work department.
    b. Call the chaplain service and ask for a chaplain visit.
    c. Ask the parent if any other family member can come and assist.
    d. Have the parent describe coping methods used for past crises.

    ANS: D
    Helping the patient to marshal internal and external resources is vital to promoting coping. The nurse should ask about previous coping methods used and help the parent adapt them to the current situation. Referring the parent to social work does not allow the nurse to be of assistance and the parent may not want to have a visit from a clergy member. Both of those options are dismissive. Other family members may or may not be able to come to assist, but this closed-ended question will not elicit much information.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 38 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

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19. The nurse is caring for a patient from a different culture and is frustrated by what appears to be a lack of cooperation on the patient's part. A colleague states that the patient is "in America and should do what everyone else does." This is an example of what trait?
    a. Ethnocentrism
    b. Cultural congruency
    c. Rudeness
    d. Ignorance

    ANS: A
    Ethnocentrism is the belief that one's culture is superior to any others. The nurse stating that all patients should follow common American behaviors is demonstrating this behavior. This does not demonstrate cultural congruency. Although the colleague may be rude or ignorant, the more specific description of this behavior is ethnocentrism.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 38 OBJ: Integrated Process: Culture and Spirituality
    MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. When providing anticipatory guidance to parents regarding disciplining children, the nurse teaches that behavioral consequences fall into which categories? (*Select all that apply.*)
    a. Corporal
    b. Natural
    c. Logical
    d. Unrelated
    e. Behavioral

    ANS: B, C, D
    Natural consequences are those that occur spontaneously. For example, a child leaves a toy outside and it is lost. Logical consequences are those that are directly related to the misbehavior. If two children are fighting over a toy, the toy is removed and neither child has it. Unrelated consequences are purposely imposed; for example, the child is late for dinner so he or she is not allowed to watch television. Corporal punishment is not part of this behavioral approach and usually takes the approach of spanking the child. Corporal punishment is highly controversial and is strongly discouraged by the American Academy of Pediatrics. Behavior modification is another disciplinary technique that rewards positive behavior and ignores negative behavior.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 45 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

2. The nurse is caring for a child from a Middle Eastern family. Which interventions should the nurse include in planning care? (*Select all that apply.*)
    a. Include the father in the decision making.
    b. Ask for a dietary consult to maintain religious dietary practices.
    c. Plan for a male nurse to care for a female patient.
    d. Ask the housekeeping staff to interpret if needed.
    e. Allow time for prayer.

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ANS: A, B, E

The man is typically the head of the household in Muslim families. So the father should be included in all decision making. Muslims do not eat pork and do not use alcohol. Many are vegetarians. The dietitian should be consulted for dietary preferences. Compulsory prayer is practiced several times throughout the day. The family should not be interrupted during prayer, and treatments should not be scheduled during this time. Muslim women often prefer a female health care provider because of laws of modesty; therefore, the female patient should not be assigned a male nurse. A housekeeping staff member should not be asked to interpret. When interpreters are used, they should be of the same country and religion, if possible, because of regional differences and hostilities.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: Table 3.1 OBJ: Integrated Process: Culture and Spirituality
MSC: Client Needs: Psychosocial Integrity

3. Traditional ethnocultural beliefs related to the maintenance of health are likely to include which of the following? (*Select all that apply.*)
   a. Avoidance of natural events such as a solar eclipse
   b. Practicing silence, meditation, and prayer
   c. Protection of the soul by avoiding envy or jealousy
   d. Understanding that a hex, spell, or the evil eye may cause illness or injury
   e. Turning to Western medicine first before trying traditional practices

   ANS: A, B, C, D

   Traditional ethnocultural beliefs related to health care can include avoiding some natural events; practicing silence, meditation, and prayer; protecting oneself against envy or jealousy on the part of others; and avoiding hexes, spells, and the evil eye. Usually people with these beliefs turn to their traditional practices prior to seeking Western medical care.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 42 OBJ: Integrated Process: Culture and Spirituality
   MSC: Client Needs: Psychosocial Integrity

4. A nurse is teaching a parenting group about behavior modification. What information does this nurse include in teaching? (*Select all that apply.*)
   a. Food rewards are highly motivating and as such are encouraged.
   b. Negative behavior from the child should be ignored by parents.
   c. Undesirable behavior may initially get worse if it is ignored.
   d. 1 minute per age is the suggested time limit for discipline.
   e. For younger kids, a behavior chart is a good visual cue.

   ANS: B, C, E

   In behavior modification parents ignore “bad” behavior by the child, which initially may get worse as the child tries to recapture the attention it once brought. Younger children respond positively to charts with stickers that show good behavior. Food rewards should not be used as food is an essential necessity plus extra food may contribute to obesity. The time limit refers to the time-out method of discipline.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 45 OBJ: Integrated Process: Teaching-Learning

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MULTIPLE CHOICE

1. Which information should the nurse include when preparing a 5-year-old child for a cardiac catheterization?
   a. A detailed explanation of the procedure
   b. A description of what the child will feel and see during procedure
   c. An explanation about the dye that will go directly into his vein
   d. An assurance to the child that he and the nurse can talk about the procedure when it is over

   ANS: B
   For a preschooler, the provision of sensory information about what to expect during the procedure will enhance the child's ability to cope with the events of the procedure and will decrease anxiety. Explaining the procedure in detail is probably more than the 5-year-old child can comprehend, and it will likely produce anxiety. Using the word "dye" with a preschooler can be frightening for the child. The child needs information before the procedure.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: Table 4.3 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

2. An important consideration for the nurse who is communicating with a 5-year-old child is to
   a. speak loudly, clearly, and directly.
   b. use picture or story books, or puppets.
   c. disguise own feelings, attitudes, and anxiety.
   d. initiate contact with child when parent is not present.

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

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: Table 4.3 OBJ: Integrated Process: Communication and Documentation
   MSC: Client Needs: Psychosocial Integrity

3. An effective technique for communicating with toddlers is to
   a. have the toddler make up a story from a picture.
   b. involve the toddler in dramatic play with dress-up clothing.
   c. use picture books.
   d. ask the toddler to draw pictures of his fears.

   ANS: C

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Activities and procedures should be described as they are about to be done. Use picture books and play for demonstration. Toddlers experience the world through their senses. Most toddlers do not have the vocabulary to make up stories. Dramatic play is associated with older children. Toddlers probably are not capable of drawing or verbally articulating their fears.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: Table 4.3 OBJ: Integrated Process: Communication and Documentation
MSC: Client Needs: Health Promotion and Maintenance

4. What is the most important consideration for effectively communicating with a child?
   a. The child's chronologic age
   b. The parent-child interaction
   c. The child's receptiveness
   d. The child's developmental level

   ANS: D
   The child's developmental level is the basis for selecting the terminology and structure of the message most likely to be understood by the child. The child's age may not correspond with the child's developmental level; therefore it is not the most important consideration for communicating with children. Parent-child interaction is useful in planning communication with children, but it is not the primary factor in establishing effective communication. The child's receptiveness is a consideration in evaluating the effectiveness of communication.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 54 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

5. Which behavior is most likely to encourage open communication?
   a. Avoiding eye contact
   b. Folding arms across chest
   c. Standing with head bowed
   d. Soft stance with arms loose at the side

   ANS: D
   An open body stance and positioning such as loose arms at the side invite communication and interaction. Avoiding eye contact, folding the arms across the chest, and standing with the head bowed, are closed body postures and do not facilitate communication.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: Table 4.1 OBJ: Integrated Process: Communication and Documentation
   MSC: Client Needs: Psychosocial Integrity

6. Which strategy is most likely to encourage a child to express feelings about the hospital experience?
   a. Avoiding periods of silence
   b. Asking yes/no questions
   c. Sharing personal experiences
   d. Using open-ended questions

   ANS: D

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Open-ended questions encourage conversation. Periods of silence can serve to facilitate communication, but this is not the most effective means of getting the child to communicate. Yes/no questions are closed ended and do not encourage conversation. Talking about yourself shifts the focus of the conversation away from the child.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 50 OBJ: Integrated Process: Communication and Documentation
MSC: Client Needs: Psychosocial Integrity

7. Which is the most appropriate question to ask when interviewing an adolescent to encourage conversation?
   a. "Are you in school?"
   b. "Are you doing well in school?"
   c. "How is school going for you?"
   d. "How do your parents feel about your grades?"

   ANS: C
   Open-ended questions encourage communication. Questions with "yes" or "no" answers do not encourage conversation. Questions that can be interpreted as judgmental do not enhance communication. Asking adolescents about their parents' feelings may block communication.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: Table 4.3 OBJ: Integrated Process: Communication and Documentation
   MSC: Client Needs: Psychosocial Integrity

8. What is the most appropriate response for the nurse to make to the parent of a 3-year-old child found in a bed with the side rails down?
   a. "You must never leave the child in the room alone with the side rails down."
   b. "I am very concerned about your child's safety when you leave the side rails down."
   c. "It is hospital policy that side rails need to be up if the child is in bed."
   d. "When parents leave side rails down, they might be considered as uncaring."

   ANS: B
   To express concern and then choose words that convey a policy without appearing to cast blame on improper behavior is appropriate. Framing the communication in the negative does not facilitate effective communication. Stating a policy to parents conveys the attitude that the hospital has authority over parents in matters concerning their children and may be perceived negatively. It also does not give information as to why the side rails need to be up. This statement conveys blame and judgment to the parent.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: Table 4.2 OBJ: Integrated Process: Communication and Documentation
   MSC: Client Needs: Psychosocial Integrity

9. What is an appropriate preoperative teaching plan for a school-age child?
   a. Begin preoperative teaching the morning of surgery.
   b. Schedule a tour of the hospital a few weeks before surgery.
   c. Show the child books and pictures 4 days before surgery.
   d. Limit teaching to 5 minutes and use simple terminology.

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ANS: C
Preparatory material can be introduced to the school-age child several days (1 to 5) in advance of the event. Books, pictures, charts, and videos are appropriate. Preoperative teaching a few hours before surgery is more appropriate for the preschool child. Preoperative materials should be introduced 1 to 5 days in advance for school-age children. Preparation too far in advance of the procedure can be forgotten or cause undue anxiety for an extended period of time. A very short, simple explanation of the surgery is appropriate for a younger child such as a toddler.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: Table 4.3 OBJ: Nursing Process: Planning
MSC: Client Needs: Health Promotion and Maintenance

10. When a child broke her favorite doll during a hospitalization, her primary nurse bought the child a new doll and gave it to her the next day. What is the best interpretation of the nurse's behavior?
    a. The nurse is displaying signs of overinvolvement.
    b. The nurse is a kind and generous person.
    c. The nurse feels a special closeness to the child.
    d. The nurse wants to make the child happy.

    ANS: A
    Buying gifts for individual children is a warning sign of overinvolvement. Nurses are kind and generous people, but buying gifts for individual children is unprofessional. Nurses may feel closer to some patients and families. This does not make giving gifts to children or families acceptable from a professional standpoint. Replacing lost items is not the nurse's responsibility. Becoming overly involved with a child can inhibit a healthy relationship.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: Box 4.2 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

11. When meeting a toddler for the first time, the nurse initiates contact by
    a. calling the toddler by name and picking the toddler up.
    b. asking the toddler for his or her first name.
    c. kneeling in front of the toddler and speaking softly to the child.
    d. telling the toddler that you are his or her nurse today.

    ANS: C
    More positive interactions occur when the toddler perceives the meeting in a nonthreatening way. Placing yourself at the toddler's level and speaking softly can be less threatening for the child. Picking a toddler up at an initial meeting is a threatening action and will more likely result in a negative response from the child. Toddlers are unlikely to respond to direct questions at a first meeting. Telling the toddler you are the nurse is not likely to facilitate or encourage cooperation. The toddler perceives you as a stranger and will find the action threatening.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 48 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Psychosocial Integrity

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12. An 8-year-old girl asks the nurse how the blood pressure apparatus works. The most appropriate nursing action is to
    a. ask why the child wants to know.
    b. determine why the child is so anxious.
    c. explain in simple terms how it works.
    d. tell the child he or she will see how it works as it is used.

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

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: Table 4.3 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

13. A positive, supportive communication technique that is effective from birth throughout adulthood is
    a. listening.
    b. physical proximity.
    c. environment.
    d. touch.

    ANS: D
    Touch can convey warmth, comfort, reassurance, security, caring, and support. In infancy, messages of security and comfort are conveyed when they are being held. Toddlers and preschoolers find it soothing and comforting to be held and rocked. School-aged children and adolescents appreciate receiving a hug or pat on the back (with permission). Listening is an essential component of the communication process. By practicing active listening skills, nurses can be effective listeners. Listening is a component of verbal communication. Individuals have different comfort zones for physical distance. The nurse should be aware of these differences and move cautiously when meeting new children and families. It is important to create a supportive and friendly environment for children including the use of child-sized furniture, posters, developmentally appropriate toys, and art displayed at a child's eye level.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 48 OBJ: Integrated Process: Communication and Documentation
    MSC: Client Needs: Health Promotion and Maintenance

14. A nurse is caring for a child who does not speak English. The parents are able to understand and speak only limited English. What action by the nurse is best?
    a. Allow the patient's 12-year-old sister to interpret.
    b. See if there is another family member who can interpret.
    c. Use a professionally trained interpreter for this family.

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d. Use the Internet to translate written information in the native language.

ANS: C
A professional interpreter is the best option in this situation. They are trained in medical interpreting and do not allow cultural influences into their work. A child should never be asked to interpret; the child may be too young to understand sophisticated concepts involved in the discussion and the information from the patient may be misconstrued and disturbing to the child. An adult family member may have to do temporarily in an emergency, but the best option is a professional interpreter.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 53 OBJ: Integrated Process: Communication and Documentation
MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. In planning care for a preschool-age child, the nurse knows that which open body postures encourage positive communication? (*Select all that apply.*)
   a. Leaning away from the preschooler
   b. Frequent eye contact
   c. Hands on hips
   d. Conversing at eye level
   e. Asking the parents to stay in the room

   ANS: B, D
   Frequent eye contact and conversing at eye level are both open body postures that encourage positive communication. Leaning away from the child and placing your hands on your hips are both closed body postures that do not facilitate effective communication. Asking the parents to stay in the room while the nurse is talking to the child is helpful but is not an open body posture.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: Table 4.1 OBJ: Integrated Process: Communication and Documentation
   MSC: Client Needs: Psychosocial Integrity

2. Which behaviors by the nurse may indicate professional separation or underinvolvement? (*Select all that apply.*)
   a. Avoiding the child or his or her family
   b. Revealing personal information
   c. Calling in sick
   d. Spending less time with a particular child
   e. Asking to trade assignments

   ANS: A, C, D, E
   Whether nurses become too emotionally involved or find themselves at the other end of the spectrum—being underinvolved—they lose effectiveness as objective professional resources. These are all indications of the nurse who is underinvolved in a child's care. Revealing personal information to a patient or his or her family is an indication of overinvolvement.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: Box 4.3 OBJ: Integrated Process: Communication and Documentation

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MSC: Client Needs: Safe and Effective Care Environment

3. While developing a care plan for a school-age child with a visual impairment, the nurse knows that which of the following actions are important in working with this special needs child? (*Select all that apply.*)
   a. Obtain a thorough assessment of the child's self-care abilities.
   b. Orient the child to various sounds in the environment.
   c. Tell the child's parents to stay continuously with their child during hospitalization.
   d. Allow the child to handle equipment as procedures are explained.
   e. Encourage the child to use a dry erase board to write his needs.

   ANS: A, B, D
   Conducting a thorough assessment of the child's self-care abilities, orienting the child to various sounds in the environment, and allowing the child to handle equipment are all ways to enhance communication with a visually impaired child. Mandating that the child's parents stay continuously with their child may not be possible and is not usually necessary if the school-age child is at the expected level of growth and development. Encouraging a child to write his needs on a dry erase board would be an appropriate intervention for a child who is hearing impaired, not for a child with a visual deficit.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 59 OBJ: Integrated Process: Communication and Documentation
   MSC: Client Needs: Psychosocial Integrity

4. A preschool-age child is being admitted for some diagnostic tests and possible surgery. The nurse planning care should use which phrases when explaining procedures to the child? (*Select all that apply.*)
   a. Fluids will be given through tubing connected to a tiny tube inserted into your arm.
   b. After surgery we will be doing dressing changes.
   c. You will get a shot before surgery.
   d. The doctor will give you medicine that will help you go into a deep sleep.
   e. We will take you to surgery on a bed on wheels.

   ANS: A, D, E
   A preschool child needs simple concrete explanations that cannot be misinterpreted. An IV should be explained as fluids going into a tube connected to a small tube in your hand; anesthesia can be explained as a medicine that will help you go into a deep sleep (put to sleep should be avoided); and a stretcher can be described as riding on a bed with wheels. The term "dressing changes" is ambiguous and will not be understood by a preschooler. The term "get a shot" should not be used. A preschooler or young child is likely to misinterpret this information.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: Table 4.4 OBJ: Integrated Process: Communication and Documentation
   MSC: Client Needs: Psychosocial Integrity

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MULTIPLE CHOICE

1. Which statement best describes development in infants and children?
   a. Development, a predictable and orderly process, occurs at varying rates within normal limits.
   b. Development is primarily related to the growth in the number and size of cells.
   c. Development occurs in a proximodistal direction with fine muscle development occurring first.
   d. Development is more easily and accurately measured than growth.

   ANS: A
   Development, a continuous and orderly process, provides the basis for increases in the child's function and complexity of behavior. The increases in rate of function and complexity can vary normally within limits for each child. An increase in the number and size of cells is a definition for growth. Development proceeds in a proximodistal direction with fine muscle organization occurring as a result of large muscle organization. Development is a more complex process that is affected by many factors; therefore, it is less easily and accurately measured. Growth is a predictable process with standard measurement methods.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 62 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

2. Frequent developmental assessments are important for which reason?
   a. Stable developmental periods during infancy provide an opportunity to identify any delays or deficits.
   b. Infants need stimulation specific to the stage of development.
   c. Critical periods of development occur during childhood.
   d. Child development is unpredictable and needs monitoring.

   ANS: C
   Critical periods are blocks of time during which children are ready to master specific developmental tasks. The earlier those delays in development are discovered and intervention initiated, the less dramatic their effect will be. Infancy is a dynamic time of development that requires frequent evaluations to assess appropriate developmental progress. Infants in a nurturing environment will develop appropriately and will not necessarily need stimulation specific to their developmental stage. Normal growth and development is orderly and proceeds in a predictable pattern based on each individual's abilities and potentials.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 64 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

3. The nurse is assessing an infant's growth and development. The parents want education on how to stimulate this process. What action suggested by the nurse is inconsistent with knowledge of this topic?

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a. Have the family draw a three-generation family pedigree.
b. Show the family how to coo and babble with their child.
c. Encourage the parents to buy interactive toys for the child.
d. Involve the child in activities that are outside the home.

ANS: A
A family pedigree can help show relationships and health care problems but will not stimulate growth and development. Activities that are stimulating for a child include the consistent use of language by the parents, allowing play time with interactive toys (toys that make noises or do something in response to the baby's actions), and exposing the child to new sights and sounds.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 66 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

4. According to Piaget's theory, the period of cognitive development in which the child is able to distinguish between concepts related to fact and fantasy, such as human beings are incapable of flying like birds, is the _____ period of cognitive development.
a. sensorimotor
b. formal operations
c. concrete operations
d. preoperational

ANS: C
Concrete operations is the period of cognitive development in which children's thinking is shifted from egocentric to being able to see another's point of view. They develop the ability to distinguish fact from fantasy. The sensorimotor stage occurs in infancy and is a period of reflexive behavior. During this period, the infant's world becomes more permanent and organized. The stage ends with the infant demonstrating some evidence of reasoning. Formal operations is a period in development in which new ideas are created through previous thoughts. Analytic reason and abstract thought emerge in this period. The preoperational stage is a period of egocentrism in which the child's judgments are illogical and dominated by magical thinking and animism.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 68 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

5. The theorist who viewed developmental progression as a lifelong series of conflicts that need resolution is
a. Erikson.
b. Freud.
c. Kohlberg.
d. Piaget.

ANS: A

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Erik Erikson viewed development as a series of conflicts affected by social and cultural factors. Each conflict must be resolved for the child to progress emotionally, with unsuccessful resolution leaving the child emotionally disabled. Sigmund Freud proposed a psychosexual theory of development. He proposed that certain parts of the body assume psychological significance as foci of sexual energy. The foci shift as the individual moves through the different stages (oral, anal, phallic, latency, and genital) of development. Lawrence Kohlberg described moral development as having three levels (preconventional, conventional, and postconventional). His theory closely parallels Piaget's.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 69 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

6. A nurse wants to assess a chronically ill child's feelings regarding a lengthy hospitalization and treatments. What action by the nurse is best?
   a. Ask direct questions of the child as to feelings.
   b. Watch the child play on several occasions.
   c. Discuss the situation with the parents.
   d. Refer the child to the child life specialist for assessment.

   ANS: B
   Play for all children is an activity woven with meaning and purpose. For chronically ill children, play can indicate their state of wellness and response to treatment. It is a way to express joy, fear, anxiety, and disappointments. The nurse can best decipher the child's emotional state by observing this activity. Children often are threatened by direct questions, especially if the questioner is not well known to the child. The nurse may want to discuss the situation with the parents or enlist the help of the child life specialist, but these will not give the nurse the rich data that can be obtained through watching the child play.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 73 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

7. Which child is most likely to be frightened by hospitalization?
   a. A 4-month-old infant admitted with a diagnosis of bronchiolitis
   b. A 2-year-old toddler admitted for cystic fibrosis
   c. A 9-year-old child hospitalized with a fractured femur
   d. A 15-year-old adolescent admitted for abdominal pain

   ANS: B
   All children can be frightened by hospitalization. However, toddlers are most likely to be frightened by hospitalization because their thought processes are egocentric, magical, and illogical. They feel very threatened by unfamiliar people and strange environments. Young infants are not as likely to be as frightened as toddlers by hospitalization because they are not as aware of the environment. The 9-year-old child's cognitive ability is sufficient for the child to understand the reason for hospitalization. The 15-year-old adolescent has the cognitive ability to interpret the reason for hospitalization.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: Table 5.2 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

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8. A nurse uses Erikson's theory to guide nursing practice. What action by a hospitalized 4-year-old child would the nurse evaluate as developmentally appropriate?
   a. Dressed and fed by the parents
   b. Independently ask for play materials or other personal needs
   c. Verbalizes an understanding of the reason for the hospitalization
   d. Asks for a parent stay in the room at all times

   ANS: B
   Erikson identifies initiative as a developmental task for the preschool child. Initiating play activities and asking for play materials or assistance with personal needs demonstrates developmental appropriateness. Parents need to foster appropriate developmental behavior in the 4-year- old child. Dressing and feeding the child do not encourage independent behavior. A 4-year-old child cannot be expected to cognitively understand the reason for hospitalization. Expecting the child to verbalize an understanding for hospitalization is an inappropriate outcome. Parents staying with the child throughout a hospitalization is not a developmental outcome. Although children benefit from parental involvement, parents may not have the support structure to stay in the room with the child at all times.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: Table 5.2 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Health Promotion and Maintenance

9. A nurse wants to work to increase the number of immunized children. What action by the nurse would best meet this goal?
   a. Present a workshop to the local home-schooling parent support group.
   b. Volunteer for a mass "back to school" immunization clinic.
   c. Prepare welcome and information packets to college freshmen.
   d. Work with the health department to bring immunizations to day cares.

   ANS: A
   Home- schooled children are often overlooked when it comes to immunizations, because they are not in immunization-friendly systems such as day care, schools, and colleges where immunizations are required. The best way for the nurse to help increase the number of immunized children is to reach out to the home-schooled group.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 75 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

10. The parents of a preschool-aged child are in the clinic and report the child is seen playing with the genitals frequently. What response by the nurse is best?
    a. Reassure parents this is normal at this age.
    b. Teach parents about behavior modification.
    c. Refer parents and child to a psychologist.
    d. Ask the provider to speak to the parents.

    ANS: A

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Preschool children are in the Phallic or Oedipal/Electra Stage of Freud's theory during which the genitals become the focus of curiosity and interest. The nurse should explain that this behavior is normal at this stage. Teaching about disciplinary techniques and referrals to psychotherapy are inappropriate. The nurse may well want the provider to speak to the parents, but the nurse is responsible for patient/parent teaching and should provide education him- or herself.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: Table 5.2 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

11. A nurse is teaching parents to avoid environmental injury to their 2-year-old child. What information does the nurse include in teaching?
    a. Avoiding sun exposure, secondhand smoke, and lead
    b. Living in a middle-class neighborhood
    c. Avoiding smoking and alcohol intake during pregnancy
    d. Limiting breastfeeding to avoid toxins being passed through breast milk

    ANS: A
    Lead can be present in the home and in toys made overseas. Environmental injury can also be the result of mercury, pesticides (flea and tick collars), radon, and exposure to the sun and secondhand smoke. It is important for the nurse to provide health teaching related to these factors. The nurse is unable to influence socioeconomic status, and the family may not want or be able to move. It is too late for the nurse to instruct the mother regarding smoking or alcohol intake during pregnancy. This should have been included in prenatal teaching. It is unlikely that a 2-year-old child will still be breastfeeding.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 65 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

12. Which immunizations should be used with caution in children with an allergy to eggs?
    a. HepB
    b. DTaP
    c. Hib
    d. MMR

    ANS: D
    Live measles vaccine is produced by using chick embryo cell culture, so there is a remote possibility of anaphylactic hypersensitivity in children with egg allergies. Most reactions are actually the result of other components in the vaccine. The other vaccines are safe for children with an egg allergy.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 77 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

13. When counseling parents and children about the importance of increased physical activity, the nurse will emphasize which of the following?
    a. Anaerobic exercise should comprise a major component of the child's daily exercise.

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b. All children should be physically active for at least 2 hours per day.
c. It is not necessary to participate in physical education classes at school if a student is taking part in other activities.
d. Make exercise a fun and habitual activity.

ANS: D
It is important to make exercise a fun and habitual activity. Encourage parents to investigate their community's different activity programs. This includes recreation centers, parks, and the YMCA. Aerobic exercise should comprise a major component of children's daily exercise; however, physical activity should also include muscle- and bone -strengthening activities. Children and adolescents should be physically active for at least 1 hour daily. Encourage all students to participate fully in any physical education classes.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 80 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

14. A student nurse is preparing to administer an Hib vaccination to an infant. What action by the student requires the registered nurse to intervene?
a. Gives the vaccine information statement prior to administering the vaccine
b. Wipes the dorsal gluteal area with alcohol prior to injection
c. Obtains written informed consent before giving the vaccine
d. Assesses the family's beliefs and values about vaccinations

ANS: B
The anterolateral thigh is the preferred site for intramuscular administration of vaccines for infants. When the student prepares the wrong site, the registered nurse should intervene. Federal law requires parents be given vaccine information statements and sign informed consent prior to the nurse's administering vaccinations. The nurse should also assess the family's beliefs and values related to vaccination, which can help dispel myths and guide teaching.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 76 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

15. A nurse is planning to teach about injury prevention to a group of parents. What action by the nurse would best ensure a successful event?
a. Have handouts listing community resources.
b. Provide free safety gear like bike helmets.
c. Group parents by child's developmental stage.
d. Present the material in an interactive way.

ANS: C
When providing anticipatory guidance to prevent injury, the most important thing for the nurse to know and understand is developmental levels of the children involved. Grouping parents by their child's developmental level allows the nurse to know this information about the group and to provide teaching specific to the group. The other options will help but are not as important as tailoring teaching to the specific needs of the children.

PTS: 1 DIF: Cognitive Level: Application/Applying

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REF: p. 80 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

16. A nurse is assessing a 1-year-old's food intake over the past 3 days. What information from the parent leads the nurse to provide education on nutrition?
    a. Child drinks 2 cups of 1% milk each day.
    b. Child loves to snack on fruit throughout the day.
    c. Child gets one 4-ounce cup of juice with breakfast.
    d. Parent allows child to regulate own portions at meals.

    ANS: A
    A child this age should not be drinking low-fat milk. Snacking on fruit, 4 ounces of juice, and not forcing the child to eat everything on the plate are appropriate activity and do not require education.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: Box 5.6 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. The nurse preparing to administer the Denver Developmental Screening Test II (DDST-II) should understand that it assesses which functional areas? (*Select all that apply.*)
    a. Personal-functional
    b. Fine motor
    c. Intelligence
    d. Language
    e. Gross motor

    ANS: A, B, D, E
    The four functional areas assessed by this tool are personal-functional, fine motor, language, and gross motor. It is not an intelligence test.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 72 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

2. An immunocompromised child is in the clinic for immunizations. Which vaccine prescriptions should the nurse question? (*Select all that apply.*)
    a. DTaP
    b. HepA
    c. IPV
    d. Varicella
    e. MMR

    ANS: D, E
    Children who are immunologically compromised should not receive live viral vaccines. Varicella is a live vaccine and should not be given except in special circumstances. MMR is a live vaccine and should not be given to immunologically compromised children. DTaP, HepA, and IPV can be given safely.

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PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 77 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

3. A preschool aged child is in the clinic for a well-child checkup. Which statement identifies an appropriate level of language development in this child? (*Select all that apply.*)
   a. Vocabulary of 300 words
   b. Relates elaborate tales
   c. Uses correct grammar in sentences
   d. Able to pronounce consonants clearly
   e. Expresses abstract thought

   ANS: B, C
   The 4-year-old child is able to use correct grammar in sentence structure and can tell elaborate tales and stories. A vocabulary of 300 words is appropriate for a 2-year-old. The 4-year- old child typically has difficulty in pronouncing consonants. The use of language to express abstract thought is developmentally appropriate for the adolescent.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 62 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

4. A 2-month-old child has not had any immunizations. Which ones should the nurse prepare to give? (*Select all that apply.*)
   a. Hib
   b. HepB
   c. MCV
   d. Varicella
   e. HPV

   ANS: A, B, C, D
   Hib, HepB, MCV, and varicella are all appropriate vaccinations for this child. HPV is for adolescents.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 75 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

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MULTIPLE CHOICE

1. A nurse assessing a 2-month-old infant notes that the child can briefly hold the head erect when held against the shoulder. What action by the nurse is best?
   a. Document the findings in the child's chart.
   b. Notify the provider immediately.
   c. Conduct a lead-exposure assessment.
   d. Prepare the parents for genetic testing.

   ANS: A
   A 2-month-old infant is able to briefly hold the head erect. If a parent were holding the infant against the parent's shoulder, the infant would be able to lift his or her head briefly. Since this is normal behavior, all that is required of the nurse is documentation. There is no need to notify the provider immediately, conduct a lead-exposure assessment, or prepare the parents for genetic testing.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: Table 6.1 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

2. Approximately how much would a newborn who weighed 7 pounds 6 ounces at birth weigh at 1 year of age?
   a. 14 3/4 lb
   b. 22 1/8 lb
   c. 29 1/2 lb
   d. Unable to estimate weigh at 1 year

   ANS: B
   An infant triples birth weight by 1 year of age. The other calculations are incorrect.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 83 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

3. Which statement made by a mother is consistent with a developmental delay?
   a. "I notice my 9-month-old infant responds consistently to his name."
   b. "My 12-month-old child does not get herself to a sitting position or pull to stand."
   c. "I am so happy when my 1 1/2-month-old infant smiles at me."
   d. "My 5-month-old infant is not rolling over in both directions yet."

   ANS: B

Critical developmental milestones for gross motor development in a 12-month-old include standing briefly without support, getting to a sitting position, and pulling to stand. If a 12-month-old child does not perform these activities, it may be indicative of a developmental delay. An infant who responds to his name at 9 months of age is demonstrating abilities to both hear and interpret sound. A social smile is present by 2 months of age. Rolling over in both directions is not a critical milestone for gross motor development until the child reaches 6 months of age.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: Table 6.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

4. The nurse is performing a routine assessment on a 14-month-old infant and notes that the anterior fontanel is closed. This should be interpreted as a(n)
   a. normal finding—nurse should document finding in chart.
   b. questionable finding—infant should be rechecked in 1 month.
   c. abnormal finding—indicates need for immediate referral to practitioner.
   d. abnormal finding—indicates need for developmental assessment.

   ANS: A
   This is a normal finding. The anterior fontanel closes between ages 12 and 18 months. The posterior fontanel closes between 2 and 3 months of age. There is no need for a recheck, a referral, or a developmental assessment.

   PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
   REF: p. 93 | Table 6.1 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

5. The nurse advises the mother of a 3-month-old exclusively breastfed infant to
   a. start giving the infant a vitamin D supplement.
   b. start using an infant feeder and add rice cereal to the formula.
   c. start feeding the infant rice cereal with a spoon at the evening feeding.
   d. continue breastfeeding without any supplements.

   ANS: A
   Breast milk does not provide an adequate amount of dietary vitamin D. Infants who are exclusively breastfed need vitamin D supplements to prevent rickets. An infant feeder is an inappropriate method of providing the infant with caloric intake. Solid foods are not recommended for a 3-month-old infant. Rice cereal and other solid foods are contraindicated in a 3-month-old infant. Solid feedings do not typically begin before 4 to 6 months of age.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 93 | Table 6.1 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

6. At what age is an infant first expected to locate an object hidden from view?
   a. 4 months of age
   b. 6 months of age
   c. 9 months of age
   d. 20 months of age

   ANS: C

By 9 months of age, an infant will actively search for an object that is out of sight. Four-month-old infants are not cognitively capable of searching out objects hidden from their view. Infants at this developmental level do not pursue hidden objects. Six-month-old infants have not developed the ability to perceive objects as permanent and do not search out objects hidden from their view. Twenty-month-old infants actively pursue objects not in their view and are capable of recalling the location of an object not in their view. They first look for hidden objects around age 9 months.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 87 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

7. The parents of a newborn infant state, "We will probably not have our baby immunized because we are concerned about the risks." What is the nurse's best response?
   a. "It is your decision to immunize your child or not."
   b. "You should probably think about this decision."
   c. "It is far riskier to not immunize your baby."
   d. "This has to be reported to the health department."

   ANS: C
   Although immunizations have been documented to have a negative effect in a small number of cases, an unimmunized infant is at greater risk for development of complications from childhood diseases than from the vaccines. Plus children who get ill from communicable diseases are a threat to those who are immunocompromised. Telling parents they should think about a decision does not give them any information to consider. Of course the parents have the final decision, but the nurse needs to educate them on the risks of that decision. The parents will not be reported to the health department.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 90 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

8. The mother of a 9-month-old infant is concerned because the infant cries when approached by an unknown shopper at the grocery store. What is the best response for the nurse to make to the mother?
   a. "You could consider leaving the infant with other people so he can adjust."
   b. "You might consider taking her to the doctor because she may be ill."
   c. "Have you noticed whether the baby is teething?"
   d. "This is a sign of stranger anxiety and demonstrates healthy attachment."

   ANS: D
   An infant who manifests stranger anxiety is showing a normal sign of healthy attachment. This behavior peaks at 7 to 9 months and is developmentally appropriate. The mother leaving the child more often will not change this developmental response to new strangers. The child does not need to see a doctor, and teething is unrelated.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: Table 6.1 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

9. Which statement concerning physiologic factors is true?

a. The infant has a slower metabolic rate than an adult.
b. An infant has an inability to digest protein and lactase.
c. Infants have a slower circulatory response than adults do.
d. The infant's kidneys are less efficient in concentrating urine than an adult's kidneys.

ANS: D
The infant's kidneys are not as effective at concentrating urine compared with an adult's because of immaturity of the renal system and slower glomerular filtration rates. This puts the infant at greater risk for fluid and electrolyte imbalance. Infants do not have slower metabolic rates, inabilities to digest protein and lactase, or a slower circulatory response compared to adults.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 86 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

10. Which is a priority in counseling parents of a 6-month-old infant?
a. Increasing food intake for secondary growth spurt
b. Encouraging the infant to smile
c. Securing a developmentally safe environment for the infant
d. Teaching strategies to teach infants to sit up

ANS: C
Safety is a primary concern as an infant becomes increasingly mobile. The infant's appetite and growth velocity decrease in the second half of infancy. Although a social smile should be present by 6 months of age, encouraging this is not of higher priority than ensuring environmental safety. Unless the infant has a neuromuscular deficit, strategies for teaching a normally developing infant to sit up are not necessary.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 96 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

11. A mother of a 2-month-old infant tells the nurse, "My child doesn't sleep as much as his older brother did at the same age." What is the best response for the nurse?
a. "Have you tried to feed the baby more often or play more before bedtime?"
b. "Infant sleep patterns vary widely, some infants sleep only 2 to 3 hours at a time."
c. "Keep a record of your baby's eating, waking, sleeping, and elimination patterns and to come back to discuss them."
d. "This infant is difficult. It is important for you to identify what is bothering the baby."

ANS: B
Newborn infants may sleep as much as 17 to 20 hours per day. Sleep patterns vary widely, with some infants sleeping only 2 to 3 hours at a time. Infants typically do not need more caloric intake to improve sleep behaviors. Stimulating activities before bedtime may keep the baby awake. There is no need for the mother to keep behavior records. Just because an infant may not sleep as much as a sibling did does not justify labeling the child as being difficult. Identifying an infant as difficult without identifying helpful actions is not a therapeutic response for a parent concerned about sleep.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 96 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

12. The mother of a 10-month-old infant tells the nurse that her infant "really likes cow's milk." What is the nurse's best response to this mother?
    a. "Milk is a nutritious choice at this time."
    b. "Children should not get cow's milk until 1 year of age."
    c. "Limit cow's milk to one bedtime bottle."
    d. "Mix cereal with cow's milk and feed it in a bottle."

    ANS: B
    It is best to wait until the infant is at least 1 year old before giving him cow's milk because of the risk of allergies and intestinal problems. Cow's milk protein intolerance is the most common food allergy during infancy. Although milk is a good source of calcium and protein for children after the first year of life, it is not the best source of nutrients for children younger than 1 year old. Bedtime bottles of formula or milk are contraindicated because of their high sugar content, which leads to dental decay in primary teeth. Food and milk or formula should not be mixed in a bottle.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 90 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

13. The mother of a 10-month-old infant asks the nurse about weaning her child. What assessment by the nurse indicates the child is not ready to be weaned?
    a. Frequently throwing the bottle down
    b. Takes very little formula from bottle
    c. Constantly chewing on the bottle nipple
    d. Appears to be sucking consistently when given a bottle

    ANS: D
    Consistent sucking is a sign that the child is not ready to be weaned. Throwing the bottle down, taking more fluids from a cup than the bottle, and chewing on the nipple all indicate readiness for weaning.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 91 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

14. A nurse is modeling play time with a 6-month-old infant. Which activity is appropriate?
    a. Pat-a-cake, peek-a-boo
    b. Ball rolling, hide-and-seek game
    c. Bright rattles and tactile toys
    d. Push-and-pull toys

    ANS: A
    Six-month-old children enjoy playing pat-a-cake and peek-a-boo. Nine-month-old infants enjoy rolling a ball and playing hide-and-seek games. Four-month-old infants enjoy bright rattles and tactile toys. Twelve-month-old infants enjoy playing with push-and-pull toys.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 99 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

15. Parents tell the nurse their 5-month-old has started sitting up without support. What teaching does the nurse plan to provide the parents?
    a. Providing solid foods safely
    b. Encouraging cruising and walking
    c. Providing cow's milk
    d. Proper sock and shoe selection

    ANS: A
    Sitting up is a sign the child is ready to begin solid foods. The nurse should teach the parents how to provide them safely and how to introduce them. The other topics are not related to sitting up.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: Box 6.3 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

16. A nurse is teaching a parent group about dental hygiene for their babies. What information does the nurse provide?
    a. Babies don't need dental care until they are three.
    b. Start brushing teeth when all of them have come in.
    c. Children are ready for dental care when they can hold a toothbrush.
    d. Start with the first tooth using a cotton swab and water to wipe the teeth.

    ANS: D
    An infant's teeth need to be cleaned as soon as they erupt. Cleaning the teeth with cotton swabs or a face cloth is appropriate. Waiting until all the baby teeth are in is inappropriate and prolongs cleaning until 2 years of age. Being able to hold a toothbrush is not necessary as the parents should clean the teeth.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 93 | Table 6.1 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

17. A nurse observes that a 3-month-old infant will hold a rattle if it is put in the hands, but the baby will not voluntarily grasp it. What action by the nurse is most appropriate?
    a. Provide anticipatory guidance.
    b. Document the findings in the chart.
    c. Refer the family to a neurologist.
    d. Perform a developmental screening.

    ANS: B
    This child is displaying normal age-appropriate behavior. The nurse should document the findings, but no other action is necessary. The nurse should always provide appropriate anticipatory guidance, but this answer is too vague to be the best response.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: Table 6.1 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

18. In terms of fine motor development, what should the 7-month-old infant be able to do?
    a. Transfer objects from one hand to the other.
    b. Use thumb and index finger in crude pincer grasp.
    c. Hold crayon and make a mark on paper.
    d. Release cubes into a cup.

    ANS: A
    By age 7 months, infants can transfer objects from one hand to the other, crossing the midline. The crude pincer grasp is apparent at approximately age 9 months. The child can scribble spontaneously at age 15 months. At age 12 months, the child can release cubes into a cup.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: Table 6.1 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

19. In terms of gross motor development, what would the nurse expect a 5-month-old infant to do?
    a. Roll from abdomen to back.
    b. Roll from back to abdomen.
    c. Sit erect without support.
    d. Move from prone to sitting position.

    ANS: A
    Rolling from abdomen to back is developmentally appropriate for a 5-month-old infant. The ability to roll from back to abdomen usually occurs at 6 months old. Sitting erect without support is a developmental milestone usually achieved by 8 months. The 10-month-old infant can usually move from a prone to a sitting position.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 93 | Table 6.1 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

20. According to Piaget, the 6-month-old infant is in what stage of the sensorimotor phase?
    a. Use of reflexes
    b. Primary circular reactions
    c. Secondary circular reactions
    d. Coordination of secondary schemata

    ANS: C
    Infants are usually in the secondary circular reaction stage from age 4 months to 8 months. This stage is characterized by a continuation of the primary circular reaction because of the response that results. Shaking is performed to hear the noise of the rattle, not just for shaking. The use of reflexes is primarily during the first month of life. Primary circular reaction stage marks the replacement of reflexes with voluntary acts. The infant is in this stage from age 1 month to 4 months. The fourth sensorimotor stage is coordination of secondary schemata. This is a transitional stage in which increasing motor skills enable greater exploration of the environment.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 87 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

21. A mother tells the nurse that she is discontinuing breastfeeding her 5-month-old infant. What response by the nurse is best?
    a. “That’s OK. formula is just as good for a 5-month-old.”
    b. “Be sure to use an iron-fortified formula instead.”
    c. “The baby will need immunizations earlier now.”
    d. “Be sure to monitor how many diapers the baby wets.”

    ANS: B
    For children younger than 1 year, the American Academy of Pediatrics recommends the use of breast milk. If breastfeeding has been discontinued, then iron-fortified commercial formula should be used. There is no need to provide immunizations on a different schedule or specific reason for monitoring wet diapers.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 90 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

22. The parent of a 2-week-old infant asks the nurse whether the baby needs fluoride supplements, since mom is exclusively breastfeeding the baby. What response by the nurse is best?
    a. “Yes, the baby needs to begin taking them now.”
    b. “Is your water fluoridated?”
    c. “She may need to begin taking them at age 6 months.”
    d. “You can use infant cereal mixed with fluoridated water instead.”

    ANS: C
    Fluoride supplementation is recommended by the American Academy of Pediatrics beginning at age 6 months if the child is not drinking adequate amounts of fluoridated water. Asking if the water is fluoridated and advising to mix water and cereal are not the best responses since the child is only 2 months old.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 94 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

23. A nurse is making a home visit on a new mother with an infant. What action by the mother requires the nurse to intervene?
    a. Cooks while holding and cuddling infant to provide comfort
    b. Keeps hand on infant while reaching for supplies on changing table
    c. Shows the nurse the water heater setting that is on 110° F (43.3° C)
    d. Places baby to sleep in crib with no blankets, toys, or other objects

    ANS: A
    Burns are a leading cause of injury in children. The mother should not be holding the baby while cooking, so the nurse must intervene at this point. The other actions all provide safety.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 97 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Safe and Effective Care Environment

MULTIPLE RESPONSE

1. A nurse has completed a teaching session for parents about “baby-proofing” the home. Which statements made by the parents indicate an understanding of the teaching? (*Select all that apply.*)
   a. “We will put plastic fillers in all electrical plugs.”
   b. “We will place poisonous substances in a high cupboard.”
   c. “We will place a gate at the top and bottom of stairways.”
   d. “We will keep our household hot water heater at 130 degrees.”
   e. “We will remove front knobs from the stove.”

   ANS: A, C, E
   By the time babies reach 6 months of age, they begin to become much more active, curious, and mobile. Putting plastic fillers on all electrical plugs can prevent an electrical shock. Putting gates at the top and bottom of stairways will prevent falls. Removing front knobs from the stove can prevent burns. Poisonous substances should be stored in a locked cabinet not in a cabinet that children can reach when they begin to climb. The household hot water heater should be turned down to 120 degrees or less.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: p. 97 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Health Promotion and Maintenance

2. The nurse understands that risk factors for hearing loss include (*Select all that apply.*)
   a. structural abnormalities of the ear.
   b. family history of hearing loss.
   c. alcohol or drug use by the mother during pregnancy.
   d. gestational diabetes.
   e. trauma.

   ANS: A, B, E
   Structural abnormalities of the ear, a family history of hearing loss, and trauma are risk factors for hearing loss. Other risk factors include persistent otitis media and developmental delay. The American Academy of Pediatrics suggests that infants who demonstrate hearing loss be eligible for early intervention and specialized hearing and language services. Prenatal alcohol or drug intake and gestational diabetes are not risk factors for hearing loss in the infant.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 88 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. The nurse is teaching a community group about preventing sudden infant death syndrome (SIDS). What information does the nurse provide? (*Select all that apply.*)
   a. Placing the baby supine to sleep
   b. Covering the baby warmly with blankets
   c. Have the baby sleep upright in the infant carrier
   d. Provide “tummy time” while awake
   e. Do not allow smoking in the house

   ANS: A, D, E

Recommendations to prevent SIDS include placing the baby supine in a crib with a well-fitting bottom sheet without covers or toys, providing tummy time during play, and avoiding exposure to environmental hazards such as smoke. The child should not be put to sleep in an infant carrier or covered warmly with blankets.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 96 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Safe and Effective Care Environment

MULTIPLE CHOICE

1. The parent of a 14-month-old child is concerned because the child's appetite has decreased. The best response for the nurse to make to the parent is,
   a. "It is important for your toddler to eat three meals a day and no snacks."
   b. "It is not unusual for toddlers to eat less due to slower growth."
   c. "Be sure to increase your child's milk consumption, which will improve nutrition."
   d. "Give your child a multivitamin daily to increase your toddler's nutrition."

   ANS: B
   Physiologically, growth slows and appetite decreases during the toddler period. So the nurse should assure the parent that this is normal behavior. Toddlers need small, frequent meals. Nutritious selection throughout the day, rather than quantity, is more important with this age-group. Milk consumption should not exceed 16 to 24 oz daily. Juice should be limited to 4 to 6 oz per day. Increasing the amount of milk will only further decrease solid food intake. Supplemental vitamins are important for all children, but they do not increase appetite.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 116 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

2. Which toy is the most developmentally appropriate for an 18- to 24-month-old child?
   a. A push-and-pull toy
   b. Nesting blocks
   c. A bicycle with training wheels
   d. A computer

   ANS: A
   Push-and-pull toys encourage large muscle activity and are appropriate for toddlers. Nesting blocks are more appropriate for a 12- to 15-month-old child. This child is too young for bicycles or computers.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: Box 7.1 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

3. The nurse is planning to teach parents of a 15-month-old child. Which is the priority concern the nurse should address?
   a. Toilet training guidelines
   b. Guidelines for weaning children from bottles
   c. Instructions on preschool readiness
   d. Instructions on a home safety assessment

   ANS: D

Accidents are the major cause of death in children, including deaths caused by ingestion of poisonous materials. Home and environmental safety assessments are priorities in this age-group because of toddlers' increased motor skills and independence, which puts them at greater risk in an unsafe environment. Although it is appropriate to give parents of a 15-month- old child toilet training guidelines, the child is not usually ready for toilet training, so it is not the priority teaching intervention. Parents of a 15-month-old child should have been advised to begin weaning from the breast or bottle at 6 to 12 months of age. Educating a parent about preschool readiness is important and can occur later in the parents' educational process. The priority teaching intervention for the parents of a 15-month-old child is the importance of a safe environment.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 119 OBJ: Nursing Process: Planning
MSC: Client Needs: Health Promotion and Maintenance

4. The nurse teaches the parents that which of the following is the primary purpose of a transitional object?
   a. It helps the parents with the guilt they feel when they leave the child.
   b. It keeps the child quiet at bedtime.
   c. It is effective in decreasing anxiety in the toddler.
   d. It decreases negativism and tantrums in the toddler.

   ANS: C
   Decreasing anxiety, particularly separation anxiety, is the function of a transitional object; it provides comfort to the toddler in stressful situations and helps make the transition from dependence to autonomy. Decreased parental guilt (distress) is an indirect benefit of a transitional object. A transitional object may be part of a bedtime ritual, but it may not keep the child quiet at bedtime. A transitional object does not significantly affect negativity and tantrums, but it can comfort a child after tantrums.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 128 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

5. The nurse is assessing a toddler's growth and development. Which statement does the nurse understand about language development in a toddler?
   a. Language development skills slow during the toddler period.
   b. The toddler understands more than he or she can express.
   c. Most of the toddler's speech is not easily understood.
   d. The toddler's vocabulary contains approximately 600 words.

   ANS: B
   The toddler's ability to understand language (receptive language) exceeds the child's ability to speak it (expressive language). Although language development varies in relationship to physical activity, language skills are rapidly accelerating by 15 to 24 months of age. By 2 years of age, 60% to 70% of the toddler's speech is understandable. The toddler's vocabulary contains approximately 300 or more words.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 112 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

6. A nurse has been teaching a parent of a toddler about effective discipline. Which statement by the parent indicates that goals for teaching have been met?
   a. “I always include explanations and morals when I am disciplining my toddler.”
   b. “I always try to be immediate and consistent when disciplining the children.”
   c. “I believe that discipline should be done by only one family member.”
   d. “My rule of thumb is no more than one spanking a day.”

   ANS: B
   Consistent and immediate discipline for toddlers is the most effective approach. Unless disciplined immediately, the toddler will have difficulty connecting the discipline with the behavior. The toddler’s cognitive level of development precludes the use of explanations and morals as a part of discipline. Discipline for the toddler should be immediate; therefore the family member caring for the child should provide discipline to the toddler when it is necessary. Discipline is required for unacceptable behavior, and the one-spanking-a-day rule contradicts the concept of a consistent response to inappropriate behavior. In addition, spanking is an inappropriate method of disciplining a child.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: p. 119 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Health Promotion and Maintenance

7. Which comments indicate that the mother of a toddler needs further teaching about dental care?
   a. “We use well water so I give my toddler fluoride supplements.”
   b. “My toddler brushes his teeth with my help.”
   c. “My child will not need a dental checkup until his permanent teeth come in.”
   d. “I use a small nylon bristle brush for my toddler’s teeth.”

   ANS: C
   Children should first see the dentist 6 months after the first primary tooth erupts and no later than age 30 months. Toddlers need fluoride supplements when they use a water supply that is not fluoridated. Toddlers need supervision with dental care. The parent should finish brushing areas not reached by the child. A small nylon bristle brush works best for cleaning toddlers’ teeth.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: p. 117 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Health Promotion and Maintenance

8. The nurse is assessing a preschool aged child during a well-child checkup. This child has gained 2 pounds in 1 year. What action by the nurse is best?
   a. Ask the parent to provide a 3-day diet diary.
   b. Assess the child’s teeth and gums.
   c. Plot the weight gain on the growth chart.
   d. Instruct the parent on today’s needed vaccinations.

   ANS: A
   Preschool children gain an average of 5 pounds a year. A gain of only 2 pounds is less than half of the expected weight gain and should be investigated. The other actions are part of a well-child checkup but are not related to the lack of weight gain.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 126 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

9. A 17-month-old child is expected to be in what stage according to Piaget?
   a. Trust
   b. Preoperations
   c. Secondary circular reaction
   d. Sensorimotor period

   ANS: D
   The 17-month-old is in the fifth stage of the sensorimotor phase, tertiary circular reactions. Learning in this stage occurs mainly by trial and error. Trust is Erikson's first stage. Preoperation is the stage of cognitive development usually present in older toddlers and preschoolers. Secondary circular reactions last from approximately ages 4 to 8 months.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 109 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

10. Which statement is correct about toilet training?
    a. Bladder training is usually accomplished before bowel training.
    b. Wanting to please the parent helps motivate the child to use the toilet.
    c. Watching older siblings use the toilet confuses the child.
    d. Children should be forced to sit on the toilet when first learning.

    ANS: B
    Voluntary control of the anal and urethral sphincters is achieved some time after the child is walking. The child must be able to recognize the urge to let go and to hold on. The child must want to please the parent by holding on rather than pleasing himself or herself by letting go. Bowel training precedes bladder training. Watching older siblings provides role modeling and facilitates imitation for the toddler. The child should be introduced to the potty chair or toilet in a nonthreatening manner.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 124 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

11. What should the nurse teach a parent who is concerned about preventing sleep problems in a 2-year-old child?
    a. Have the child always sleep in a quiet, darkened room.
    b. Provide high-carbohydrate snacks before bedtime.
    c. Have the child's daytime caretaker eliminate naps.
    d. Use a nightlight in the child's room.

    ANS: D
    The boundaries between reality and fantasy are not well defined for children of this age, so monsters and scary creatures that lurk in the preschooler's imagination become real to the child after the light is turned off. A nightlight may help ease the child's fears. A dark room may be scary to a preschooler. High-carbohydrate snacks increase energy and do not promote relaxation. Most 2-year-olds take one nap each day. Many give up the habit by age 3 years. Insufficient rest during the day can lead to irritability and difficulty sleeping at night.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 118 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

12. Which statement, made by a nursing student to the father of a 4-year-old child, warrants correction by the nurse?
    a. "Because the 'baby teeth' are not permanent, they are not important to the child."
    b. "Encourage your child to practice brushing his teeth after you have thoroughly cleaned them."
    c. "Your child's 'permanent teeth' will begin to come in around 6 years of age."
    d. "Fluoride supplements are needed if you do not have fluoridated water."

    ANS: A
    Deciduous teeth are important because they maintain spacing and play an important role in the growth and development of the jaws and face and in speech development. Toddlers and preschoolers lack the manual dexterity to remove plaque adequately, so parents must assume this responsibility. But encouraging the child to practice will aid in increasing his or her abilities. Secondary teeth erupt at approximately 6 years of age. If the family does not have fluoridated water, the child will need fluoride treatments.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 118 OBJ: Nursing Process: Evaluation
    MSC: Client Needs: Physiologic Integrity

13. What do parents of preschool children need to understand about discipline?
    a. Both parents and the child should agree on the method of discipline.
    b. Discipline should involve some physical restriction.
    c. The method of discipline should be consistent with that of the child's peers.
    d. Discipline should include positive reinforcement of desired behaviors.

    ANS: D
    Effective discipline strategies should involve a comprehensive approach that includes consideration of the parent -child relationship, reinforcement of desired behaviors, and consequences for negative behaviors. Discipline does not need to be agreed on by the child. Preschoolers feel secure with limits and appropriate, consistent discipline. Both parents should be in agreement so that the discipline is consistently applied. Discipline does not necessarily need to include physical restriction. Discipline does not need to be consistent with that of the child's peers.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 119 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

14. In providing anticipatory guidance to parents whose child will soon be entering kindergarten, which is a critical factor to include in this teaching?
    a. The child needs to be able to sit still.
    b. The child should be able to count to 25.
    c. The parent should have interaction and be responsive to the child.
    d. The child should attend a preschool program first.

    ANS: C

The earliest interactions between parent and infant lay the foundation for school readiness. Probably the most important factor in the development of academic competency is the relationship between parent and child. Sitting still and counting are important skills but are not as vital as parental involvement and responsiveness. Preschool is a helpful experience but not required to enter kindergarten.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 127 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

15. The parents of a newborn say that their toddler "hates the baby.… He suggested that we put him in the trash can so the trash truck could take him away." The nurse's best action is to
    a. assess the older child for signs of child abuse.
    b. refer the family for psychological counseling.
    c. assist the family to deal with this response.
    d. encourage the family to give the toddler extra attention.

    ANS: C
    The arrival of a new infant represents a crisis for even the best prepared toddler. Toddlers have their entire schedule and routines disrupted because of the new family member. This is a normal response. The nurse should work with parents on ways to involve the toddler in the newborn's care and to help focus attention on the toddler. There is no need to assess for child abuse or to refer the family for counseling. Giving the toddler some extra attention and "special time" will probably help, but this is too narrow in scope to be the best answer. The nurse should help brainstorm several different strategies.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 125 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

16. A parent is very frustrated by the amount of time a toddle says "no" and asks the nurse about effective strategies to manage this negativism. The most appropriate recommendation is to
    a. punish the child for the behavior.
    b. provide more attention to the child.
    c. ask the child to not always say "no."
    d. reduce the opportunities for a "no" answer.

    ANS: D
    The nurse should suggest that the parent phrase questions or directives with restrictive choices rather than yes or no answers. This provides a sense of control for the toddler and reduces the opportunity for negativism. Negativism is not an indication of stubbornness or insolence and should not be punished. The negativism is not a function of attention; the child is testing limits to gain an understanding of the world. The toddler is too young for this approach.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 113 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

17. A father tells the nurse that his toddler wants the same plate and cup used at every meal, even if they go to a restaurant. The nurse should suggest that the family do which of the following? a. Do not take the child to restaurants until this behavior has stopped.

b. Take the child but do not give in to this demand.
c. Explain to the child that restaurants have their own dishes.
d. Suggest the family take the dishes and use them at the restaurant.

ANS: D
The child is exhibiting the ritualism that is characteristic at this age. Ritualism is the need to maintain the sameness and reliability. It provides a sense of comfort to the toddler. It will dictate certain principles in feeding practices, including rejecting a favorite food because it is served in a different container. The family can take the dishes and serve the toddler's food and drink with them. Not taking the child out sometimes deprives him or her of a social experience. Not giving in sets the stage for temper tantrums. This child is too young to understand an explanation.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 113 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

18. Parents tell the nurse that their preschool-age child seems to have an imaginary friend named Bob. Whenever their child is scolded or disciplined, the child in turn scolds Bob. What response by the nurse is most appropriate?
a. Ask the child to introduce Bob when the parents are not present.
b. Inform the parents that this is normal behavior in this age group.
c. Suggest the parents discuss the situation with the provider.
d. Refer the child for hearing and vision screening.

ANS: B
In the early preschool years, boundaries between reality and fantasy blur. Children at the age may develop imaginary friends who can keep them company or take the blame when the child misbehaves. The nurse informs the parents that this is normal behavior. The child likely will not "introduce" Bob to a stranger. The nurse him- or herself needs to provide this anticipatory guidance and not just suggest the parents talk to the provider. There is no reason for sensory screening.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 115 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

19. The nursing student has planned teaching for a toddler parent group on poison prevention in the home. In reviewing the presentation with the nurse, what information requires the nurse to provide more instruction to the student?
a. Lock all medications away securely.
b. Place cleaning supplies in a top cabinet.
c. Try not to let your child watch you take pills.
d. Call Poison Control right away for an exposure.

ANS: B
Anything potentially poisonous including things like medication, cleaning supplies, or personal care items must be stored in places completely inaccessible to children. Toddlers view climbing as a challenge, so a top cabinet is not inaccessible. The other instructions are appropriate.

PTS: 1 DIF: Cognitive Level: Application/Applying

REF: p. 109 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

20. The nurse is presenting information on burn safety to a toddler and preschool parenting group at a local community center. To avoid the most common cause of fire death in children this age, what information does the nurse provide?
    a. Practice family fire drills often.
    b. Cover outlets with plastic covers.
    c. Turn the water heater temperature to 110° F (43.3° C).
    d. Keep children out of the kitchen when cooking.

    ANS: A
    Children younger than 5 years are at the greatest risk for burn deaths in a house fire. They often panic and hide in closets or under beds rather than escape safely. Parents need to practice fire drills with their children to teach them what to do in the event of a house fire. Covering outlets, turning the water heater down, and keeping children out of the kitchen when cooking are more appropriate for younger children.

    PTS: 1 DIF: Cognitive Level: Comprehension REF: p. 133
    OBJ: Nursing Process: Planning MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. Which play patterns does a 3-year-old child typically display? (*Select all that apply.*)
    a. Imaginary play
    b. Parallel play
    c. Cooperative play
    d. Structured play
    e. Associative play

    ANS: A, B, C, E
    Children between ages 3 and 5 years enjoy parallel and associative play. Children learn to share and cooperate as they play in small groups. Play is often imitative, dramatic, and creative. Structured play is typical of school-age children.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 122 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

2. The nurse plans a teaching session with a toddler's parents on car safety. Which will the nurse teach? (*Select all that apply.*)
    a. Secure in a rear-facing, upright car safety seat.
    b. Place the car safety seat in the rear seat, behind the driver's seat.
    c. Harness safety straps should fit snugly.
    d. Place the car safety seat in the front passenger seat equipped with an airbag.
    e. After the age of 2 years, toddlers can be placed in a forward-facing car seat.

    ANS: A, C, E

Toddlers should be secured in a rear- facing, upright, approved car safety seat. Harness straps should be adjusted to provide a snug fit. After age 2, the child can sit in a forward-facing car seat. The car safety seat should be placed in the middle of the rear seat. Children younger than 13 years should not ride in a front passenger seat that is equipped with an airbag.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 115 OBJ: Nursing Process: Planning
MSC: Client Needs: Health Promotion and Maintenance

3. The nurse is assessing parental knowledge of temper tantrums. Which are true statements about temper tantrums? (*Select all that apply.*)
   a. Temper tantrums are a common response to anger and frustration in toddlers.
   b. Temper tantrums often include screaming, kicking, throwing things, and head banging.
   c. Parents can effectively manage temper tantrums by giving in to the child's demands.
   d. Children having temper tantrums should be safely isolated and ignored.
   e. Parents can learn to anticipate times when tantrums are more likely to occur.

   ANS: A, B, D, E
   Temper tantrums are a common response to anger and frustration in toddlers. They occur more often when toddlers are tired, hungry, bored, or excessively stimulated. A nap before fatigue or a snack if mealtime is delayed will be helpful in alleviating the times when tantrums are most likely to occur. Tantrums may include screaming, kicking, throwing things, biting themselves, or banging their head. Effective management of tantrums includes safely isolating and ignoring the child. The child should learn that nothing is gained by having a temper tantrum. Giving in to the child's demands only increases the behavior.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: pp. 119-120 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

4. A nurse is planning care for a hospitalized toddler in the preoperational thinking stage. Which characteristics should the nurse expect in this stage? (*Select all that apply.*)
   a. Concrete thinking
   b. Egocentrism
   c. Animism
   d. Magical thought
   e. Ability to reason

   ANS: B, C, D
   The characteristics of preoperational thinking that occur for the toddler include egocentrism (views everything in relation to self), animism (believes that inert objects are alive), and magical thought (believes that thinking something causes that event). Concrete thinking is seen in school-age children, and ability to reason is seen with adolescents.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: pp. 124-125 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

5. The increase in the number of overweight children in this country is addressed in *Healthy People 2020.* Strategies designed to approach this issue include (*Select all that apply*.)
   a. decreased calcium and iron intake.
   b. increased fiber and whole grain intake.
   c. decreased use of sugar and sodium.
   d. increase fruit and vegetable intake.
   e. decrease the use of solid fats.

   ANS: B, C, D, E
   Along with these recommendations, children at risk for being overweight should be screened beginning at age 2 years. Children with a family history of dyslipidemia or early cardiovascular disease development, children whose body mass index percentile exceeds the definition for overweight, and children who have high blood pressure should have a fasting lipid screen. The nurse should instruct parents that calcium and iron intake should be increased as part of this strategy.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 117 OBJ: Nursing Process: Planning
   MSC: Client Needs: Health Promotion and Maintenance

6. A nurse is assessing a child for toilet training readiness during a home visit. Which behaviors by the child are positive signs? (*Select all that apply.*)
   a. Removes own clothing
   b. Walks into bathroom on own
   c. Has been walking for 6 months
   d. Will give up toy when asked to
   e. Scratches as legs periodically

   ANS: A, B, D
   Signs of readiness for toilet training include being able to remove own clothing, being willing to let go of a toy when asked, is able to sit, squat, and walk well, has been walking for 1 year, noticing if diaper is wet, pulls on diaper or exhibits other behavior indicating diaper needs to be changed, communicating the need to go to the bathroom or goes there by self and wanting to please parent by staying dry.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: Box 7.4 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE CHOICE

1. Which statement made by a mother of a school-age boy indicates a need for further teaching?
   a. "My child is playing soccer on a team this year."
   b. "He is always active with his friends playing games."
   c. "I limit his television watching to about 2 hours a day."
   d. "I am glad his coach emphasizes winning and discipline in today's society."

   ANS: D
   Team sports are important for the development of sportsmanship and teamwork and for exercise and refinement of motor skills. A coach who emphasizes winning and strict discipline is not appropriate for children in this age-group. Team sports such as soccer are appropriate for exercise and refinement of motor skills. Limiting television to 2 hours a day is an appropriate restriction. School-age children should be encouraged to participate in physical activities.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: p. 133 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Health Promotion and Maintenance

2. A nurse is assessing an 8-year-old child. Which finding leads the nurse to conduct further assessment?
   a. Understands that his or her point of view is not the only one
   b. Enjoys telling riddles and silly jokes
   c. Demonstrates the principle of object conservation
   d. Engages in fantasy and magical thinking

   ANS: D
   The preschool- age child engages in fantasy and magical thinking. The school-age child moves away from this type of thinking and becomes more skeptical and logical. Belief in Santa Claus or the Easter Bunny ends in this period of development. If the child demonstrated this type of thinking, the nurse would need to follow up with more developmental screening. School -age children enter the stage of concrete operations. They learn that their point of view is not the only one. The school-age child has a sense of humor. The child's increased language mastery and increased logic allow for appreciation of plays on words, jokes, and incongruities. The school-age child understands that properties of objects do not change when their order, form, or appearance does (object conservation).

   PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
   REF: p. 134 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

3. The ability to mentally understand that 1 + 3 = 4 and 4 – 1 = 3 occurs in which stage of cognitive development?
   a. Concrete operations
   b. Formal operations
   c. Intuitive thought

d. Preoperations

ANS: A
By 7 to 8 years of age, the child is able to retrace a process (reversibility) and has the skills necessary for solving mathematical problems. This stage is called concrete operations. The formal operations stage deals with abstract reasoning and does not occur until adolescence. Thinking in the intuitive stage is based on immediate perceptions. A child in this stage often solves problems by random guessing.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 133 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

4. Which activity does the nurse recommend to help develop fine motor skills in the school-age child?
   a. Drawing
   b. Singing
   c. Soccer
   d. Swimming

   ANS: A
   Activities such as drawing, building models, and playing a musical instrument increase the school -age child's fine motor skills. Activities such as soccer or swimming help develop gross motor skills. Singing does not increase motor skills.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 133 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Health Promotion and Maintenance

5. A school nurse is teaching a health class for 5th grade children. The nurse plans to include which statement to best describe growth in the early school-age period?
   a. Boys grow faster than girls.
   b. Puberty occurs earlier in boys than in girls.
   c. Puberty occurs at the same age for all races and ethnicities.
   d. It is a period of rapid physical growth.

   ANS: A
   During the school-age developmental period, boys are approximately 1 inch taller and 2 pounds heavier than girls. Puberty occurs 1 1/2 to 2 years later in boys, which is developmentally later than puberty in girls (not unusual in 9- or 10-year-old girls) . Puberty occurs approximately 1 year earlier in African-American girls than in white girls. Physical growth is slow and steady during the school-age years.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 130 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

6. The nurse is talking to a 7-year-old boy during a well-child clinic visit. The boy states "I am a Power Ranger, so don't make me angry!" What action by the nurse is best?
   a. Ask the child about other friends he might play with.
   b. Find out why the child thinks he is a Power Ranger.
   c. Ask the parents if he has any opposite sex friends.

d. Conduct further developmental screening on the child.

ANS: D
Magical thinking is developmentally appropriate for the preschooler not a 7-year-old. The nurse should assess this child's development further. Asking about other friends or special powers will not provide information related to development. A 7-year-old does not typically have opposite sex playmates.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 134 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

7. A school nurse is conducting a class on safety for a group of school-age children. Which statement indicates that the children may need further teaching?
   a. "My sister and I know two different ways to get out of the house."
   b. "I can dial 911 if there is a fire or a burglar in the house."
   c. "If we have a fire, we have to meet at the neighbor's house."
   d. "If there is a fire I will go back for my cat Fluffy because she will be scared."

   ANS: D
   Fire safety is important at any age, but for this age group children should know two different ways out of the house, how to call 911, and where the family will meet outside the house. Children should be taught never to return to a burning house, not even for a pet.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: p. 140 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Health Promotion and Maintenance

8. Which statement is the most accurate about moral development in the 9-year-old school-age child?
   a. Right and wrong are based on physical consequences of behavior.
   b. The child obeys parents because of fear of punishment.
   c. The school-age child conforms to rules to please others.
   d. Parents are the determiners of right and wrong for the school-age child.

   ANS: C
   The 7- to 12-year-old child bases right and wrong on a good-boy or good-girl orientation in which the child conforms to rules to please others and avoid disapproval. Children 4 to 7 years of age base right and wrong on consequences. Consequences are the most important consideration for the child between 4 and 7 years of age. Parents determine right and wrong for the child younger than 4 years of age.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 135 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

9. In providing anticipatory guidance to parents, which parental behavior does the nurse teach as most important in fostering moral development?
   a. Telling the child what is right and wrong
   b. Vigilantly monitoring the child and her peers
   c. Weekly family meetings to discuss behavior
   d. Living as the parents say they believe

ANS: D
Parents living what they believe gives non-ambivalent messages and fosters the child's moral development and reasoning. Telling the child what is right and wrong is not effective unless the child has experienced what she hears. Parents need to live according to the values they are teaching to their children. Vigilant monitoring of the child and her peers is an inappropriate action for the parent to initiate. It does not foster moral development and reasoning in the child. Weekly family meetings to discuss behaviors may or may not be helpful in the development of moral reasoning.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 135 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

10. The nurse is providing anticipatory guidance for parents of a school-age child. Which behavior does the nurse suggest to best assist the child in negotiating the developmental task of industry?
    a. Identifying failures immediately and asking the child's peers for feedback
    b. Structuring the environment so that the child can master tasks
    c. Completing homework for children who are having difficulty with them
    d. Decreasing expectations to eliminate potential failures

    ANS: B
    The task of the caring teacher or parent is to identify areas in which a child is competent and to build on successful experiences to foster feelings of mastery and success. Structuring the environment to enhance self- confidence and to provide the opportunity to solve increasingly more complex problems will promote a sense of mastery. Asking peers for feedback reinforces the child's feelings of failure. When parents complete children's homework for them, it sends the message that they do not trust their child to do a good job. Providing assistance and suggestions and praising their best efforts are more appropriate. Decreasing expectations to eliminate failures will not promote a sense of achievement or mastery.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 141 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

11. A nurse is assessing an older school-age child recently admitted to the hospital. Which assessment does the nurse perform to determine if child is in an appropriate stage of cognitive development?
    a. Give the child a collection of similar objects, and ask him or her to organize them.
    b. Ask the child to perform a series of math problems using subtraction.
    c. Determine the child's vocabulary and reading comprehension.
    d. Find out what play activities the child enjoys engaging in.

    ANS: B

The ability to classify things from simple to complex and the ability to identify differences and similarities are cognitive skills of the older school-age child; this demonstrates use of classification and logical thought processes. The emergency of this ability explains why children of this age enjoy collecting things. Subtraction and addition are appropriate cognitive activities for the young school-age child. Vocabulary is not as valid an assessment of cognitive ability as is the child's ability to classify. Play activity is not as valid an assessment of cognitive function as is the child's ability to classify.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 134 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

12. Which does the nurse teach as an appropriate disciplinary intervention for the school-age child?
    a. Time-out periods
    b. Consequences that are consistent with the behavior
    c. Physical punishment
    d. Lectures about inappropriate behavior

ANS: B
A consequence that is related to the inappropriate behavior is the recommended discipline. Responsibility can be developed in children through the use of natural and logical consequences related to actions. Time-out periods are more appropriate for younger children. Physical intervention is an inappropriate form of discipline. It does not connect the discipline with the child's inappropriate behavior. Lengthy discussions typically are not helpful.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 139 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

13. A parent of a chubby 8-year-old wants to know how to keep the child from gaining more weight. What response by the nurse is best?
    a. Do not allow your child to snack.
    b. Make a school lunch every day.
    c. Model the behaviors you'd like to see.
    d. Place your child on a restricted diet.

ANS: C
One good option for obesity prevention is to model the behaviors the parents want the child to emulate. The parents should set good examples with eating health and engaging in regular exercise. Snacks, if healthy, can be an important part of a nutritious day. Even if the parent makes a lunch for school each day, there is no guarantee the child will eat it. Children will likely rebel against a strict diet.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 144 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

14. An 8-year-old girl tells the nurse that she has cancer because God is punishing her for "being bad." She shares her concern that if she dies, she will go to hell. What action by the nurse is most appropriate?

a. Reassure the child that she is not being punished.
b. Share concerns about development with the parents.
c. Request a child-life specialist to intervene.
d. Have the chaplain console the child.

ANS: A
Children at this age may view illness or injury as a punishment for a real or imagined transgression. The nurse should reassure the child that she is not being punished. Since this is a common belief at this age, there are no concerns to share with parents. A child-life specialist or chaplain visit may be appropriate, but the nurse needs to respond to this statement him- or herself.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 136 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

15. A group of boys ages 9 and 10 years have formed a "boys-only" club that is open to neighborhood and school friends who have skateboards. This should be interpreted as
a. behavior that encourages bullying and sexism.
b. behavior that reinforces poor peer relationships.
c. characteristic of social development of this age.
d. characteristic of children who are at risk for membership in gangs.

ANS: C
One of the outstanding characteristics of middle childhood is the creation of formalized groups or clubs. Peer-group identification and association are essential to a child's socialization. Poor relationships with peers and a lack of group identification can contribute to bullying. A boys-only club does not have a direct correlation with later gang activity.

PTS: 1 DIF: Cognitive Level: Application REF: p. 134
OBJ: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

16. A 9-year-old girl often comes to the school nurse complaining of stomach pains. Her teacher says she is completing her schoolwork satisfactorily, but lately she has been somewhat aggressive and stubborn in the classroom. What action by the school nurse is most appropriate?
a. Assess the child for unusual stress.
b. Perform a detailed physical exam.
c. Call the parents in for a conference.
d. Screen the child for developmental delay.

ANS: A
Signs of stress include stomach pains or headache, sleep problems, bedwetting, changes in eating habits, aggressive or stubborn behavior, reluctance to participate, or regression to early behaviors. The nurse should assess the child for stress. The other actions are not warranted although the nurse may want to have a conference with parents after screening the child.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: Box 8.2 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychological Integrity

17. The school nurse has been asked to begin teaching sex education in the 5th grade. The nurse should recognize that
    a. children in 5th grade are too young for sex education.
    b. children should be discouraged from asking too many questions.
    c. correct terminology should be reserved for children who are older.
    d. sex can be presented as a normal part of growth and development.

    ANS: D
    When sexual information is presented to school-age children, sex should be treated as a normal part of growth and development. Fifth graders are usually 10 to 11 years old. This age is not too young to speak about physiologic changes in their bodies. The students should be encouraged to ask questions. Preadolescents need precise and concrete information.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 132 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

18. A nurse is interested in preventing injuries to children while they play. What action by the nurse would most likely lead to the biggest impact?
    a. Volunteering for an organization that gives away bicycle helmets.
    b. Providing education on the need for knee pads when skating.
    c. Teaching parents that children too big for child care seats should sit in the front seat.
    d. Encouraging children to play only on formal, constructed playgrounds.

    ANS: A
    Head injuries from bicycles are a large part of serious injury to children in this age group. They need to be taught to only ride a bike while wearing a helmet. The nurse's best option is to volunteer for an organization that gives away helmets. Knee pads when skating is also a good idea, but that won't have the impact of helmets. Once a child is too big for a child care seat and the seat belt fits appropriately, the child should sit in the back seat. Playing on constructed playgrounds only will not prevent injuries and is unrealistic.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 139 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

19. A parent reports getting annoyed with a 6-year-old child who seems to always get cranky and irritable when playing with friends. What suggestion by the nurse is best?
    a. Maybe he should not play with those friends anymore.
    b. The parents should monitor the children's play more closely.
    c. When the child gets cranky he should be told to rest.
    d. The parents should assess the child's diet for protein.

    ANS: C
    Children often do not recognize that they are becoming fatigued. Six-year-olds in particular are quite bad about this. Signs of fatigue include being cranky. The parent should have the child rest at this point. Forbidding the child's friends, monitoring play more closely, and assessing the diet for protein are not needed for this problem.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 133 OBJ: Integrated Process: Teaching-Learning

MSC: Client Needs: Physiologic Integrity

20. A school nurse reports to the parents that their child is complaining of frequent headaches. What suggestion does the nurse offer to the parents?
    a. A complete neurologic workup
    b. A vision screening exam
    c. Decreased amount of household stress
    d. Assessment for seasonal allergies

    ANS: B
    Children often manifest visual problems during the school-age period. These children may squint, move closer to the television or to the front of the class if possible, or complain of headaches. The parents should obtain a visual screening exam for their child. None of the other options is needed at this point.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 134 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

21. A school-age child got a hand-knitted sweater from a relative as a gift. The child refuses to wear it, and it is causing a great deal of conflict in the family as the relative wants to see the child in it. What information can the nurse provide the family about this issue?
    a. This is a time when strict discipline is needed and should be enforced.
    b. It's best to choose your battles carefully or you'll fight over everything.
    c. Teach the child a polite way of expressing dislike for the sweater.
    d. Children this age find it painful to be different from their peers.

    ANS: D
    Children at this age do find it very painful to be different in any way from their peers. The sweater may be very different from anything the peers are wearing, which makes the child reluctant to wear it. The nurse can provide this information to the family so they have information they can use in working out a solution to this problem. Strict discipline is not needed. Telling parents to choose their battles does not help them solve this situation. Children should be taught polite ways in which to express themselves, but this also does not help to solve the family conflict.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 136 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

22. A parent is worried that a child is not eating well. What does the nurse teach the parent to address this problem?
    a. Limit sports and team events that occur over the dinner hour.
    b. Pack a nutritious lunch to take to school every day.
    c. Teach about healthy snacks available at school.
    d. Ensure the child gets 2 cups of milk products a day.

    ANS: A

Sports and team schedules often disrupt mealtime, especially dinner, and families often find themselves eating fast food on the way to practices and games. The family's best option is to limit activities that occur during this time. The child may not eat a packed lunch and may choose unhealthy foods from the schools' vending machines. Children in this age group need 3 cups of milk and dairy products per day.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 145 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. Which demonstrates the school-age child's developing logic in the stage of concrete operations? (*Select all that apply.*)
   a. Recognizes that 1 lb of feathers is equal to 1 lb of metal
   b. Recognizes that he can be a son, brother, or nephew at the same time
   c. Understands the principles of adding, subtracting, and reversibility
   d. Has thinking that is characterized by egocentrism, animism, and centration
   e. Often solves problems with random guessing instead of logic

   ANS: A, B, C
   The school-age child understands that the properties of objects do not change when their order, form, or appearance does. Conservation occurs in the concrete operations stage. Comprehension of class inclusion occurs as the school -age child's logic increases. The child begins to understand that a person can be in more than one class at the same time. This is characteristic of concrete thinking and logical reasoning. The school-age child is able to understand principles of adding and subtracting, as well as the process of reversibility, which occurs in the stage of concrete operations. Egocentrism, animism, and centration occur in the intuitive thought stage, as does random guessing.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: pp. 133-134 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Health Promotion and Maintenance

2. Which interventions should the nurse teach that are appropriate for preventing childhood obesity? (*Select all that apply.*)
   a. Establish consistent times for meals and snacks.
   b. Sign your child up for sports teams.
   c. Teach the family and child how to prepare foods in a healthy manner.
   d. Show the family how to read food labels.
   e. Limit computer and television time.

   ANS: A, C, D, E
   Preventing obesity includes encouraging families to establish consistent times for meals and snacks, teaching them how to select and prepare healthful foods, and limiting computer and television time. Participating in sports is a great activity, but parents should not sign their kids up for teams without consulting them first.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 144 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

3. Which strategies can a nurse teach to parents of a child experiencing uncomplicated school refusal? (*Select all that apply.*)
   a. The child should be allowed to stay home until the anxiety about going to school is resolved.
   b. Parents should be empathetic yet firm in their insistence that the child attend school.
   c. A modified school attendance may be necessary.
   d. Parents need to pick the child up at school whenever the child wants to come home.
   e. Parents need to communicate with the teachers about the situation.

   ANS: B, C, E
   In uncomplicated cases of school refusal, the parent needs to return the child to school as soon as possible. If symptoms are severe, a limited period of part-time or modified school attendance may be necessary. For example, part of the day may be spent in the counselor's or school nurse's office, with assignments obtained from the teacher. Parents should be empathetic yet firm and consistent in their insistence that the child attend school. Parents should not pick the child up at school once the child is there or let the child stay home until this issue is resolved. The principal and teacher should be told about the situation so that they can cooperate with the treatment plan.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 143 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

4. The nurse teaches parents signs that a child might be being bullied or otherwise victimized. What signs does the nurse include in this teaching? (*Select all that apply.*)
   a. Spends an inordinate amount of time in the nurse's office
   b. Belongings frequently go missing or are damaged.
   c. The child wants to be driven to school.
   d. School performance improves.
   e. The child freely talks about his day.

   ANS: A, B, C
   Signs that may indicate a child is being bullied are similar to signs of other types of stress and include nonspecific illness or complaints, withdrawal, depression, school refusal, and decreased school performance. Children express fear of going to school or riding the school bus. Very often, children will not talk about what is happening to them. Improving school performance and talking about the day are not indications of bullying.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 147 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Psychosocial Integrity

5. The student nurse learns that which factors place children at risk for malocclusion? (*Select all that apply.*)
   a. Sucking the thumb
   b. Mouth breathing
   c. Cleft palate
   d. Early loss of "baby" teeth

e. Heredity

ANS: B, C, D, E
Factors that contribute to malocclusion include mouth breathing, cleft palate, early loss of deciduous teeth, and heredity. Sucking the thumb is not a contributing factor unless it persists beyond 2 to 4 years.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: pp. 136-137 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE CHOICE

1. The nurse is explaining Tanner staging to an adolescent and mother. Which statement best describes Tanner staging?
   a. Predictable stages of puberty that are based on chronologic age
   b. Staging of puberty based on the initiation of menarche and nocturnal emissions
   c. Predictable stages of puberty based on primary and secondary sexual characteristics
   d. Staging of puberty based on the initiation of primary sexual characteristics

   ANS: C
   Tanner sexual-maturing ratings are based on the development of stages of primary and secondary sexual characteristics. Tanner stages are not based on chronologic age. The age at which an adolescent enters puberty is variable. The puberty stage in girls begins with breast development. Puberty stage in boys begins with genital enlargement. Primary sexual characteristics are not the basis of Tanner staging.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 151 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

2. Which behavior suggests appropriate psychosocial development in the adolescent?
   a. The adolescent seeks validation for socially acceptable behavior from older adults.
   b. The adolescent is self-absorbed and self-centered and has sudden mood swings.
   c. Adolescents move from peers and enjoy spending time with family members.
   d. Conformity with the peer group increases in late adolescence.

   ANS: B
   During adolescence, energy is focused within. Adolescents concentrate on themselves in an effort to determine who they are or who they will be. Adolescents are likely to be impulsive and impatient. Parents often describe their teenager as being “self-centered or lazy.” The peer group validates acceptable behavior during adolescence. Adolescents move from family and enjoy spending time with peers. Adolescents also spend time alone; they need this time to think and concentrate on themselves. Conformity becomes less important in late adolescence.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 155 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

3. The parents of a 14-year-old girl are concerned that their adolescent spends too much time looking in the mirror. Which statement is the most appropriate for the nurse to make?
   a. “Your teenager needs clearer and stricter limits about her behavior.”
   b. “Your teenager needs more responsibility at home.”
   c. “During adolescence this behavior is not unusual.”
   d. “The behavior is abnormal and needs further investigation.”

   ANS: C

Egocentric and narcissistic behavior, such as staring at oneself in the mirror, is normal during this period of development. The teenager is seeking a personal identity. Stricter limits are not an appropriate response for a behavior that is part of normal development. More responsibility at home is not an appropriate response for this situation. The behavior is normal and needs no further investigation.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 156 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

4. Which statement is the most appropriate advice to give parents of a 16-year-old who is rebellious?
   a. "You need to be stricter so that your teen stops trying to test the limits."
   b. "Try to collaborate to set limits that are perceived as being reasonable."
   c. "Increasing your teen's involvement with her peers will improve her behavior."
   d. "Allow your teenager to choose the type of discipline that is used in your home."

   ANS: B
   Allowing teenagers to choose between realistic options and offering consistent and structured discipline typically enhances cooperation and decreases rebelliousness. Structure helps adolescents to feel more secure and assists them in the decision-making process. Setting stricter limits typically does not decrease rebelliousness or decrease testing of parental limits. Increasing peer involvement does not typically improve behavior. Allowing teenagers to choose the method of discipline is not realistic and typically does not reduce rebelliousness.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 157 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

5. Which statement by the nurse is most appropriate to a 15-year-old whose friend has mentioned suicide?
   a. "Tell your friend to come to the clinic immediately."
   b. "You need to gather details about your friend's suicide plan."
   c. "Your friend's threat needs to be taken seriously and he needs immediate help."
   d. "If your friend mentions suicide again get your friend some help."

   ANS: C
   Suicide is the second most common cause of death among American adolescents and young adults aged 15 to 24. A suicide threat from an adolescent serves as a dramatic message to others and should be taken seriously. Adolescents at risk should be targeted for supportive guidance and counseling before a crisis occurs. Instructing a 15-year-old to tell a friend to come to the clinic immediately provides the teen with limited information and does not address the concern. The teen should not be responsible for getting more information from the friend. Waiting until the teen discusses suicide a second time may be too late.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 163 OBJ: Integrated Process: Caring
   MSC: Client Needs: Psychosocial Integrity

6. When planning care for adolescents, the nurse should
   a. teach parents first, and they, in turn, will teach the teenager.

b. provide information for long-term health needs.
c. provide explanations for treatment and procedures to the parents only.
d. give information privately to adolescents on specific problems that they identify.

ANS: D
Problems that teenagers identify and are interested in are typically the problems that they are the most willing to address. Confidentiality is important to adolescents. Adolescents prefer to confer privately (without parents) with the nurse and health care provider. Teenagers are socially and cognitively at the developmental stage where the health care provider can teach them. Teenagers are more interested in immediate health care needs than in long-term needs. Teenagers are at the developmental level that allows them to receive explanations about health care directly from the nurse.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 159 OBJ: Nursing Process: Planning
MSC: Client Needs: Health Promotion and Maintenance

7. A 17-year-old tells the nurse that he is not having sex because it would make his parents very angry. This response indicates that the adolescent has a developmental lag in which area?
a. Cognitive development
b. Moral development
c. Psychosocial development
d. Psychosexual development

ANS: B
The appropriate moral development for a 17-year- old would include evidence that the teenager has internalized a value system and does not depend on parents to determine right and wrong behaviors. Adolescents who remain concrete thinkers may never advance beyond conformity to please others and avoid punishment. Cognitive development is related to moral development, but it is not the pivotal point in determining right and wrong behaviors. Identity formation is the psychosocial development task. Energy is focused within the adolescent, who exhibits behavior that is self-absorbed and egocentric. Although a task during adolescence is the development of a sexual identity, the teenager's dependence on the parents' sanctioning of right or wrong behavior is more appropriately related to moral development.

PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
REF: p. 158 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Health Promotion and Maintenance

8. What is the best response a nurse can make to a 15-year-old girl who has verbalized a desire to have a baby?
a. "Have you talked with your parents about this?"
b. "Do you have plans to continue school?"
c. "Will you be able to support the baby?"
d. "Can you tell me how your life will be if you have an infant?"

ANS: D

Having the teenager describe how the infant will affect her life will allow the teen to think more realistically. Her description will allow the nurse to assess the teen's perception and reality orientation. Asking the teenager whether she has talked to her parents is not particularly helpful to the teen or the nurse and may terminate the communication. A direct question about continuing school will not facilitate communication. Open-ended questions encourage communication. Asking the teenager about how she will support the child will not facilitate communication. Open-ended questions encourage communication.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 166 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

9. Many adolescents decide to follow a vegetarian diet during their teen years. The nurse can advise the adolescent and his or her parents that
   a. this diet will not meet the nutritional requirements of growing teens.
   b. a vegetarian diet can be healthy for this population.
   c. an adolescent on a vegetarian diet is less likely to eat high-fat foods.
   d. a vegetarian diet requires little extra meal planning.

   ANS: B
   A vegetarian diet is healthy for this population, and the low-fat aspect of the diet can prevent future cardiovascular problems. Several dietary organizations have suggested that a vegetarian diet, if correctly followed, is healthy for this population. As with any adolescent, nurses need to advise teens who follow a vegetarian eating plan to avoid low-nutrient, high-fat foods. The nurse can assist with planning food choices that will provide sufficient calories and necessary nutrients. The focus is on obtaining enough calories for growth and energy from a variety of fruits and vegetables, whole grains, nuts, and soymilk.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 160 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

10. Which is assessed with Tanner staging?
    a. Hormone levels
    b. Secondary sex characteristics
    c. Growth hormone secretion
    d. Hyperthyroidism

    ANS: B
    Tanner stages are used to assess staging of secondary sex characteristics at puberty. Hormone levels are assessed by their concentration in the blood. Growth hormone secretion tests are not associated with Tanner staging. Tanner stages are not associated with hyperthyroidism.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 151 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

11. A nurse is teaching adolescent boys about pubertal changes. The first sign of pubertal change seen with boys is
    a. testicular enlargement.
    b. facial hair.

c. scrotal enlargement.
d. voice deepens.

ANS: A
The first sign of pubertal changes in boys is testicular enlargement in response to testosterone secretion, which usually occurs in Tanner stage 2. Slight pubic hair is present and the smooth skin texture of the scrotum is somewhat altered. During Tanner stages 4 and 5, facial hair appears at the corners of the upper lip and chin. As testosterone secretion increases, the penis, testes, and scrotum enlarge. During Tanner stages 4 and 5, rising levels of testosterone cause the voice to deepen.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 150 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

12. A student nurse learns that according to Erikson, the psychosocial task of adolescence is to develop
a. intimacy.
b. identity.
c. initiative.
d. independence.

ANS: B
Traditional psychosocial theory holds that the developmental crises of adolescence lead to the formation of a sense of identity. Intimacy is the developmental stage for early adulthood. Initiative is the developmental stage for early childhood. Independence is not one of Erikson's developmental stages.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 155 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

13. A student nurse learns that according to Piaget, the adolescent is in the fourth stage of cognitive development, or period of what?
a. Formal operations
b. Concrete operations
c. Conventional thought
d. Postconventional thought

ANS: A
Cognitive thinking culminates with capacity for abstract thinking. This stage, the period of formal operations, is Piaget's fourth and last stage. Concrete operations usually develops between ages 7 and 11 years. Conventional and postconventional thought refer to Kohlberg's stages of moral development.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 154 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

14. A student nurse asks the faculty why peer relationships become more important during adolescence. Which of the following is the nurse's best response?
a. Adolescents dislike their parents.

b. Adolescents no longer need parental control.
c. They provide adolescents with a feeling of belonging.
d. They promote a sense of individuality in adolescents.

ANS: C
The peer group serves as a strong support to teenagers, providing them with a sense of belonging (versus individuality) and a sense of strength and power. During adolescence, the parent/child relationship changes from one of protection-dependency to one of mutual affection and quality. This does not mean teens do not like their parents who continue to play an important role in their personal and health-related decisions.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 155 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

15. A 14-year-old male seems to be always eating, although his weight is appropriate for his height. The parents ask the nurse if they should be concerned about this behavior. Which response by the nurse is best?
a. This is normal because of increase in body mass during this time.
b. This is abnormal and suggestive of possible future obesity.
c. His caloric intake would have to be excessive for him to gain weight.
d. He is substituting food for unfilled needs.

ANS: A
In adolescence, nutritional needs are closely related to the increase in body mass. The peak requirements occur in the years of maximal growth. The caloric and protein requirements are higher than at almost any other time of life. It is not suggestive of possible future obesity or unmet psychosocial needs. It may be true that the teen would need to eat an enormous amount of food in order to gain weight, but that does not give the parents the information they are requesting.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 159 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

16. What does the nurse learn that predisposes the adolescent to feel an increased need for sleep?
a. An inadequate diet
b. Rapid physical growth
c. Decreased activity
d. Typical lack of ambition

ANS: B
Rapid physical growth, the tendency toward overexertion, and the overall increased activity of this age contributes to fatigue in this population. It is not due to dietary factors, decreased activity, or lack of ambition.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 161 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

17. A nurse wants to volunteer for an organization that helps prevent death in older adolescents. What action by the nurse would have the most impact?

a. Volunteer for a suicide hotline.
b. Teach firework safety classes.
c. Work on a poison control hot line.
d. Educate teens on gun safety.

ANS: A
Of the four causes of death listed, suicide ranks highest, being the second most common cause of death in the 15 to 24 age group. The nurse would make the biggest impact volunteering for a suicide hotline.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 163 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

18. In girls, the initial indication of puberty is
a. menarche.
b. growth spurt.
c. growth of pubic hair.
d. breast development.

ANS: D
In most girls, the initial indication of puberty is the appearance of breast buds, an event known as thelarche. The usual sequence of secondary sexual characteristic development in girls is breast changes, rapid increase in height and weight, growth of pubic hair, appearance of axillary hair, menstruation, and abrupt deceleration of linear growth.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 152 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. Which factors contribute to early adolescents engaging in risk-taking behaviors? (*Select all that apply.*)
a. Peer pressure
b. A desire to master their environment
c. Trying to separate from their parents
d. A belief that they are invulnerable
e. Impulsivity

ANS: A, D, E
Peer pressure (including impressing peers) is a factor contributing to adolescent injuries. During early to middle adolescence, children feel that they are exempt from the consequences of risk-taking behaviors; they believe that negative consequences only happen to others. Feelings of invulnerability (“It can’t happen to me”) are evident in adolescence. Impulsivity places adolescents in unsafe situations. Mastering the environment is the task of young school-age children. Emancipation is a major issue for the older adolescent. The process is accomplished as the teenager gains an education or vocational training.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 154 OBJ: Nursing Process: Assessment

MSC: Client Needs: Health Promotion and Maintenance

2. A parent calls the emergency department (ED) reporting a front tooth completely knocked out of an adolescent's mouth while playing soccer. What information should the nurse provide? (*Select all that apply.*)
   a. Rinse the tooth in lukewarm tap water.
   b. Place the tooth in saline, milk, or water.
   c. Scrub the tooth with a disinfectant.
   d. Come to the ED within 1 hour.
   e. Prognosis is best if they are seen within 30 minutes.

   ANS: A, B, E
   The parent should be advised to rinse the tooth in lukewarm tap water and to place it in saline, milk, or a commercial tooth preservative. Prognosis is best if the tooth can be re-implanted within 30 minutes. The tooth should not be scrubbed.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 160 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

3. Parents of a teenager ask the nurse what signs they should look for if their child is in a gang. The nurse should include which signs when answering? (*Select all that apply.*)
   a. Plans to try out for the debate team at school
   b. Skipping classes to go to the mall
   c. Hanging out with friends they have had since childhood
   d. Unexplained source of money
   e. Fear of the police

   ANS: B, D, E
   Signs of gang involvement include skipping classes, unexplained sources of money, and fear of the police. Associating with new friends while ignoring old friends is also a sign. A change in attitude toward participating in activities is another sign of gang involvement. Plans to become more involved in school activities and hanging around old friends are not signs.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: Box 9.3 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

4. The school nurse is presenting information on some risks of tattoos. What information should the nurse provide? (*Select all that apply.*)
   a. Amateur tattoos are difficult to remove.
   b. Tattoos pose a risk for bloodborne and skin infections.
   c. A tattoo may keep you from getting an MRI.
   d. Tattoo dyes may cause allergic reactions.
   e. Tattoo parlors are well regulated.

   ANS: B, C, D

Tattoos carry the risk for contracting bloodborne diseases such as hepatitis B and HIV. Infection, allergic reaction to the dye, scarring, or keloid formation can occur. Should an MRI ever be required, it is important to notify the health care professionals, because the dyes can contain iron and other metals. Amateur tattoos are easily removed; however, studio tattoos made with red and green dye are extremely difficult to remove. Very little regulation exists in the tattoo industry; therefore, the cleanliness of each tattoo parlor varies. Teens should be counseled to avoid making an impulsive decision to get a tattoo.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: pp. 164-165 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

5. The school nurse is evaluating the school's athletic programs for safety. What factors should the nurse assess? (*Select all that apply.*)
   a. Students get adequate rest periods.
   b. Equipment is in good condition.
   c. Practices are appropriate for students.
   d. Post-game concussion assessment if needed
   e. Adequate fluids are available at all times.

   ANS: A, B, C, E
   A safe athletic program has several features including adequate rest periods, good quality equipment, appropriate practice schedules and regimes, and adequate fluids. Concussion testing if warranted, should occur immediately as the student is withdrawn from the game, and not wait until after the game is over.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: Safety Alert Box OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Safe and Effective Care Environment

6. A nurse is planning for a sports pre-participation physical exam day. What goals for this event does the nurse set? (*Select all that apply.*)
   a. Comprehensive physical examination
   b. Assess general health
   c. Identify limiting conditions
   d. Provide wellness counseling
   e. Adhere to insurance requirements

   ANS: B, C, D, E
   In a pre-participation sports examination, goals are to identify the teen's general health, identify any condition that would limit participation, provide wellness counseling, and ensure that participants meet insurance guidelines for participation. It is not meant to be a comprehensive physical examination.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: Box 9.1 OBJ: Nursing Process: Planning
   MSC: Client Needs: Safe and Effective Care Environment

7. A nurse works for an organization that seeks to limit adolescent violence. In talking with donors, which risk factors for violence may lead to programming decisions? (*Select all that apply.*)

a. Drug or alcohol use/abuse
b. Poverty
c. Hopelessness about the future
d. Narcissism
e. Lack of supervision

ANS: A, B, C, E
Drug and alcohol use/abuse, poverty, hopelessness, and lack of supervision all are risk factors for violence. Narcissism is not.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: Box 9.5 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

8. The nurse is discussing contraceptive choices with an adolescent girl who wants to become sexually active. Which factors are important to consider? (*Select all that apply.*)
a. Motivation
b. Cognitive development
c. Chronological age
d. Parental opinions
e. Frequency of intercourse

ANS: A, B, E
Motivation, cognitive development, and planned frequency of intercourse are some of the factors to consider when counseling an adolescent about birth control choices. Chronological age is not as important as developmental state. Parents generally do not need to give consent or be informed when a teen seeks contraception.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: Nursing Quality Alert Box | Box 9.4
OBJ: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE CHOICE

1. How can a woman avoid exposing her fetus to teratogens?
   a. Update her immunizations during the first trimester of her pregnancy.
   b. Use saunas and hot tubs during the winter months only.
   c. Use only class A drugs during her pregnancy.
   d. Use alcoholic beverages only in the first and third trimesters of pregnancy.

   ANS: C
   In well-controlled studies, class A drugs have no demonstrated fetal risk. Immunizations, such as rubella, are contraindicated in pregnancy. Maternal hyperthermia is an important teratogen. Alcohol is an environmental substance known to be teratogenic.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 177 OBJ: Nursing Process: Planning
   MSC: Client Needs: Health Promotion and Maintenance

2. The karyotype of a person is 47, XY, +21. This person is a
   a. normal male.
   b. male with Down syndrome.
   c. normal female.
   d. female with Turner syndrome.

   ANS: B
   This person is male because his sex chromosomes are XY. He has one extra copy of chromosome 21 (for a total of 47 instead of 46), resulting in Down syndrome. A normal male has 46 chromosomes. A normal female has 46 chromosomes and XX for the sex chromosomes. A female with Turner syndrome has 45 chromosomes; the sex chromosomes have just one X.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 175 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. People who have two copies of the same abnormal autosomal dominant gene will usually be
   a. more severely affected by the disorder than will people with one copy of the gene.
   b. infertile and unable to transmit the gene.
   c. carriers of the trait but not affected with the disorder.
   d. mildly affected with the disorder.

   ANS: A
   People who have two copies of an abnormal gene are usually more severely affected by the disorder because they have no normal gene to maintain normal function. Infertility may or may not be caused by chromosomal defects. A carrier of a trait has one recessive gene. Those mildly affected with the disorder will have only one copy of the abnormal gene.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 173 OBJ: Nursing Process: Assessment

MSC: Client Needs: Physiologic Integrity

4. A baby is born with blood type AB. The father is type A, and the mother is type B. The father asks why the baby has a blood type different from those of his parents. The nurse's answer should be based on the knowledge that
   a. both A and B blood types are dominant.
   b. the baby has a mutation of the parents' blood types.
   c. type A is recessive and links more easily with type B.
   d. types A and B are recessive when linked together.

   ANS: A
   Types A and B are equally dominant, and the baby can thus inherit one from each parent. The infant has inherited both blood types from the parents; it is not a mutation.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 172 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

5. Which statement is true of multifactorial disorders?
   a. They may not be evident until later in life.
   b. They are usually present and detectable at birth.
   c. The disorders are characterized by multiple defects.
   d. Secondary defects are rarely associated with multifactorial disease.

   ANS: B
   Multifactorial disorders result from an interaction between a person's genetic susceptibility and environmental conditions that favor development of the defect. They are characteristically present and detectable at birth. They are usually single isolated defects, although the primary defect may cause secondary defects. Secondary defects can occur with multifactorial disorders.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 176 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

6. Both members of an expectant couple are carriers for phenylketonuria (PKU), an autosomal recessive disorder. In counseling them about the risk to their unborn child, the nurse should tell them that
   a. the child has a 25% chance of being affected.
   b. the child will be a carrier, like the parents.
   c. the child has a 50% chance of being affected.
   d. one of four of their children will be affected.

   ANS: A
   Each child born to a couple who carries an autosomal recessive trait has a 25% chance of having the disorder, because the child receives either a normal or an abnormal gene from each parent. If one member of the couple has the autosomal recessive disorder, all of their children will be carriers. If both parents are carriers, each child has a 50% chance of being a carrier. Each child has the identical odds of being affected.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: Box 10.1 OBJ: Integrated Process: Teaching-Learning

MSC: Client Needs: Physiologic Integrity

7. Which statement should a nurse make when telling a couple about the prenatal diagnosis of genetic disorders?
   a. Diagnosis can be obtained promptly through most hospital laboratories.
   b. Common disorders can quickly be diagnosed through blood tests.
   c. A comprehensive evaluation will result in an accurate diagnosis.
   d. Diagnosis may be slow and could be inconclusive.

   ANS: D
   Even the best efforts at diagnosis do not always yield the information needed to counsel patients. They may require many visits over several weeks. Some tests must be sent to a special laboratory, which requires a longer waiting period for results. There is no quick blood test available at this time to diagnose genetic disorders. Despite a comprehensive evaluation, a diagnosis may never be established.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 178 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

8. A woman tells the nurse at a prenatal interview that she has quit smoking, only has a glass of wine with dinner, and has cut down on coffee to four cups a day. What response by the nurse will be most helpful in promoting lifestyle changes?
   a. “You have made some great progress toward having a healthy baby. Let’s talk about the changes you have made.”
   b. “You need to do a lot better than that. You may still be hurting your baby right now.”
   c. “Here are some pamphlets for you to study. They will help you find more ways to improve.”
   d. “Those few things won’t cause any trouble. Good for you.”

   ANS: A
   Praising her for making positive changes is an effective technique for motivating a patient. She still has to identify the risk factors to optimize the results so a discussion with the nurse can facilitate that. Telling her she has to do better is belittling to the patient. She will be less likely to confide in the nurse. The nurse is not acknowledging the efforts that the woman has already accomplished by simply giving her pamphlets. Those accomplishments need to be praised to motivate the woman to continue. Plus before giving written material, the nurse must assess the woman’s literacy level. Alcohol and coffee consumption are still major risk factors and need to be addressed in a positive, nonjudgmental manner.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 180 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

9. A 35-year-old woman has an amniocentesis performed to find out whether her baby has a chromosome defect. Which statement by this patient indicates that she understands her situation?
   a. “The doctor will tell me if I should have an abortion when the test results come back.”
   b. “I know support groups exist for parents who have a baby with birth defects, but

we have plenty of insurance to cover what we need."

c. "When all the lab results come back, my husband and I will make a decision about the pregnancy."
d. "My mother must not find out about all this testing. If she does, she will think I'm having an abortion."

ANS: C
The final decision about genetic testing and the future of the pregnancy lies with the patient. She will involve only those people whom she chooses in her decisions. The final decision about the future of the pregnancy lies with the patient only. Support groups are extremely important for parents of a baby with a defect. Insurance will help cover expenses, but the defect also takes a toll on the emotional, physical, and social aspects of the parents' lives. The nurse should ensure the woman understands that her care is confidential.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 180 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Health Promotion and Maintenance

10. Which question by the nurse will most likely promote sharing of sensitive information during a genetic counseling interview?
a. "How many people in your family are mentally retarded or handicapped?"
b. "What kinds of defects or diseases seem to run in the family?"
c. "Did you know that you can always have an abortion if the fetus is abnormal?"
d. "Are there any family members who have learning or developmental problems?"

ANS: D
The nurse should probe gently by using lay-oriented terminology rather than direct questions or statements.

PTS: 1 DIF: Cognitive Level: Application REF: p. 180
OBJ: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

11. A maternal-newborn nurse is caring for a mother who just delivered a baby born with Down syndrome. What nursing diagnosis is the most essential in caring for the mother of this infant?
a. Disturbed body image
b. Interrupted family processes
c. Anxiety
d. Risk for injury

ANS: B
This mother likely will experience a disruption in the family process related to the birth of a baby with an inherited disorder. Family disruption is common, and the strain of having a child with a serious birth defect may lead to divorce. Siblings may feel neglected because the child with a disorder requires more of their parents' time and attention. Women commonly experience body image disturbances in the postpartum period, but this is unrelated to giving birth to a child with Down syndrome. The mother likely will have a mix of emotions that may include anxiety, guilt, and denial, but this is not the most essential nursing diagnosis for this family. Risk for injury is not applicable.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 181 OBJ: Nursing Process: Diagnosis
MSC: Client Needs: Psychosocial Integrity

12. A couple has been counseled for genetic anomalies. They ask the nurse, “What is karyotyping?” Which of the following is the nurse’s best response?
    a. “Karyotyping will reveal if the baby’s lungs are mature.”
    b. “Karyotyping will reveal if your baby will develop normally.”
    c. “Karyotyping will provide information about the number and structure of the chromosomes.”
    d. “Karyotyping will detect any physical deformities the baby has.”

    ANS: C
    Karyotyping provides genetic information, such as gender and chromosomal structure. Karyotyping is completed by photographing or using computer imaging to arrange chromosomes in pairs from largest to smallest. The karyotype can then be analyzed. Karyotyping does not determine lung maturity or if the baby is developing normally. Although karyotyping can detect genetic anomalies, not all such anomalies display obvious physical deformities. The term deformities is a nondescriptive word. Furthermore, physical anomalies may be present that are not detected by genetic studies (e.g., cardiac malformations).

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 172 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

13. In practical terms regarding genetic health care, nurses should be aware that
    a. genetic disorders equally affect people of all socioeconomic backgrounds, races, and ethnic groups.
    b. genetic health care is more concerned with populations than individuals.
    c. the most important related nursing function is providing emotional support to the family during counseling.
    d. taking genetic histories is usually only done at large universities and medical centers.

    ANS: C
    Nurses should be prepared to help with a variety of stress reactions from a couple facing the possibility of a genetic disorder. Although anyone may have a genetic disorder, certain disorders appear more often in certain ethnic and racial groups. Genetic health care is highly individualized, because treatments are based on the phenotypic responses of the individual. Individual nurses at any facility can take a genetic history and provide basic genetic information, although larger facilities may have better support services.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 179 OBJ: Nursing Process: Planning
    MSC: Client Needs: Psychosocial Integrity

14. The nurse is working in an OB/GYN office and commonly obtains patient histories and performs initial assessments. Which woman is likely to be referred for genetic counseling after her first visit?
    a. A pregnant woman who will be 40 years or older when her infant is born
    b. A woman whose partner is 41 years of age
    c. A patient who carries a Y-linked disorder
    d. An anxious woman with a normal quadruple screening result

ANS: B
A genetics referral should be made if the woman's (male) partner is over the age of 40 at conception. Other reasons for referral include pregnant women who will be 35 or older at the time of birth or abnormal quadruple (or other) screening results. Women do not carry Y chromosomes.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: Box 10.4 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

15. A nurse is seeing a pregnant woman who has had genetic testing on her unborn fetus and has been given the results. The nurse notes the results confirm that the husband could not be the father. What action by the nurse is best?
    a. Do not discuss this information with the mother.
    b. Inform the mother genetic testing does not establish paternity.
    c. Call the husband immediately to break the news.
    d. Be available and offer support as the mother absorbs the news.

    ANS: D
    Genetic testing can reveal paternity; hopefully the couple was informed that this can occur before the testing was done. The nurse should offer support to the woman as she tries to absorb the news and determine what to do next. Refusing to discuss the information may leave the woman feeling abandoned and does not address her emotional needs. The nurse should not call the husband.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: Box 10.5 OBJ: Integrated Process: Caring
    MSC: Client Needs: Psychosocial Integrity

16. A nurse is creating a pedigree for a couple whose son has Tay-Sachs disease. What information from the pedigree would the nurse most likely find?
    a. Parental consanguinity
    b. Disease has skipped a generation.
    c. Only men have had this disorder.
    d. Only women have had this disorder.

    ANS: A
    Parental consanguinity increases the risk for autosomal recessive disorders such as Tay-Sachs disease. The pedigree would not show the disease skipping generations. Males and females are equally affected by this disorder.

    PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
    REF: Box 10.1 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. A patient at 34 weeks of gestation has reported to the OB triage unit for assessment of oligohydramnios. The nurse assigned to care for this patient is aware that prolonged oligohydramnios may result in (*Select all that apply.*)

a. intrauterine limb amputations.
b. clubfoot.
c. delayed lung development.
d. other fetal abnormalities.
e. fetal deformations.

ANS: B, C, D
Oligohydramnios, an abnormally small volume of amniotic fluid, reduces the cushion surrounding the fetus and may result in deformations such as clubfoot. Prolonged oligohydramnios interferes with fetal lung development because it does not allow normal development of the alveoli. Oligohydramnios may not be the primary fetal problem but rather may be related to other fetal anomalies. This does not lead to intrauterine limb amputations or fetal deformations.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 178 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

2. The nurse knows that which of the following chromosomal abnormalities are structural in nature? (*Select all that apply.*)
a. Part of a chromosome is missing.
b. The material within a chromosome is rearranged.
c. One or more sets of chromosomes are added.
d. An entire single chromosome is added.
e. Two chromosomes adhere to each other.

ANS: A, B, E
Characteristics of structural abnormalities include part of a chromosome missing or added, rearrangement of material within chromosomes, two chromosomes that adhered to each other, and fragility of a specific site on the X chromosome. The addition of a single chromosome (trisomy), the deletion of a single chromosome (monosomy), and one or more added sets of chromosomes (polyploidy) are numerical abnormalities.

PTS: 1 DIF: Cognitive Level: Comprehension REF: pp. 175-176
OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

3. The generalist nurse working with child-bearing families understands that his or her practice related to genetics includes which of the following? (*Select all that apply.*)
a. Identifying families at risk and providing referrals
b. Interpreting genetic test results for the family
c. Assessing the couple’s concern about genetic alterations
d. Helping create a family tree or pedigree
e. Providing support in all phases of genetic counseling

ANS: A, C, D, E
The nurse who works with women and families in the childbearing years is in a wonderful position to help identify families at risk and provide referrals, assess concerns, create pedigrees, and provide support. Interpreting genetic test results is provided by those who have advanced training and education in that area and would not be expected of the generalist nurse.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 180 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

4. The faculty member teaches students that which of the following are examples of autosomal recessive disorders or traits? (*Select all that apply.*)
   a. Blood group O
   b. Tay-Sachs disease
   c. Huntington disease
   d. Neurofibromatosis
   e. Hemophilia A

   ANS: A, B
   Autosomal recessive traits and disorders include blood group O, Tay-Sachs disease, and cystic fibrosis. Huntington disease and neurofibromatosis are examples of autosomal dominant disorders. Hemophilia A is an X-linked disorder.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: Box 10.1 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. Which man is most likely to have abnormal sperm formation resulting in infertility?
   a. A 20-year-old man with undescended testicles
   b. An uncircumcised 40-year-old man
   c. A 35-year-old man with previously treated sexually transmitted disease
   d. A 16-year-old adolescent who is experiencing nocturnal emissions

   ANS: A
   For normal sperm formation, a man's testes must be cooler than his core body temperature. The cremaster muscle attached to each testicle causes the testes to rise closer to the body and become warmer or allow the testes to fall away from the body to become cooler. Circumcision does not prevent fertility. Scar tissue in the fallopian tubes as a result of a sexually transmitted disease can be a cause of infertility in women. Nocturnal emissions of seminal fluid are normal and expected in teenagers.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 193 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

2. A nurse is teaching a woman about spinnbarkeit. The student nurse asks why the woman would need this information. What response by the nurse is most appropriate?
   a. To assist in becoming pregnant or preventing pregnancy
   b. To determine if she can breastfeed
   c. To assess risk for genetic defects in the fetus
   d. To find out if her ova are suitable for fertilization

   ANS: A
   Spinnbarkeit refers to the elasticity of cervical mucosa. The woman can assess this to avoid or promote pregnancy. It does not refer to breastfeeding, genetics, or her ova status.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 192 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

3. Which of these is a secondary sexual characteristic?
   a. Female breast development
   b. Production of sperm
   c. Maturation of ova
   d. Secretion of gonadotropin-releasing hormone

   ANS: A
   A secondary sexual characteristic is one not directly related to reproduction, such as development of the characteristic female body form. Production of sperm, maturation of ova, and secretion of hormones are all directly related to reproduction and not secondary sexual characteristics.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering

REF: p. 183 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

4. The nursing students learn that fertilization of the ovum takes place in which part of the fallopian tube?
   a. Interstitial portion
   b. Ampulla
   c. Isthmus
   d. Infundibulum

   ANS: B
   The ampulla is the wider middle part of the tube lateral to the isthmus and is where fertilization occurs. It does not occur in the interstitial portion, isthmus, or infundibulum.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 188 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

5. Which 16-year-old female is most likely to experience secondary amenorrhea?
   a. A girl who is 5 ft 2 in, 130 lb
   b. A girl who is 5 ft 9 in, 150 lb
   c. A girl who is 5 ft 7 in, 96 lb
   d. A girl who is 5 ft 4 in, 120 lb

   ANS: C
   Low body fat is a risk factor for secondary amenorrhea. The girl who is 5 ft 7 inches tall and only weighs 96 pounds has less body fat that the other girls and a higher likelihood of secondary amenorrhea.

   PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
   REF: p. 185 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

6. It is important for the nurse to understand that the levator ani is a(n)
   a. imaginary line that divides the true and false pelvis.
   b. basin-shaped structure at the lower end of the spine.
   c. collection of three pairs of muscles.
   d. division of the fallopian tube.

   ANS: C
   The levator ani is a collection of three pairs of muscles that support internal pelvic structures and resist increases in intra-abdominal pressure. The linea terminalis is the imaginary line that divides the false pelvis from the true pelvis. The basin-shaped structure at the lower end of the spine is the bony pelvis. The fallopian tube divisions are the interstitial portion, isthmus, ampulla, and infundibulum.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 189 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

7. In describing the size and shape of the nonpregnant uterus to a patient, the nurse would say it is approximately the size and shape of a

a. cantaloupe.
b. grapefruit.
c. pear.
d. large orange.

ANS: C
The nonpregnant uterus is approximately 7.5 × 5.0 × 2.5 cm, which is close to the size and shape of a pear.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 186 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

8. If a woman's menstrual cycle began on June 2 and normally lasts 28 days, ovulation would mostly likely occur on June
a. 10
b. 16
c. 21
d. 29

ANS: B
Ovulation occurs approximately 12 to 14 days after the beginning of the menstrual period in a 28-day cycle. In this woman, ovulation would most likely occur on June 16. June 10 would just be 8 days into the cycle and too early for ovulation. June 21 would be 18 days into the cycle. Ovulation should have already occurred at this point. June 29 would be 27 days into the cycle and almost time for the next period.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 190 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

9. A patient states, "My breasts are so small, I don't think I will be able to breastfeed." The nurse's best response is
a. "It may be difficult, but you should try anyway."
b. "You can always supplement with formula."
c. "Breast size is not related to the ability to breastfeed."
d. "The ability to breastfeed depends on secretion of estrogen and progesterone."

ANS: C
All women have approximately the same amount of glandular tissue to secrete milk, despite breast size. Saying that nursing will be difficult or that the woman can use formula does not provide the woman with accurate information. Increased estrogen decreases the production of milk.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 192 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

10. The function of the cremaster muscle in men is to
a. aid in voluntary control of excretion of urine.
b. entrap blood in the penis to produce an erection.
c. assist with transporting sperm.

d. aid in temperature control of the testicles.

ANS: D
A cremaster muscle is attached to each testicle. Its function is to bring the testicle closer to the body to warm it or allow it to fall away from the body to cool it, thus promoting normal sperm production. It is not involved in urination, causing an erection or assist in transporting sperm.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 193 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

11. The average man is taller than the average woman at maturity because of
a. a longer period of skeletal growth.
b. earlier development of secondary sexual characteristics.
c. earlier onset of growth spurt.
d. starting puberty at an earlier age.

ANS: A
The man's greater height at maturity is the combined result of beginning the growth spurt at a later age and continuing it for a longer period. Girls develop earlier than boys. Boys' growth spurts start at a later age. Girls start puberty approximately 6 months to 1 year earlier than boys.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 185 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

12. A student nurse just read that up to 200 million sperm are deposited in the vagina with each ejaculation and asks the faculty why so many are needed. What response by the faculty is most accurate?
a. Competition results in fewer genetic defects.
b. Sperm are weak and die off quickly.
c. Few sperm reach the fallopian tube and ova.
d. Most sperm are not the correct shape.

ANS: C
Although a huge quantity of sperm are released with each ejaculation, very few make it to the fallopian tube where an ovum may be waiting to be fertilized.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 194 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

13. The student nurse learns that follicle stimulating hormone is produced in which gland?
a. Anterior pituitary
b. Posterior pituitary
c. Hypothalamus
d. Adrenal glands

ANS: A
Follicle stimulating hormone is produced in the anterior pituitary gland.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: Table 11.1 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. A young female patient comes to the school nurse to discuss her irregular periods. In providing education regarding the female reproductive cycle, *which* phases of the ovarian cycle does the nurse include? (*Select all that apply.*)
   a. Follicular
   b. Ovulatory
   c. Luteal
   d. Proliferative
   e. Secretory

   ANS: A, B, C
   The follicular phase is the period during which the ovum matures. It begins on day 1 and ends around day 14. The ovulatory phase occurs near the middle of the cycle, approximately 2 days before ovulation. After ovulation and under the influence of the luteinizing hormone, the luteal phase corresponds with the last 12 days of the menstrual cycle. The proliferative and secretory phases are part of the endometrial cycle. The proliferative phase takes place during the first half of the ovarian cycle when the ovum matures. The secretory phase occurs during the second half of the cycle when the uterus is prepared to accept the fertilized ovum. These are followed by the menstrual phase if fertilization does not occur.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 190 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

2. The anterior pituitary gland is responsible for producing which hormones? (*Select all that apply.*)
   a. Follicle-stimulating hormone (FSH)
   b. Luteinizing hormone (LH)
   c. Gonadotropin-releasing hormone (GnRH)
   d. Oxytocin
   e. Prolactin

   ANS: A, B, E
   FSH and LH are both produced by the anterior pituitary gland. Both of these hormones assist in the stimulation and maturation of the ovarian follicle. Prolactin is also produced by the anterior pituitary and is required for milk production (lactogenesis) to occur. GnRH is produced by the hypothalamus and stimulates the release of FSH and LH. Oxytocin is produced by the posterior pituitary gland and is responsible for stimulating uterine contractions during birth.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: Table 11.1 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. Which part of the mature sperm contains the male chromosomes?
   a. The head of the sperm
   b. The middle portion of the sperm
   c. X-bearing sperm
   d. The tail of the sperm

   ANS: A
   The head of the sperm contains the male chromosomes that will join the chromosomes of the ovum. The middle portion of the sperm supplies energy for the tail's whip-like action. If an X-bearing sperm fertilizes the ovum, the baby will be female. The tail of the sperm helps propel the sperm toward the ovum.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 197 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

2. One of the assessments performed in the delivery room is checking the umbilical cord for blood vessels. Which finding is considered within normal limits?
   a. Two arteries and one vein
   b. Two arteries and two veins
   c. Two veins and one artery
   d. One artery and one vein

   ANS: A
   The umbilical cord contains two arteries and one vein to transport blood between the fetus and the placenta. Any option other than two arteries and one vein is considered abnormal and requires further assessment.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 206 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. The purpose of the ovum's zona pellucida is to
   a. make a pathway for more than one sperm to reach the ovum.
   b. allow the 46 chromosomes from each gamete to merge.
   c. prevent multiple sperm from fertilizing the ovum.
   d. stimulate the ovum to begin mitotic cell division.

   ANS: C
   Fertilization causes the zona pellucida to change its chemical composition so that multiple sperm cannot fertilize the ovum. Each gamete (sperm and ovum) has only 23 chromosomes. There will be 46 chromosomes when they merge. Mitotic cell division begins when the nuclei of the sperm and ovum unite.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 195 OBJ: Integrated Process: Teaching-Learning

MSC: Client Needs: Physiologic Integrity

4. While teaching an early pregnancy class, the nurse explains that the morula is a
   a. fertilized ovum before mitosis begins.
   b. flattened disk-shaped layer of cells within a fluid-filled sphere.
   c. double layer of cells that becomes the placenta.
   d. solid ball composed of the first cells formed after fertilization.

   ANS: D
   The morula is so named because it resembles a mulberry. It is a solid ball of 12 to 16 cells that develops after fertilization. The fertilized ovum is called the zygote. This is the embryonic disk. It will develop into the baby. The placenta is formed from two layers of cells: the trophoblast, which is the other portion of the fertilized ovum, and the decidua, which is the portion of the uterus where implantation occurs.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 198 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

5. The nursing faculty explains to students that the upper uterus is the best place for the fertilized ovum to implant because it is here that the
   a. placenta attaches most firmly.
   b. developing baby is best nourished.
   c. uterine endometrium is softer.
   d. maternal blood flow is lower.

   ANS: B
   The uterine fundus is richly supplied with blood and has the thickest endometrium, both of which promote optimal nourishment of the fetus. If the placenta attaches too deeply, it does not easily detach after birth. Softness is not a concern with implantation; attachment and nourishment are the major concerns. The blood supply is rich in the fundus, which allows for optimal nourishment of the fetus.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 199 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

6. The student nurse learns that some of the embryo’s intestines remain within the umbilical cord during the embryonic period because the
   a. umbilical cord is much larger at this time than it will be at the end of pregnancy.
   b. intestines begin their development within the umbilical cord.
   c. nutrient content of the blood is higher in this location.
   d. abdomen is too small to contain all the organs while they are developing.

   ANS: D
   The abdominal contents grow more rapidly than the abdominal cavity, so part of their development takes place in the umbilical cord. By 10 weeks, the abdomen is large enough to contain them. The intestines remain within the umbilical cord only until approximately week 10. Intestines begin their development within the umbilical cord but only because the liver and kidneys occupy most of the abdominal cavity. All the intestines are within the abdominal cavity around week 10.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: Table 12.2 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

7. A woman is 16 weeks pregnant with her first baby. She asks how long it will be before she feels the baby move. The best answer is
   a. "You should have felt the baby move by now."
   b. "Within the next month, you should start to feel fluttering sensations."
   c. "The baby is moving, but you can't feel it yet."
   d. "Some babies are quiet, and you don't feel them move."

   ANS: B
   Maternal perception of fetal movement usually begins 17 to 20 weeks after conception, particularly if this is the first pregnancy. "The baby is moving, but you can't feel it yet" is a true statement. The fetus's movements are not strong enough to be felt until 17 to 20 weeks; however, this statement does not answer the concern of the woman. If no movement is felt at the end of 20 weeks, further assessment is needed.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 204 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

8. During a pregnancy group meeting, the nurse teaches patients that the fetal period is best described as one of
   a. development of basic organ systems.
   b. resistance of organs to damage from external agents.
   c. maturation of organ systems.
   d. development of placental oxygen–carbon dioxide exchange.

   ANS: C
   During the fetal period, the body systems grow in size and mature in function to allow independent existence after birth. Basic organ systems are developed during the embryonic period. The organs are always at risk for damage from external sources; however, the older the fetus, the more resistant the organs will be. The greatest risk is when the organs are developing. The placental system is complete by week 12, but that is not the best description of the fetal period.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 204 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

9. A new mother is distresses over the "white substance" covering her infant because it "looks ugly." What action by the nurse is most appropriate?
   a. Scrub the substance off of the baby.
   b. Reassure the mom that it will go away.
   c. Report the findings to the provider.
   d. Explain that the vernix caseosa protects fetal skin from amniotic fluid.

   ANS: D

Prolonged exposure to amniotic fluid during the fetal period could result in breakdown of the skin without the protection of the vernix caseosa. This can be washed off gently, when the baby gets the first bath. Although it will not remain, this statement does not explain the purpose of the substance. This does not need to be reported.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 204 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

10. A woman who is 16 weeks pregnant asks the nurse, “Is it possible to tell by ultrasound if the baby is a boy or girl yet?” The best answer is
    a. “A baby’s sex is determined as soon as conception occurs, and the differences are apparent.”
    b. “The baby has developed enough that we can determine the sex by examining the genitals through ultrasound.”
    c. “Boys and girls look alike until approximately 20 weeks after conception, and then they begin to look different.”
    d. “It might be possible to determine your baby’s sex, but the external organs look very similar right now.”

    ANS: B
    Although gender is determined at conception, the external genitalia of males and females look similar through the 9th week. By the 12th week, the external genitalia are distinguishable as male or female.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 204 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

11. The placenta allows exchange of oxygen, nutrients, and waste products between the mother and fetus by
    a. contact between maternal blood and fetal capillaries within the chorionic villi.
    b. interaction of maternal and fetal pH levels within the endometrial vessels.
    c. a mixture of maternal and fetal blood within the intervillous spaces.
    d. passive diffusion of maternal carbon dioxide and oxygen into the fetal capillaries.

    ANS: A
    Fetal capillaries within the chorionic villi are bathed with oxygen- and nutrient-rich maternal blood within the intervillous spaces. The endometrial vessels are part of the uterus. There is no interaction with the fetal blood at this point. Maternal and fetal blood do not normally mix. Maternal carbon dioxide does not enter into the fetal circulation.

    PTS: 1 DIF: Cognitive Level: Knowledge/Understanding
    REF: p. 206 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

12. A patient is sent from the physician’s office for assessment of oligohydramnios. The nurse is aware that this condition can result in
    a. excessive fetal urine secretion.
    b. newborn respiratory distress.
    c. central nervous system abnormality.

d. gastrointestinal blockage.

ANS: B
Because an abnormally small amount of amniotic fluid restricts normal lung development, the infant may have inadequate respiratory function after birth, when the placenta no longer performs respiratory function. Oligohydramnios may be caused by a decrease in urine secretion. Excessive amniotic fluid production may occur when the fetus has a central nervous system abnormality. Excessive amniotic fluid production may occur when the gastrointestinal tract prevents normal ingestion of amniotic fluid.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 209 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

13. When explaining twin conception, the nurse points out that dizygotic twins develop from
a. a single fertilized ovum and are always of the same sex.
b. a single fertilized ovum and may be the same sex or different sexes.
c. two fertilized ova and are the same sex.
d. two fertilized ova and may be the same sex or different sexes.

ANS: D
Dizygotic twins are two different zygotes, each conceived from a single ovum and a single sperm. They may be both male, both female, or one male and one female. A single fertilized ovum that produces twins is called monozygotic. Monozygotic twins are always the same sex. Dizygotic twins are from two fertilized ova and may or may not be the same sex.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 213 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

14. Which statement related to oogenesis is correct?
a. Two million primary oocytes will mature.
b. At birth, all ova are contained in the female's ovaries.
c. The oocytes complete their division during fetal life.
d. Monthly, at least two oocytes mature.

ANS: B
All of the cells that may undergo meiosis in a woman's lifetime are contained in the ovaries at birth. Only 400 to 500 ova will mature during the approximately 35 years of a woman's reproductive life. The primary oocytes begin their first meiotic division during fetal life but remain suspended until puberty. Every month, one primary oocyte matures and completes meiotic division yielding two unequal cells.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 195 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

15. After implantation, tiny projections develop out of the trophoblast and extend into the endometrium. These projections are referred to as
a. decidua basalis.
b. decidua capsularis.
c. decidua vera.

d. chorionic villi.

ANS: D
These villi are vascular processes that obtain oxygen and nutrients from the maternal bloodstream and dispose of carbon dioxide and waste products into the maternal blood. The deciduas basalis is the portion of the endometrium where the chorionic villi tap into the maternal blood vessels. The deciduas capsularis is the portion of the endometrium that covers the blastocyst. The portion of the endometrium that lines the rest of the uterus is called decidua vera.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 199 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

16. A nurse is teaching a prenatal class. The nurse teaches that during weeks 25 to 28, which fetal development occurs?
    a. Eyes reopen.
    b. Vernix caseosa covers the skin.
    c. Lanugo may develop.
    d. Brown fat is deposited.

    ANS: A
    During this time frame the eyes reopen, and the fetus becomes plumper with smoother skin. The other changes occur during weeks 17 to 20.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 206 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

17. A young patient comes in for her first prenatal examination. This is her first child. She asks "How does my baby get air inside my uterus?" The correct response is
    a. "The baby's lungs work in the uterus to exchange oxygen and carbon dioxide."
    b. "The baby absorbs oxygen from your blood system."
    c. "The placenta provides oxygen to the baby and excretes carbon dioxide into your bloodstream."
    d. "The placenta delivers oxygen-rich blood through the umbilical artery to the baby's abdomen."

    ANS: C
    The placenta functions by supplying oxygen and excreting carbon dioxide to the maternal bloodstream. The fetal lungs do not function for respiratory gas exchange in utero. The baby does not simply absorb oxygen from a woman's blood system. Blood and gas transport occurs through the placenta. The placenta delivers oxygen-rich blood through the umbilical vein, not artery.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 206 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

18. The most basic information a maternity nurse should have concerning conception is
    a. ova are considered fertile 48 to 72 hours after ovulation.
    b. sperm remain viable in the woman's reproductive system for an average of 12 to

24 hours.

c. conception is achieved when a sperm successfully penetrates the membrane surrounding the ovum.
d. implantation in the endometrium occurs 6 to 10 days after conception.

ANS: D
Implantation occurs 6 to 10 days after conception and is complete after 10 days. Ova are considered fertile for approximately 24 hours after ovulation. Sperm remain viable in the woman's reproductive system for an average of 2 to 3 days. Penetration of the ovum by the sperm is called fertilization. Conception occurs when the zygote, the first cell of the new individual, is formed.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 198 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

19. With regard to the structure and function of the placenta, the maternity nurse should be aware that
a. as the placenta widens, it gradually thins to allow easier passage of air and nutrients.
b. as one of its early functions, the placenta acts as an endocrine gland.
c. the placenta is able to keep out most potentially toxic substances, such as cigarette smoke, to which the mother is exposed.
d. optimal blood circulation is achieved through the placenta when the woman is lying on her back or standing.

ANS: B
The placenta produces four hormones necessary to maintain the pregnancy. The placenta widens until week 20 and continues to grow thicker. Toxic substances such as nicotine and carbon monoxide readily cross the placenta into the fetus. Optimal circulation occurs when the woman is lying on her side.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 206 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

20. Which statement is accurate about the development of fetal organs and systems?
a. The cardiovascular system is the first organ system to function in the developing human.
b. Hematopoiesis originating in the yolk sac begins in the liver at 10 weeks.
c. The body changes from straight to C-shaped at 8 weeks.
d. The gastrointestinal system is mature at 32 weeks.

ANS: A
The heart is developmentally complete by the end of the embryonic stage. Hematopoiesis begins in the liver during the 6th week. The body becomes C-shaped at 21 weeks. The gastrointestinal system is complete at 36 weeks.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 204 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

21. What does the student learn about recent trends in multiple births?
    a. The rate of twin births has declined.
    b. The rate of higher order pregnancies has increased.
    c. Higher order pregnancies are now very rare.
    d. Twinning is the most common form of multiple pregnancy.

    ANS: D
    Twinning is the most common form of multiple pregnancy, and the rate has been increasing, not declining. Higher order births increased for a time but have now decreased, although they are not rare.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 212 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. The nurse assesses pregnant women for exposure to human teratogens, including which of the following? (*Select all that apply.*)
    a. Infections
    b. Radiation
    c. Maternal conditions
    d. Drugs
    e. Chemicals

    ANS: A, B, C, D
    Exposure to radiation and a number of infections may result in profound congenital deformities. These include varicella, rubella, syphilis, parvovirus, CMV, and toxoplasmosis. Certain maternal conditions such as diabetes and PKU may also affect organs and other parts of the embryo during this developmental period. Drugs such as antiseizure medication and some antibiotics, as well as chemicals including lead, mercury, tobacco, and alcohol, also may result in structural and functional abnormalities. Coffee is not considered a teratogen.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: Appendix A OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

2. The nursing faculty teaches that the placenta produces many hormones necessary for normal pregnancy. These include (*Select all that apply.*)
    a. human chorionic gonadotropin (hCG).
    b. insulin.
    c. estrogen.
    d. progesterone.
    e. testosterone.

    ANS: A, C, D
    The placenta produces hCG, estrogen, and progesterone. It does not produce insulin or testosterone.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 209 OBJ: Integrated Process: Teaching-Learning

MSC: Client Needs: Physiologic Integrity

3. The student learns about shunts that support fetal circulation. Which of the following are included in this support system? (*Select all that apply.*)
   a. Ductus venosus
   b. Foramen ovale
   c. Ductus arteriosus
   d. Foramen magnum
   e. Ductus deferens

   ANS: A, B, C
   The ductus venosus, foramen ovale, and ductus arteriosus are part of fetal circulation. The foramen magnum is located at the base of the skull. The ductus (or vas) deferens is part of the male reproductive system.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 210 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

4. The nursing faculty explains that the fetus can survive in a low-oxygen environment due to which of the following? (*Select all that apply.*)
   a. Fetal hemoglobin carries more oxygen than an adult's.
   b. The fetus has higher average hemoglobin and hematocrit.
   c. Hemoglobin carries more oxygen at low partial pressures of carbon dioxide.
   d. Fetal blood is more acidic than the maternal blood.
   e. The fetus does not need gas exchange while in utero.

   ANS: A, B, C
   The fetus can survive in low oxygen environments due to its hemoglobin being able to carry more oxygen that the mom, having a higher level of hemoglobin and hematocrit, and the fact that hemoglobin can carry more oxygen at low partial pressures of carbon dioxide. Fetal blood is alkaline. The fetus does need gas exchange in utero.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 208 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. A pregnant woman's mother is worried that her daughter is not "big enough" at 20 weeks. The nurse palpates and measures the fundal height at 20 cm, which is even with the woman's umbilicus. What should the nurse report to the woman and her mother?
   a. "The body of the uterus is at the belly button level, just where it should be at this time."
   b. "You're right. We'll inform the practitioner immediately."
   c. "When you come for next month's appointment, we'll check you again to make sure that the baby is growing."
   d. "Lightening has occurred, so the fundal height is lower than expected."

   ANS: A
   At 20 weeks, the fundus is usually located at the umbilical level. Because the uterus grows in a predictable pattern, obstetric nurses should know that the uterus of 20 weeks of gestation is located at the level of the umbilicus. There is no need to inform the practitioner. The nurse should reassure both mother and patient that the findings are normal. The descent of the fetal head (lightening) occurs in late pregnancy.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 214 | p. 229 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

2. While the nurse assesses the vital signs of a pregnant woman in her third trimester, the patient complains of feeling faint, dizzy, and agitated. Which nursing intervention is appropriate?
   a. Have the patient stand up and retake her blood pressure.
   b. Have the patient sit down and hold her arm in a dependent position.
   c. Have the patient lie supine for 5 minutes and recheck her blood pressure on both arms.
   d. Have the patient turn to her left side and recheck her blood pressure in 5 minutes.

   ANS: D
   Blood pressure is affected by positions during pregnancy. The supine position may cause occlusion of the vena cava and descending aorta. Turning the pregnant woman to a lateral recumbent position alleviates pressure on the blood vessels and quickly corrects supine hypotension. Pressures are significantly higher when the patient is standing. This option causes an increase in systolic and diastolic pressures. The arm should be supported at the same level of the heart. The supine position may cause occlusion of the vena cava and descending aorta, creating hypotension.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 216 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

3. A pregnant woman has come to the emergency department with complaints of nasal congestion and epistaxis. What action by the nurse is best?
   a. Refer the patient to an ear, nose, and throat specialist.

b. Explain that nasal stuffiness and nosebleeds are caused by a decrease in progesterone.
c. Attach the woman to a cardiac monitor, and draw blood for hemoglobin and hematocrit.
d. Teach that the increased blood supply to the mucous membranes and can result in congestion and nosebleeds.

ANS: D
As capillaries become engorged, the upper respiratory tract is affected by the subsequent edema and hyperemia, which causes these conditions, seen commonly during pregnancy. No referral is needed. The patient does not need to be attached to a cardiac monitor or have lab drawn. The patient should be taught that estrogen causes these changes, not progesterone.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 218 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

4. Which finding in the urine analysis of a pregnant woman is considered a variation of normal?
a. Proteinuria
b. Glycosuria
c. Bacteria
d. Ketonuria

ANS: B
Small amounts of glucose may indicate "physiologic spilling," which occurs because the filtered load exceeds the renal tubules' ability to absorb them. The presence of protein could indicate kidney disease or preeclampsia. Urinary tract infections are associated with bacteria in the urine. An increase in ketones indicates that the patient is exercising too strenuously or has an inadequate fluid and food intake.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 219 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

5. Which suggestion is appropriate for the pregnant woman who is experiencing nausea and vomiting?
a. Eat only three meals a day so the stomach is empty between meals.
b. Drink plenty of fluids with each meal.
c. Eat dry crackers or toast before arising in the morning.
d. Drink coffee or orange juice immediately on arising in the morning.

ANS: C
This will assist with the symptoms of morning sickness. It is also important for the woman to arise slowly. Instruct the woman to eat five to six small meals rather than three full meals per day. Nausea is more intense when the stomach is empty. Fluids should be taken separately from meals. Fluids overstretch the stomach and may precipitate vomiting. Coffee and orange juice stimulate acid formation in the stomach. It is best to suggest eating dry carbohydrates when rising in the morning.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 230 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

6. Which statement related to changes in the breasts during pregnancy is the most accurate?
   a. During the early weeks of pregnancy there is decreased sensitivity.
   b. Nipples and areolae become more pigmented.
   c. Montgomery tubercles are no longer visible around the nipples.
   d. Venous congestion of the breasts is more visible in the multiparous woman.

   ANS: B
   Nipples and areolae become more pigmented, and the nipples become more erectile and may express colostrum. Fullness, heightened sensitivity, tingling, and heaviness of the breasts occur in the early weeks of gestation in response to increased levels of estrogen and progesterone. Montgomery tubercles may be seen around the nipples. These sebaceous glands may have a protective role in that they keep the nipples lubricated for breastfeeding. Venous congestion in the breasts is more obvious in primigravidas.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 216 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

7. A student nurse reads a patient's chart and sees the term "striae gravidarum," The student asks the registered nurse what this means. What response by the nurse is accurate?
   a. Stretch marks on the abdomen and breasts
   b. Dark pigmentation on the woman's face
   c. Bluish-purple discoloration of the vagina and labia
   d. Reddened bleeding gums in a pregnant woman

   ANS: A
   Stretch marks occurring on the abdomen and/or breasts of a pregnant woman are called striae gravidarum. Dark pigmentation on the face is known as melisma, chloasma, or the mask of pregnancy. The bluish tint to the vagina and labia is known as Chadwick's sign. Reddened and bleeding gums are known as gingivitis in both pregnant and non-pregnant women.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 219 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

8. The maternity nurse understands that vascular volume increases 40% to 60% during pregnancy to
   a. compensate for decreased renal plasma flow.
   b. provide adequate perfusion of the placenta.
   c. eliminate metabolic wastes of the mother.
   d. prevent maternal and fetal dehydration.

   ANS: B
   The primary function of increased vascular volume is to transport oxygen and nutrients to the fetus via the placenta. Renal plasma flow increases during pregnancy. Assisting with pulling metabolic wastes from the fetus for maternal excretion is one purpose of the increased vascular volume. However, this answer is not the best because it doesn't explain the overall purpose and only includes one purpose. Prevention of dehydration is not the reason for increased vascular volume.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering

REF: p. 216 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

9. A nurse is taking vital signs on a pregnant woman. Preconception pulse was 76 beats/minute. Today the pulse is 97 beats/minute. What action by the nurse is best?
   a. Inform the provider immediately.
   b. Document findings in the chart.
   c. Prepare to start an IV infusion.
   d. Retake the pulse in 15 minutes.

   ANS: B
   The pulse of a pregnant woman increases about 15 to 20 beats/minute throughout the pregnancy. The nurse should document the findings, but no other actions are needed as this is a normal finding.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 216 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

10. Physiologic anemia often occurs during pregnancy as a result of
    a. inadequate intake of iron.
    b. dilution of hemoglobin concentration.
    c. the fetus establishing iron stores.
    d. decreased production of erythrocytes.

    ANS: B
    When blood volume expansion is more pronounced and occurs earlier than the increase in red blood cells, the woman will have physiologic anemia, which is the result of dilution of hemoglobin concentration rather than inadequate hemoglobin. Inadequate intake of iron may lead to true anemia. If the woman does not take an adequate amount of iron, true anemia may occur when the fetus pulls stored iron from the maternal system. There is an increased production of erythrocytes during pregnancy.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 216 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

11. While assessing her patient, what does the nurse interpret as a positive sign of pregnancy?
    a. Fetal movement felt by the woman
    b. Amenorrhea
    c. Breast changes
    d. Visualization of fetus by ultrasound

    ANS: D
    The only positive signs of pregnancy are auscultation of fetal heart tones, visualization of the fetus by ultrasound, and fetal movement felt by the examiner. Fetal movement felt by the woman, amenorrhea, and breast changes are all presumptive signs.

    PTS: 1 DIF: Cognitive Level: Knowledge/Comprehension
    REF: p. 224 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

12. A woman is currently pregnant; she has a 5-year-old son and a 3-year-old daughter born at full term. She had one other pregnancy that terminated at 8 weeks. Her gravida and para are
    a. gravida 3 para 2.
    b. gravida 4 para 3.
    c. gravida 4 para 2.
    d. gravida 3 para 3.

    ANS: C
    She has had four pregnancies, including the current one (gravida 4). She had two pregnancies that terminated after 20 weeks (para 2). The pregnancy that terminated at 8 weeks is classified as an abortion, which is not included in the gravida-para classification.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 225 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

13. A woman's last menstrual period was June 10. The nurse estimates the date of delivery (EDD) to be
    a. April 7.
    b. March 17.
    c. March 27.
    d. April 17.

    ANS: B
    To determine the EDD, the nurse uses the first day of the last menstrual period (June 10), subtracts 3 months (March 10), and adds 7 days (March 17). The year is corrected if needed. April 7 would be subtracting 2 months instead of 3 months and then subtracting 3 days instead of adding 7 days. March is the correct month, but instead of adding 7 days, 17 days were added to get March 27. April 17 is subtracting 2 months instead of 3 months.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 225 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

14. A nurse sees a woman in her first trimester of pregnancy. The nurse explains that the woman can expect to visit her physician every 4 weeks so that
    a. she develops trust in the health care team.
    b. her questions about labor can be answered.
    c. the condition of the mother and fetus can be monitored.
    d. problems can be eliminated.

    ANS: C
    This routine allows monitoring of maternal health and fetal growth and ensures that problems will be identified early. If the woman begins prenatal care in the first trimester, every 4 weeks is the recommended schedule for visits. Developing a trusting relationship should be established during these visits, but that is not the primary reason. Most women do not have questions concerning labor until the last trimester of the pregnancy. All problems cannot be eliminated because of prenatal visits, but they can be identified.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 228 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

15. A patient in her first trimester complains of nausea and vomiting. She asks, “Why does this happen?” The nurse’s best response is
    a. “It is due to an increase in gastric motility.”
    b. “It may be due to changes in hormones.”
    c. “It is related to an increase in glucose levels.”
    d. “It is caused by a decrease in gastric secretions.”

    ANS: B
    Nausea and vomiting are believed to be caused by increased levels of hormones and decreased gastric motility. Glucose levels decrease in the first trimester. Hypoglycemia, if experienced, can also lead to nausea. Gastric secretions do decrease, but this is not the main cause of nausea and vomiting.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 231 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

16. The nurse teaches a pregnant woman that one of the most effective methods for preventing venous stasis is to
    a. wear elastic stockings in the afternoons.
    b. sleep with the foot of the bed elevated.
    c. rest often with the feet elevated.
    d. sit with the legs crossed.

    ANS: C
    Elevating the feet and legs improves venous return and prevents venous stasis. Elastic stockings should be applied before lowering the legs in the morning. Elevating the legs at night may cause pressure on the diaphragm and increase breathing problems. Sitting with the legs crossed will decrease circulation in the legs and increase venous stasis.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 230 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

17. A patient notices that the doctor writes “positive Chadwick’s sign” on her chart. She asks the nurse what this means. The nurse’s best response is
    a. “It refers to the bluish color of the cervix in pregnancy.”
    b. “It means the cervix is softening.”
    c. “The doctor was able to flex the uterus against the cervix.”
    d. “That refers to a positive sign of pregnancy.”

    ANS: A
    Increased vascularity of the pelvic organs during pregnancy results in the bluish color of the cervix, vagina, and labia, called Chadwick’s sign. The nurse should also know that this is a presumptive, not positive, sign of pregnancy. Softening of the cervix is Goodell’s sign. The softening of the lower segment of the uterus (Hegar’s sign) can allow the uterus to be flexed against the cervix.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 215 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

18. A woman is at her first prenatal visit and is distressed at needing an HIV test. What response by the nurse is best?
    a. “We ask all women to be tested for HIV during their pregnancy.”
    b. “This test is required by law for pregnant women.”
    c. “Infection with HIV will make your pregnancy very high risk.”
    d. “You could have been exposed and not know it.”

    ANS: A
    A voluntary HIV test should be conducted on all women, regardless of risk factors. This explanation is accurate and helps lessen the woman’s feeling of stigma. It also lets the woman know it is voluntary. The test is not required by law. Although an HIV infection will increase the risk of complications, this explanation is too limited to be a good answer. It is true the woman may have been exposed, but that comment is demeaning and could be offensive.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: Table 13.3 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

19. To relieve a leg cramp, the patient should be instructed to
    a. massage the affected muscle.
    b. stretch and point the toe.
    c. dorsiflex the foot.
    d. apply a warm pack.

    ANS: C
    Dorsiflexion of the foot stretches the leg muscle and relieves the painful muscle contraction. Since she is prone to blood clots in the legs, massaging the affected leg muscle is contraindicated. Pointing the toes will contract the muscle and not relieve the pain. Warm packs can be used to relax the muscle, but more immediate relief is necessary, such as dorsiflexion of the foot.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 231 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

20. The multiple marker screen is used to assess the fetus for which condition?
    a. Down syndrome
    b. Diaphragmatic hernia
    c. Congenital cardiac abnormality
    d. Anencephaly

    ANS: A
    The maternal serum level of alpha- fetoprotein is used to screen for trisomy 18 or 21 and neural tube defects. The quadruple marker test does not detect hernias. Additional testing, such as ultrasonography, would be required to diagnose diaphragmatic hernia. Congenital cardiac abnormality would most likely be identified during an ultrasound examination.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: Table 13.3 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

21. A nurse is caring for patients in the prenatal clinical who are all 35 weeks along. Which patient should the nurse see first?
    a. Shortness of breath when climbing stairs
    b. Abdominal pain
    c. Ankle edema in the afternoon
    d. Backache with prolonged standing

    ANS: B
    Abdominal pain may indicate preterm labor or placental abruption so this patient should be seen first. Shortness of breath climbing stairs, afternoon ankle edema, and backache are all normal findings at this stage of pregnancy.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 236 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Safe and Effective Care Environment

22. A patient at 32 weeks of gestation reports that she has severe lower back pain. The nurse's assessment should include
    a. observation of posture and body mechanics.
    b. palpation of the lumbar spine.
    c. exercise pattern and duration.
    d. ability to sleep for at least 6 hours uninterrupted.

    ANS: A
    Correct posture and body mechanics can reduce lower back pain caused by increasing lordosis. Pregnancy should not cause alterations in the spine. Any assessment for malformation should be done early in the pregnancy. Exercise and sleep are not as important to assess as are posture and body mechanics, which can contribute to the pain.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 230 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

23. A pregnant couple has formulated a birth plan and is reviewing it with the nurse at an expectant parent's class. Which aspect of their birth plan would require further discussion with the nurse?
    a. "My husband and I have agreed that my sister will be my coach."
    b. "We plan to use Lamaze to reduce the pain during labor."
    c. "We want the labor and birth to take place in a birthing room with our son present.
    d. "We will not use the fetal monitor during labor."

    ANS: D
    A birth plan consists of what the woman and partner wish to have happen during labor and delivery. Intermittent or continuous fetal monitoring is one aspect of care for consideration; however, it is unrealistic to state that monitoring will not be used. The nurse should explain the purpose to ensure the couple is making an informed decision. The woman can refuse this procedure but would need to understand how this might negatively impact her child. The couple also need to understand that the entire plan is tentative depending on what events actually occur. The other statements are appropriate for a birth plan.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: Box 13.2 OBJ: Nursing Process: Implementation

MSC: Client Needs: Health Promotion and Maintenance

24. A couple ask the prenatal nurse to explain *centering pregnancy*. Which statement accurately applies to this model of care?
    a. A way to control labor pain and remain centered during the process
    b. A philosophy of making the pregnancy the center of the family's life
    c. Education and support sessions are provided to small cohorts of women
    d. Labor practice where the woman is surrounded by an extensive network of people

    ANS: C
    This method involves ten 1.5- to 2-hour sessions with small groups of women and health care providers beginning at 12 to 16 weeks of pregnancy and ending in early postpartum. Sessions include assessment, education, and social support. It is not a way to control labor pain, a philosophy of making the pregnancy the center of the family's life, or the use of a large network of people during labor.

    PTS: 1 DIF: Cognitive Level: Application REF: p. 228
    OBJ: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

25. Which comment by a woman in her first trimester indicates ambivalent feelings?
    a. "I wanted to become pregnant, but I'm scared about being a mother."
    b. "I haven't felt well since this pregnancy began."
    c. "I'm concerned about the amount of weight I've gained."
    d. "My body is changing so quickly."

    ANS: A
    Ambivalence refers to conflicting feelings. This woman is demonstrating this conflict. The other statements do not indicate ambivalence.

    PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
    REF: p. 236 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

26. A patient who is 7 months pregnant states, "I'm worried that something will happen to my baby." The nurse's best response is
    a. "There is nothing to worry about."
    b. "The doctor is taking good care of you and your baby."
    c. "Tell me about your concerns."
    d. "Your baby is doing fine."

    ANS: C
    Encouraging the client to discuss her feelings is the best approach. Women during their third trimester need reassurance that such fears are not unusual in pregnancy. An open-ended request to share information will encourage the patient to explain concerns further. The other statements belittle the patient's concerns and provide false hope.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 238 OBJ: Integrated Process: Communication and Documentation
    MSC: Client Needs: Psychosocial Integrity

27. Which of the following behaviors by a pregnant woman would be an example of mimicry? a. Babysitting for a neighbor's children

b. Wearing maternity clothes before they are needed
c. Daydreaming about the newborn
d. Imagining oneself as a good mother

ANS: B
Mimicry refers to observing and copying the behaviors of others, in this case, other pregnant women. Wearing maternity clothes before they are needed helps the expectant mother "feel" what it's like to be obviously pregnant. Babysitting other children is a form of role playing where the woman practices the expected role of motherhood. Daydreaming is a type of fantasy where the woman "tries on" a variety of behaviors in preparation for motherhood. Imagining herself as a good mother is the woman's effort to look for a good role fit. She observes behavior of other mothers and compares them with her own expectations.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 239 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

28. A step in maternal role attainment that relates to the woman giving up certain aspects of her previous life is termed
a. looking for a fit.
b. role playing.
c. fantasy.
d. grief work.

ANS: D
The woman experiences sadness as she realizes that she must give up certain aspects of her previous self and that she can never go back. Looking for a fit is when the woman observes the behaviors of mothers and compares them with her own expectations. Role playing involves searching for opportunities to provide care for infants in the presence of another person. Fantasies allow the woman to try on a variety of behaviors. This usually deals with how the child will look and the characteristics of the child.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 240 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

29. The maternal task that begins in the first trimester and continues throughout the neonatal period is called
a. seeking safe passage for herself and her baby.
b. securing acceptance of the baby by others.
c. learning to give of herself.
d. developing attachment with the baby.

ANS: D
Developing attachment (strong ties of affection) to the unborn baby begins in early pregnancy when the woman accepts that she is pregnant. By the second trimester, the baby becomes real, and feelings of love and attachment surge. Seeing safe passage is a task that ends with delivery. During this task the woman seeks health care and cultural practices. Securing acceptance continues throughout pregnancy as the woman reworks relationships. Learning to give of herself occurs during pregnancy and is sometimes noticed as the woman gives to others in the form of food or presents.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 240 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

30. Which situation best describes a man “trying on” fathering behaviors?
    a. Spending more time with his siblings
    b. Taking a nephew to the park to play
    c. Reading books on newborn care
    d. Exhibiting physical symptoms related to pregnancy

    ANS: B
    Interacting with children and assuming the behavior and role of a father best describe a man “trying on” being a father. The man normally will seek closer ties with his father during this time, not his siblings. While some fathers do everything they can to learn about infant care, others are not ready to learn when the information is presented, so the nurse should provide the information again after the baby is born and it is more relevant. Exhibiting symptoms related to pregnancy is called *couvade.*

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 241 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

31. A 36-year-old divorcee with a successful modeling career finds out that her 18-year-old married daughter is expecting her first child. What is a major factor in determining how the woman will respond to becoming a grandmother?
    a. Her career
    b. Being divorced
    c. Her age
    d. Age of the daughter

    ANS: C
    Age is a major factor in determining the emotional response of prospective grandparents. Young grandparents may not be happy with the stereotype of grandparents as being old. Career responsibilities may have demands that make the grandparents not as accessible, but it is not a major factor in determining the woman’s response to becoming a grandmother. Being divorced is not a major factor that determines adaptation of grandparents. The age of the daughter is not a major factor that determines adaptation of grandparents. The age of the grandparent is a major factor.

    PTS: 1 DIF: Cognitive Level: Comprehension REF: p. 242
    OBJ: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

32. The nurse who practices in a prenatal clinic understands that a major concern of lower socioeconomic groups is to
    a. maintain group health insurance on their families.
    b. meet health needs as they occur.
    c. practice preventive health care.
    d. maintain an optimistic view of life.

    ANS: B

Because of economic uncertainty, lower socioeconomic groups place more emphasis on meeting the needs of the present rather than on future goals. Lower socioeconomic groups usually do not have group health insurance. They may value health care but cannot afford preventive health care. They may struggle for basic needs and often do not see a way to improve their situation. It is difficult to maintain optimism.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: Table 13.6 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

33. What comment by a new mother exhibits understanding of her toddler's response to a new sibling?
    a. "I can't believe he is sucking his thumb again."
    b. "He is being difficult, and I don't have time to deal with him."
    c. "My husband will stay with the baby so I can take our son to the park."
    d. "When we brought the baby home, we made our son stop sleeping in the crib."

    ANS: C
    It is important for a mother to seek time alone with her toddler to reassure him that he is loved. Toddlers can feel jealous and resentful having to share the mother's attention. It is normal for a child to regress when a new sibling is introduced into the home. As difficult as it is, the mother must make time to spend with the toddler. Changes in sleeping arrangements should be made several weeks before the birth so that the child does not feel displaced by the new baby.

    PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
    REF: p. 242 OBJ: Nursing Process: Evaluation
    MSC: Client Needs: Health Promotion and Maintenance

34. A nurse in labor and delivery is caring for a Muslim woman during the active phase of labor. You note that when you touch her, she quickly draws away. Which response by the nurse is best?
    a. Continue to touch her as much as you need to while providing care.
    b. Assume that she doesn't like you and decrease your time with her.
    c. Limit touching to a minimum, as this may not be acceptable in her culture.
    d. Ask the charge nurse to reassign you to another patient.

    ANS: C
    Touching is an important component of communication in various cultures, but if the patient appears to find it offensive, the nurse should respect her cultural beliefs and limit touching her. By continuing to touch her, the nurse is showing disrespect for her cultural beliefs. A cultural response to touch does not reflect like or dislike. Being assigned to another patient is inappropriate; all nurses must be able to provide culturally appropriate care.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 246 OBJ: Integrated Process: Culture and Spirituality
    MSC: Client Needs: Psychosocial Integrity

35. A nurse is encouraging a patient to attend an early pregnancy class for the second trimester. What topic would be inconsistent with the nurse's knowledge of topics presented in this class? a. Fetal development

b. Body mechanics
c. Childbirth choices
d. Managing morning sickness

ANS: D
Managing morning sickness would be taught in a first trimester early pregnancy class. The other topics are appropriate for second trimester classes.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 231 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

36. A pregnant patient of 28 weeks' gestation complains of pain in the right inguinal area. What action by the nurse is best?
a. Assess the woman for early labor.
b. Position the woman on the right side.
c. Palpate the woman's abdomen.
d. Document the findings in the chart.

ANS: B
Pain in the right inguinal area is most likely due to the round ligament. The nurse can position the woman on her right side to see if that relieves the pain. Heat can also help. There is no need to assess for labor or palpate the abdomen. The findings should be documented after the nurse responds.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 230 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

37. A student nurse is teaching a pregnant woman ways to manage constipation. Which instruction by the student causes the nurse to provide a correction?
a. Drink at least 8 glasses of liquids a day.
b. The fat in cheese helps lubricate the bowels.
c. You do need to continue your iron pills.
d. Add extra fiber, which can be found in fruit.

ANS: B
Cheese tends to cause constipation, so this statement by the student needs correction by the nurse. The other statements are all correct.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 231 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

38. The nurse is caring for a patient whose English is limited. When the nurse provides information, the patient smiles and nods her head. What action by the patient indicates that the goal for a primary nursing diagnosis for this patient has been met?
a. Keeps next appointment and brings a translator with her.
b. Gains an appropriate amount of weight at next visit.
c. Husband accompanies patient to appointments.
d. Continues to eat culturally appropriate foods.

ANS: A
The primary goal for this situation is Impaired Verbal Communication due to lack of English proficiency. If the patient is able to understand and keep her next appointment and brings a translator with her to help facilitate communication that shows that the goal of adequate communication has been met. The other actions do not address communication.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 246 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Psychosocial Integrity

39. The nurse in the OB triage area has four patients to see. Which patient should the nurse see first?
    a. First trimester, vomiting for an hour
    b. Second trimester, fingers swollen
    c. Third trimester, painful urination
    d. Third trimester, painful vaginal bleeding

ANS: D
This patient may have a placenta previa or abruptio placentae or might be having a spontaneous abortion. The nurse needs to see this patient first. The other patients may have normal vomiting of the first trimester. Swollen fingers indicate edema that needs to be investigated. Painful urination probably indicates a urinary tract infection. The priority patient is the one with bleeding.

PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
REF: Safety Alert Box OBJ: Nursing Process: Assessment
MSC: Client Needs: Safe and Effective Care Environment

MULTIPLE RESPONSE

1. The nurse is caring for a woman who had infibulation performed on her as a child. Which of the following actions by the perinatal nursing staff are appropriate for this patient? (*Select all that apply.*)
    a. Obtaining frequent urinalysis collections
    b. Providing larger equipment for exams
    c. Astute assessments for pain during procedures
    d. Monitoring for infections
    e. Draping the woman maximally

ANS: A, C, D, E
Female genital mutilation, cutting, or circumcision, also called infibulation, involves removal of some or all of the external female genitalia. The labia majora are often stitched together over the vaginal and urethral opening as part of this practice. The woman is at risk for many issues including urinary tract and other genital infections and pain. Often the woman will not give any verbal or nonverbal signs of pain so the nurse must be astute in assessing for it. Draping the woman should be done as completely as possible. The equipment for exams must be smaller, such as a pediatric speculum.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 246 OBJ: Integrated Process: Culture and Spirituality
MSC: Client Needs: Psychosocial Integrity

2. A pregnant woman reports that she works in a long-term care setting and is concerned about the impending flu season. She asks about receiving the flu vaccine. Which vaccines could this patient receive? (*Select all that apply.*)
   a. Tetanus
   b. Hepatitis A and B
   c. Measles, mumps, rubella (MMR)
   d. Influenza
   e. Varicella

   ANS: A, B, D
   Inactivated vaccines such as those for tetanus, hepatitis A, hepatitis B, and influenza are safe to administer for women who have a risk for contracting or developing the disease. Immunizations with live virus vaccines such as MMR, varicella (chickenpox), or smallpox are contraindicated during pregnancy because of the possible teratogenic effects on the fetus.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 235 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

3. During pregnancy there are a number of changes that occur as a direct result of the presence of the fetus. Which of these adaptations meet these criteria? (*Select all that apply.*)
   a. Leukorrhea
   b. Development of a mucous plug
   c. Quickening
   d. Ballottement
   e. Lightening

   ANS: A, C, E
   Leukorrhea is a white or slightly gray vaginal discharge that develops in response to cervical stimulation by estrogen and progesterone. Quickening is the first recognition of fetal movements, or “feeling life.” Quickening is often described as a flutter and is felt earlier in multiparous women than in primiparas. Lightening occurs when the fetus begins to descent into the pelvis. This occurs 2 weeks before labor in the nullipara and at the start of labor in the multipara. Mucus fills the cervical canal, creating a plug that acts as a barrier against bacterial invasion during pregnancy. Passive movement of the unengaged fetus is referred to as ballottement.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 222 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

4. A pregnant woman asks the nursing student what to do about her frequent heartburn. What suggestions can the student make that are appropriate? (*Select all that apply.*)
   a. Try chewing gum during the day.
   b. Take Alka-Seltzer or other antacid.
   c. Drink a small sip of cream before meals.
   d. Eat small amounts of dry crackers.
   e. Wear loose-fitting clothing.

   ANS: A, C, E

Chewing gum, a small sip of cream before meals, and wearing loose clothing all can help relieve heartburn. The patient can take antacids recommended by the provider, but Alka-Seltzer has too much sodium. Dry crackers help with morning sickness.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 230 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. Which pregnant woman should have the least weight gain during pregnancy?
   a. Woman pregnant with twins
   b. Woman in early adolescence
   c. Woman shorter than 62 inches or 157 cm
   d. Woman who was obese before pregnancy

   ANS: D
   The recommended weight gain for overweight or obese women is 11 to 20 pounds. This will provide sufficient nutrients for the fetus. Overweight and obese women should be advised to lose weight prior to conception in order to achieve the best pregnancy outcomes. A higher weight gain in twin gestations may help prevent low birth weights. Adolescents need to gain weight toward the higher acceptable range, which will provide for their own growth as well as for fetal growth. In the past women of short stature were advised to restrict their weight gain; however, evidence to support these guidelines has not been found.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 255 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

2. The major source of nutrients in the diet of a pregnant woman should be composed of
   a. simple sugars.
   b. fats.
   c. fiber.
   d. complex carbohydrates.

   ANS: D
   Complex carbohydrates supply the pregnant woman with vitamins, minerals, and fiber. The most common simple carbohydrate is table sugar, which is a source of energy but does not provide any nutrients. Fats provide 9 kcal in each gram, in contrast to carbohydrates and proteins, which provide only 4 kcal in each gram. However, fat is not a good source of nutrients. Fiber is supplied mainly by the complex carbohydrates.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 257 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. To increase the absorption of iron in a pregnant woman, the nurse teaches her that iron preparations should be given with
   a. milk.
   b. tea.
   c. orange juice.
   d. coffee.

   ANS: C

A vitamin C source may increase the absorption of iron. The calcium and phosphorus in milk decrease iron absorption. Tannin in the tea reduces the absorption of iron. Coffee reduces iron absorption.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: Patient-Centered Teaching Box| p. 262
OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

4. Four women are admitted to Labor and Delivery. Which woman met the goal for a healthy weight gain in pregnancy?
   a. 17 years old, 5′2″ tall, initial weight 116 pounds, today's weight 120 pounds
   b. 22 years old, 5′2″ tall, initial weight 230 pounds, today's weight 245 pounds
   c. 24 years old, 5′3″ tall, initial weight 135, today's weight 182 pounds
   d. 27 years old, 5′6″ tall, initial weight 112 pounds, today's weight 135 pounds

   ANS: B
   This woman was obese at the start of her pregnancy, so a weight gain of 11 to 20 pounds has met the goal (245 − 230 = 15). Adolescents need to gain enough weight to support both their needs and those of the fetus, so they should gain the recommended amount for normal weight women, so this teen should weigh between 127 and 136, so she clearly did not gain enough weight. The woman who weighed a healthy 135 pounds should not weigh more than 170 pounds, so this woman gained more weight than recommended. The woman who was 5′6″ tall was underweight at conception, so she needed to gain 28 to 40 pounds, which would put her minimum acceptable weight at delivery at 140.

   PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
   REF: Table 14.1 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

5. A pregnant woman's diet may not meet her need for folate. The nurse teaches the woman to take how much folate as a supplement each day?
   a. 100 to 200 mcg
   b. 200 to 400 mcg
   c. 400 to 600 mcg
   d. 400 to 800 mcg

   ANS: D
   The current recommendation for folate (folic acid) is 400 to 800 mcg (0.4 to 0.8 mg) per day.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 260 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

6. The nurse teaches a pregnant woman that one danger in using nonfood supplementation of nutrients is
   a. increased absorption of all vitamins.
   b. development of pregnancy-induced hypertension (PIH).
   c. increased caloric intake.
   d. toxic effects on the fetus.

   ANS: D

The use of supplements in addition to food may increase the intake of some nutrients to doses much higher than the recommended amounts. Overdoses of some nutrients have been shown to cause fetal defects. Supplements do not have better absorption than natural vitamins and minerals. There is no relationship between supplements and PIH. Supplements do not contain significant calories.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 261 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

7. A student nurse in the perinatal clinic sees the term “pica” on a woman’s chart and asks the registered nurse what this means. What definition is most accurate?
   a. Intolerance of milk products
   b. Iron deficiency anemia
   c. Ingestion of nonfood substances
   d. Episodes of anorexia and vomiting

   ANS: C
   The practice of eating substances not normally thought of as food is called pica. Clay or dirt and solid laundry starch are the substances most commonly ingested. It is not intolerance of milk products, iron deficiency anemia, or episodes of anorexia and vomiting.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 267 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

8. The nurse is assisting a normally active pregnant woman in developing a meal plan. Before she got pregnant, she ate 1800 calories a day. How many calories does she need now?
   a. 2000
   b. 2140
   c. 2342
   d. 2400

   ANS: B
   A woman should increase her daily caloric intake by 340 calories during the second trimester, so this woman needs 2140 daily calories.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: Table 14.2 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

9. A pregnant woman in the perinatal clinic is a recovering anorexic. She is distressed at the emphasis on weight gain. The nurse explains that the most important reason for evaluating the pattern of weight gain in pregnancy is to
   a. prevent excessive adipose tissue deposits.
   b. identify potential nutritional problems or complications of pregnancy.
   c. assess if this woman has relapsed.
   d. determine cultural influences on the woman’s diet.

   ANS: B

Deviations from the recommended pattern of weight gain may indicate nutritional problems or developing complications. The nurse should assure this patient that monitoring weight gain is a routine part of prenatal care to ensure the baby's well-being. Preventing adipose tissue deposits is not the reason for monitoring weight gain. Determining cultural influences on diet and weight gain is important but not the most important reason.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 255 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

10. The nurse is counseling a woman in her third trimester about eating enough protein. If the woman already gets her non-pregnant RDA of protein, how much more does she need in her diet?
    a. 5 grams/day
    b. 10 grams/day
    c. 25 grams/day
    d. 30 grams/day

    ANS: C
    The current RDA for protein in the non-pregnant woman is 46 grams. To reach the recommendation for protein in the second half of pregnancy (71 grams), the patient needs to add 25 more grams of protein to her diet daily.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: Table 14.2 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

11. A pregnant patient would like to know a good food source of calcium other than dairy products. Which answer by the nurse is best?
    a. Legumes
    b. Yellow vegetables
    c. Lean meat
    d. Whole grains

    ANS: A
    Although dairy products contain the greatest amount of calcium, it also is found in legumes, nuts, dried fruits, and some dark green leafy vegetables. Yellow vegetables are rich in vitamin A. Lean meats are rich in protein and phosphorus. Whole grains are rich in zinc and magnesium.

    PTS: 1 DIF: Cognitive Level: Knowledge REF: p. 258 | Table 14.3
    OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

12. Which pregnant adolescent is most at risk for a nutritional deficit during pregnancy?
    a. A 15-year-old of normal height and weight
    b. A 17-year-old who is 10 pounds underweight
    c. A 16-year-old who is 10 pounds overweight
    d. A 16-year-old of normal height and weight

    ANS: B

All adolescents are at nutritional risk during pregnancy, but the adolescent who is pregnant and underweight is most at risk, because she is already deficient in nutrition and must now supply the nutritional intake for both herself and her fetus.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 265 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

13. A patient has the nursing diagnosis: Imbalanced Nutrition: Less Than Body Requirements related to diet choices inadequate to meet nutrient requirements of pregnancy. What goal is most appropriate for this diagnosis?
    a. Weight change from 135 pounds to 165 pounds at delivery
    b. Take daily supplements consistently.
    c. Decrease intake of snack foods.
    d. Increase intake of complex carbohydrates.

    ANS: A
    A weight gain of 30 lb is one indication that the patient has gained a sufficient amount for the nutritional needs of pregnancy. A daily supplement is not the best goal for this patient. It does not meet the basic need of proper nutrition during pregnancy. Decreasing snack foods may be the problem and should be assessed. However, assessing the weight gain is the best method of monitoring nutritional intake for this pregnancy. Increasing the intake of complex carbohydrates is important for this patient, but monitoring the weight gain should be the end goal.

    PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
    REF: p. 256 | Table 14.1 OBJ: Nursing Process: Evaluation
    MSC: Client Needs: Health Promotion and Maintenance

14. A patient who is in week 28 of gestation is concerned about her weight gain of 1 pound in 1 week. Which response by the nurse is best?
    a. “You should try to decrease your amount of weight gain for the next 12 weeks.”
    b. “You have gained an appropriate amount for the number of weeks of your pregnancy.”
    c. “You should not gain any more weight until you reach the third trimester.”
    d. “You have not gained enough weight for the number of weeks of your pregnancy.”

    ANS: B
    At 28 weeks, a weight gain of 1 pound in 1 week is within the recommended range of 0.8 to 1 pound per week. The woman should be reassured that this is normal and healthy. The other responses are inaccurate.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 256 | Table 14.1 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

15. In teaching the pregnant adolescent about nutrition, what suggestion by the nurse is best?
    a. Eliminate common teen snack foods, because they are too high in fat and sodium.
    b. Work with the teen to include some fast food in a healthy prenatal diet.
    c. Suggest that she not eat at fast-food restaurants where the foods are of poor nutritional value.

d. Realize that most adolescents are unwilling to make dietary changes during pregnancy.

ANS: B
Adolescents have some special nutritional needs during pregnancy, but they also need to feel that they fit in with their peers. Working with the teen to develop a healthy diet while including some snack and fast foods has the best chance of providing good nutrition. Telling the teen to eliminate certain foods or restaurants is likely not to work. Including the teen will make her more willing to make dietary changes.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 265 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

16. The traditional diet of Asian women includes little meat or dairy products and may be low in calcium and iron. The nurse can help the woman increase her intake of these foods by
a. emphasizing the need for increased milk intake during pregnancy.
b. suggesting she eat more "hot" foods during pregnancy.
c. telling her husband that she must increase her intake of fruits and vegetables for the baby's sake.
d. suggesting she eat more tofu, bok choy, and broccoli.

ANS: D

To increase the intake of calcium and iron in a culturally-appropriate way, the nurse can suggest the woman eat more broccoli and tofu for calcium and to eat more tofu and leafy green vegetables such as bok choy for iron.

PTS: 1 DIF: Cognitive Level: Knowledge REF: p. 289
OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

17. A pregnant woman's diet consists almost entirely of whole grain breads and cereals, fruits, and vegetables. The nurse should be most concerned about this woman's intake of which nutrient?
a. Calcium
b. Protein
c. Vitamin B12
d. Folic acid

ANS: C
This diet is consistent with that followed by a strict vegetarian (vegan). Vegans consume only plant products. Because vitamin B12 is found in foods of animal origin, this diet is deficient in vitamin B12. Depending upon the woman's food choices this diet may be adequate in calcium, protein, and folic acid.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 266 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

18. Which statement made by a lactating woman leads the nurse to believe that the woman might have lactose intolerance?
a. "I always have heartburn after I drink milk."

b. “If I drink more than a cup of milk, I get abdominal cramps and bloating.”
c. “Drinking milk usually makes me break out in hives.”
d. “Sometimes I notice that I have bad breath after I drink a cup of milk.”

ANS: B
One problem that can interfere with milk consumption is lactose intolerance, which is the inability to digest milk sugar because of a lack of the enzyme lactose in the small intestine. Milk consumption may cause abdominal cramping, bloating, and diarrhea in such people, although many lactose-intolerant individuals can tolerate small amounts of milk without symptoms. The woman with lactose intolerance is more likely to experience bloating and cramping, not heartburn. A woman who breaks out in hives after consuming milk is more likely to have a milk allergy. Bad breath is not a sign of lactose intolerance.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 266 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

19. To prevent GI upset, patients should be instructed to take iron supplements
a. on a full stomach.
b. at bedtime.
c. after eating a meal.
d. with milk.

ANS: B
Taking iron supplements at bedtime may reduce GI upset. Iron supplements are best absorbed if they are taken when the stomach is empty. Bran, tea, coffee, milk, and eggs may reduce absorption.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 261 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

20. Which statement by a patient indicates that she understands the role of protein in her pregnancy?
a. “Protein will help my baby grow.”
b. “Eating protein will prevent me from becoming anemic.”
c. “Eating protein will make my baby have strong teeth after he is born.”
d. “Eating protein will prevent me from being diabetic.”

ANS: A
Protein is the nutritional element basic to growth. An adequate protein intake is essential to meeting the increasing demands of pregnancy. These demands arise from the rapid growth of the fetus; the enlargement of the uterus, mammary glands, and placenta; the increase in the maternal blood volume; and the formation of amniotic fluid. Iron intake prevents anemia. Calcium intake is needed for fetal bone and tooth development. Eating protein will not prevent diabetes.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 257 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Health Promotion and Maintenance

21. Which nutritional recommendation about fluids is accurate?

a. A woman's daily intake should be 8 to 10 cups, and most of it should be water.
b. Coffee should be limited to no more than 2 cups, but tea and cocoa can be consumed without worry.
c. Of the artificial sweeteners, only aspartame has not been associated with any maternity health concerns.
d. Water with fluoride is especially encouraged because it reduces the child's risk of tooth decay.

ANS: A
Eight to 10 cups is the standard for fluids; however, they should be the right fluids. All beverages containing caffeine, including tea, cocoa, and some soft drinks, should be avoided or should be drunk only in limited amounts. Artificial sweeteners, including aspartame, have no ill effects on the normal mother or fetus. However, mothers with phenylketonuria (PKU) should avoid aspartame. No evidence indicates that prenatal fluoride consumption reduces childhood tooth decay. However, it still helps the mother.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 262 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

22. The nurse explains to the expectant mother that which vitamin or mineral can lead to congenital malformations of the fetus if taken in excess by the mother?
a. Zinc
b. Vitamin D
c. Folic acid
d. Vitamin A

ANS: D
Zinc, vitamin D, and folic acid are vital to good maternity and fetal health and are highly unlikely to be consumed in excess. Vitamin A, taken in excess, causes a number of problems. An analog of vitamin A appears in prescribed acne medications, which must not be taken during pregnancy.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 266 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

23. A nurse teaching a prenatal class is discussing nutrition. What foods does the nurse advise pregnant women to avoid?
a. Canned white tuna as a preferred choice
b. Shark, swordfish, and mackerel
c. Treating fish caught in local waterways as the safest
d. High levels of mercury in salmon and shrimp

ANS: B
As a precaution against ingesting too much mercury, the pregnant patient should avoid eating all of these as well as the less common tilefish. Six ounces a week of canned albacore tuna is acceptable. Pregnant women should check with local authorities on the safety of eating locally caught fish, but if no advisories are in effect, eating them is fine. Salmon and shrimp are fine too up to 12 ounces a week.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding

REF: p. 263 | Safety Alert Box OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

24. A pregnant woman is at a picnic and asks a friend of hers, who is a nurse, what foods she can eat. What response by the nurse is best?
    a. Bologna sandwich
    b. Hot dog
    c. Smoked salmon spread
    d. Cheddar cheese and crackers

    ANS: D
    Hard cheeses like cheddar are safe for the pregnant woman to eat. She should not eat lunch meat or hotdogs unless they are heated until steaming. She should also not eat refrigerated smoked seafood.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 263 | Safety Alert Box OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

25. The woman in her third trimester asks the nurse how fast she will lose weight after giving birth. What information from the nurse is most accurate?
    a. You will lose about 20 pounds immediately.
    b. By the end of 2 weeks after birth you will have lost about 21 pounds.
    c. You can go on a diet after your first postnatal checkup.
    d. Most women do not lose all the weight they gain during pregnancy.

    ANS: B
    The woman can expect to lose 12 pounds immediately after birth and another 9 pounds by the end of the 2nd week, putting her total weight loss at that time around 21 pounds. The woman should wait 3 weeks before going on a diet. Most women lose all but a pound or two after childbirth, but this statement is discouraging to the patient.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 269 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. The nurse working with pregnant women understands that anorexia and bulimia are associated with which conditions in the newborn? (*Select all that apply.*)
    a. Food cravings
    b. Low birth weight
    c. Food aversions
    d. Electrolyte imbalance
    e. Small for gestational age infants

    ANS: B, D, E

These conditions are associated with electrolyte imbalance, low birth weight, and small for gestational age infants. All women should be asked about eating disorders, and nurses should watch for behaviors that may indicate disordered eating. Some women eat normally during pregnancy for the sake of the fetus, but others continue their previous dysfunctional eating patterns during pregnancy or in the early postpartum period. Food cravings and aversions are normal for most women during pregnancy. Women may have a strong preference or strong dislike for certain foods. They're generally not harmful, and some, like aversion to alcohol, may be beneficial.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 267 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

2. When assessing cultural influences on a pregnant woman's diet, which actions by the nurse are best? (*Select all that apply.*)
   a. Learn about traditional foods in that culture.
   b. Ask the woman how she prepares food.
   c. Determine if there are specific "pregnancy" foods.
   d. Assess how traditional the woman is.
   e. Find out what support she has locally.

   ANS: A, B, C
   The nurse should ask about traditional foods in her culture and how she (or others) prepare the food. In some cultures, specific foods are eaten during pregnancy, and the nurse should determine this as well. Assessing how traditional the woman is may or may not be helpful; some women who are not traditional at all return to their cultural practices during pregnancy for a number of reasons. Support systems are not related to food.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 263 OBJ: Integrated Process: Culture and Spirituality
   MSC: Client Needs: Health Promotion and Maintenance

3. A lactating woman tells the nurse she is glad to no longer have to follow specific dietary recommendations, now that her baby has been born. The nurse responds by teaching her that lactating women have an even greater need for which nutrients? (*Select all that apply.*)
   a. Vitamin A
   b. Vitamin D
   c. Folic acid
   d. Iron
   e. Iodine

   ANS: A, E
   The lactating woman needs more vitamin A and iodine than the pregnant woman. The requirements for vitamin D are the same in both groups. The lactating woman needs less folic acid and iron than a pregnant woman.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: Table 14.3 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

4. The nurse is teaching a pregnant woman to reduce her intake of sodium. What products does the nurse teach the woman to avoid? (*Select all that apply.*)
   a. Products with the word “soda” in the ingredients
   b. Packaged gravy mixes
   c. Mayonnaise
   d. Cake mixes
   e. Fruit juices

   ANS: A, B, D
   Products with the word “soda” in the ingredient list are high in sodium, as are packaged gravy mixes and cake mixes. Mayonnaise and fruit juice are lower in sodium and acceptable.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: Box 14.2 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

5. The nurse has taught a vegetarian pregnant woman foods that are high in iron. Which menu selections demonstrate good understanding of the material? (*Select all that apply.*)
   a. Cooked soybeans
   b. Canned stewed tomatoes
   c. Raisin bran cereal
   d. White bread
   e. Peaches

   ANS: A, B, C
   Cooked soybeans, canned stewed tomatoes, and Raisin Bran cereal are all high in iron. White bread and peaches are not.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: Table 14.4 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. A pregnant woman's biophysical profile score is 8. She asks the nurse to explain the results. The nurse's best response is
   a. "The test results are within normal limits."
   b. "Immediate delivery by cesarean birth is needed."
   c. "Further tests are needed to determine the meaning of this score."
   d. "We will inform you of your options within the next week."

   ANS: A
   The normal biophysical score ranges from 8 to 10 points if the amniotic fluid volume is adequate. A normal score allows conservative treatment of high-risk patients. Delivery can be delayed if fetal well-being is indicated. An immediate delivery is not needed. The results of the biophysical profile are usually available immediately after the procedure is performed.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 283 | Table 15.1 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

2. Which analysis of maternal serum may predict chromosomal abnormalities in the fetus?
   a. Multiple-marker screening
   b. Lecithin/sphingomyelin (L/S) ratio
   c. Biophysical profile
   d. Type and crossmatch of maternal and fetal serum

   ANS: A
   Maternal serum can be analyzed for abnormal levels of alpha-fetoprotein, human chorionic gonadotropin, and estriol. This multiple-marker screening may predict chromosomal defects in the fetus. The L/S ratio is used to determine fetal lung maturity. A biophysical profile is used for evaluating fetal status during the antepartum period. Five variables are used, but none is concerned with chromosomal problems. The blood type and crossmatch will not predict chromosomal defects in the fetus.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 278 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. The nurse providing care for the pregnant woman understands that a factor indicating the need for fetal diagnostic procedures is
   a. maternal diabetes.
   b. maternal age older than 30 years.
   c. previous infant more than 3000 g at birth.
   d. weight gain of 25 pounds.

   ANS: A

Diabetes is a risk factor in pregnancy because of possible impairment of placental perfusion. Other indications for testing include a maternal age greater than 35 years, having had another infant weighing greater than 4000 g at birth, or excessive weight gain. A weight gain of 25 to 35 pounds is recommended for the woman who begins pregnancy at a normal weight.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: Box 15.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

4. When is the best time to determine gestational age based on biparietal diameter through ultrasound?
   a. First trimester only
   b. Second trimester only
   c. Any time
   d. Second half of pregnancy

ANS: D
The biparietal diameter is used to determine gestational age during the second half of pregnancy.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 276 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

5. The primary reason for evaluating alpha-fetoprotein (AFP) levels in maternal serum is to determine if the fetus has
   a. hemophilia.
   b. a neural tube defect.
   c. sickle cell anemia.
   d. a normal lecithin/sphingomyelin (L/S) ratio.

ANS: B
An open neural tube allows a high level of AFP to seep into the amniotic fluid and enter the maternal serum. Hemophilia is a genetic defect and is best detected with chromosomal studies such as chorionic villus sampling or amniocentesis. Sickle cell is a genetic defect and is best detected with chromosomal studies such as chorionic villus sampling or amniocentesis. L/S ratios are determined with an amniocentesis, which is usually done in the third trimester.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 277 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

6. While working with the pregnant woman in her first trimester, the nurse is aware that chorionic villus sampling (CVS) can be performed during pregnancy as early as _____ weeks.
   a. 4
   b. 8
   c. 10
   d. 12

ANS: C
CVS is usually performed between 10 and 13 weeks of gestation to diagnose fetal chromosomal, metabolic, or DNA abnormalities.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 278 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

7. The nurse's role in diagnostic testing is to provide
   a. advice to the couple.
   b. assistance with decision making.
   c. information about the tests.
   d. reassurance about fetal safety.

   ANS: C
   The nurse should provide the couple with all necessary information about a procedure so that the couple can make an informed decision. The nurse's role is to inform, not to advise the couple. Decision making should always lie with the couple involved. Ensuring fetal safety is not possible with all of the diagnostic testing. To offer this is to give false reassurance to the parents.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 286 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

8. The nurse teaches a pregnant woman that which diagnostic test evaluates the effect of fetal movement on fetal heart activity?
   a. Contraction stress test (CST)
   b. Sonography
   c. Biophysical profile
   d. Nonstress test (NST)

   ANS: D
   An NST evaluates the ability of the fetal heart to accelerate either spontaneously or in association with fetal movement. CST evaluates the fetal reaction to contractions. Sonographic examinations visualize the fetus and are done for various other reasons. The biophysical profile evaluates fetal status using many variables.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 281 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

9. Which nursing intervention is necessary before a second trimester transabdominal ultrasound?
   a. Place the woman NPO for 12 hours.
   b. Instruct the woman to drink 1 to 2 quarts of water.
   c. Administer a soapsuds enema.
   d. Perform an abdominal prep.

   ANS: B
   During the second trimester, a full bladder may be needed to displace the intestines and elevate the uterus for better visibility. If indicated, the woman should be instructed to drink several glasses of clear fluid an hour before the time of the examination and to delay urination until the examination is completed. Since she needs to fill her bladder, being NPO is not appropriate. Enemas and abdominal preps are not necessary for this procedure.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 276 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

10. The major advantage of chorionic villus sampling (CVS) over amniocentesis is that it
    a. is not an invasive procedure.
    b. does not require hospitalization.
    c. has less risk of spontaneous abortion.
    d. is performed earlier in pregnancy.

    ANS: D
    CVS is performed between 10 and 13 weeks of gestation, providing earlier results than amniocentesis, which is normally done during the second and third trimesters, although it can be done as early as 11 weeks if needed. The woman does not need hospitalization for this invasive procedure, and the risk of spontaneous abortion is about the same for both procedures.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 279 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

11. What is the purpose of amniocentesis for the patient hospitalized at 34 weeks with pregnancy-induced hypertension?
    a. Identification of abnormal fetal cells
    b. Detection of metabolic disorders
    c. Determination of fetal lung maturity
    d. Identification of sex of the fetus

    ANS: C
    During the third trimester, amniocentesis is most often performed to determine fetal lung maturity. In pregnancy-induced hypertension, preterm delivery may be necessary because of changes in placental perfusion. It is not done to identify abnormal fetal cells, detect metabolic disorders, or identify the sex of the fetus.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 279 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

12. An NST in which two or more fetal heart rate (FHR) accelerations of 15 beats per minute (bpm) or more occur with fetal movement in a 20-minute period is termed
    a. nonreactive.
    b. positive.
    c. negative.
    d. reactive.

    ANS: D
    The NST is *reactive* (normal) when two or more FHR accelerations of at least 15 bpm (each with a duration of at least 15 seconds) occur in a 20-minute period. A nonreactive result means that the heart rate did not accelerate during fetal movement. Positive and negative are not results given with this test.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering

REF: p. 281 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

13. The purpose of initiating contractions in a CST is to
    a. determine the degree of fetal activity.
    b. apply a stressful stimulus to the fetus.
    c. identifying fetal acceleration patterns.
    d. increase placental blood flow.

    ANS: B
    The CST involves recording the response of the FHR to stress induced by uterine contractions. The NST and biophysical profiles look at fetal movements. The NST looks at fetal heart accelerations with fetal movements. The CST records the fetal response to stress. It does not increase placental blood flow.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 282 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

14. A pregnant woman states “This test isn’t my idea, but my husband insists.” Which response by the nurse is most appropriate?
    a. “Don’t worry. Everything will be fine.”
    b. “Why don’t you want to have this test?”
    c. “You’re concerned about having this test?”
    d. “It’s your decision.”

    ANS: C
    The nurse should clarify the statement and assist the patient in exploring her feelings about the test. Stating that everything will be fine is giving false reassurance and belittles the woman’s concerns. “Why” questions usually put people on the defensive and are not therapeutic. Of course having the test is the woman’s decision, but this closed statement does not encourage the woman to express her feelings.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 286 OBJ: Integrated Process: Communication and Documentation
    MSC: Client Needs: Psychosocial Integrity

15. A nurse is preparing a woman for a nonstress test (NST). What nursing action is most appropriate?
    a. Position the woman on her left side.
    b. Seat the woman comfortably in a recliner.
    c. Have the woman to drink 1 liter of water prior to the test.
    d. Place conduction gel on the obese woman’s abdomen.

    ANS: B
    To correctly position the pregnant patient for an NST, the woman usually sits in a reclining chair. Alternatively she can be in a semi-Fowler position with a lateral tilt. This will optimize uterine perfusion and prevent supine hypotension. The woman does not need to drink water. Conduction gel is used in all NST tests.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 281 OBJ: Nursing Process: Implementation

MSC: Client Needs: Health Promotion and Maintenance

16. Which statement regarding various biochemical assessments used during pregnancy is correct?
    a. Chorionic villus sampling (CVS) is becoming more popular because it provides early diagnosis.
    b. Screening for maternal serum alpha-fetoprotein (MSAFP) levels is recommended between 10 and 12 weeks of gestation in order to give parents time to consider options.
    c. Percutaneous umbilical blood sampling (PUBS) is one of the multiple marker screen tests for Down syndrome.
    d. MSAFP is a screening tool only; it identifies candidates for more definitive procedures.

    ANS: D
    MSAFP is a screening tool, not a diagnostic tool. Further diagnostic testing is indicated after an abnormal MSAFP. CVS does provide a rapid result, but it is declining in popularity because of advances in noninvasive screening techniques. MSAFP screening is recommended for all pregnant women. Screening is recommended between 15 and 20 weeks of gestation. Abnormal findings give parents time to have additional tests done.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 277 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

17. A woman is scheduled for an ultrasound and is asking the nurse questions about this test. Which statement by the nurse regarding ultrasonography during pregnancy is most accurate?
    a. Ultrasonography uses infrared technology to create an image.
    b. Ultrasonography is only utilized as an adjunct to more invasive tests.
    c. Ultrasonography is not harmful to the fetus.
    d. Ultrasonography is not a component of biophysical profile testing.

    ANS: C
    Most women look forward to the results of this test, which causes no harm to the fetus. Ultrasonography uses sound waves to create an image. As an adjunct to more invasive tests, ultrasonography can provide visual guidance for increased safety. It can be done as a standalone test. Ultrasonography is a component of biophysical profile testing.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 274 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

18. A nurse is teaching a woman how to do “kick counts.” What information about this assessment is most appropriate?
    a. Notify your provider if the baby’s movement patterns change.
    b. Count the number of fetal movements over 2 hours.
    c. Call the OB triage area if there are fewer than 10 movements/hour.
    d. Have your partner verify your count at the same time you perform it.

    ANS: A

Since there is no consensus on how the mother should be taught to perform this assessment, it is more important that she become familiar with her baby's movements and patterns and notify the provider about any change from normal.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 285 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. A patient is at 6 weeks' gestation and is having a transvaginal ultrasound. While preparing the patient for this procedure, she expresses concerns over the necessity for this test. The nurse explains that this diagnostic test may be necessary to determine which of the following? (*Select all that apply.*)
   a. Multifetal gestation
   b. Bicornuate uterus
   c. Presence and location of pregnancy (intrauterine or elsewhere)
   d. Amniotic fluid volume
   e. Presence of ovarian cysts

   ANS: A, B, C, E
   A transvaginal ultrasound done in the first trimester can detect multifetal gestations, bicornuate uterus, presence and location of pregnancy, and presence of ovarian cysts. Amniotic fluid volume is assessed during the second and third trimesters.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 275 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

2. The nurse teaches a student that indications for percutaneous umbilical cord sampling (PUBS) include which of the following? (*Select all that apply.*)
   a. Rh disease
   b. Fetal well-being
   c. Infection
   d. Lung maturity
   e. Karyotyping

   ANS: A, C, E
   Rh disease, infection, and, infrequently, for karyotyping are all indications for PUBS. NST or BPP are used to determination fetal well-being. An amniocentesis is done in order to determine lung maturity.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 281 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

COMPLETION

1. A pregnant woman has the following assessments determined from a biophysical profile: reactive nonstress test, 3 fetal breathing movements within 30 minutes, 1 trunk movement in 30 minutes, opened and closed hand twice in 30 minutes, largest amniotic pocket of 1 cm. Calculate this woman's score.
   This woman's score is _____.

   ANS:
   8

   The scoring is as follows for each criteria: 2-2-1-2-1 = 8.

   PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
   REF: Table 15.1 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. The maternity nurse understands that as the uterus contracts during labor, maternal-fetal exchange of oxygen and waste products
   a. continues except when placental functions are reduced.
   b. increases as blood pressure decreases.
   c. diminishes as the spiral arteries are compressed.
   d. is not significantly affected.

   ANS: C
   During labor contractions, the maternal blood supply to the placenta gradually stops as the spiral arteries supplying the intervillous space are compressed by the contracting uterine muscle. The maternal blood supply to the placenta gradually stops with contractions and the exchange of oxygen and waste products decreases.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 290 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

2. A student nurse is trying to assess vital signs on a laboring woman. Which statement by the registered nurse is the best rationale for assessing maternal vital signs between contractions?
   a. During a contraction, assessing fetal heart rates is the priority.
   b. Maternal circulating blood volume increases temporarily during contractions.
   c. Maternal blood flow to the heart is reduced during contractions.
   d. Vital signs taken during contractions are not accurate.

   ANS: B
   During uterine contractions, blood flow to the placenta temporarily stops, causing a relative increase in the mother's blood volume, which in turn temporarily increases blood pressure and slows pulse. It is important to monitor fetal response to contractions, but the question is concerned with the maternal vital signs so assessing the fetal heart rate is not the priority. Vital signs are altered by contractions but are considered accurate for that period of time. However, they do not reflect the woman's baseline.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 289 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

3. Which mechanism of labor occurs when the largest diameter of the fetal presenting part passes the pelvic inlet?
   a. Engagement
   b. Extension
   c. Internal rotation
   d. External rotation

   ANS: A

Engagement occurs when the presenting part fully enters the pelvic inlet. Extension occurs when the fetal head meets resistance from the tissues of the pelvic floor and the fetal neck stops under the symphysis. This causes the fetal head to extend. Internal rotation occurs when the fetus enters the pelvic inlet. The rotation allows the longest fetal head diameter to conform to the longest diameter of the maternal pelvis. External rotation occurs after the birth of the head. The head then turns to the side so the shoulders can internally rotate and are positioned with their transverse diameter in the anteroposterior diameter of the pelvic outlet.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 299 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

4. To adequately care for patients, the nurse understands that labor contractions facilitate cervical dilation by
   a. contracting the lower uterine segment.
   b. enlarging the internal size of the uterus.
   c. promoting blood flow to the cervix.
   d. pulling the cervix over the fetus and amniotic sac.

   ANS: D
   Effective uterine contractions pull the cervix upward at the same time that the fetus and amniotic sac are pushed downward. The contractions are stronger at the fundus. The internal size becomes smaller with the contractions; this helps to push the fetus down. Blood flow decreases to the uterus during a contraction.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 290 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

5. A student asks how pregnant women can usually tolerate the normal blood loss associated with childbirth. Which response by the nurse is best? “It is because they have
   a. a higher hematocrit.”
   b. increased blood volume.”
   c. a lower fibrinogen level.”
   d. increased leukocytes.”

   ANS: B
   Women have a significant increase in blood volume during pregnancy, which allows them to tolerate the normal blood loss seen in delivery. The hematocrit decreases with pregnancy due to the high fluid volume. Fibrinogen levels increase with pregnancy. Leukocyte levels increase during labor, but that is not the reason for the toleration of blood loss.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 290 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

6. To assess the duration of labor contractions, the nurse determines the time
   a. from the beginning of one contraction to the beginning of the next.
   b. from the beginning to the end of each contraction.
   c. of the strongest intensity of each contraction.
   d. of uterine relaxation between two contractions.

ANS: B
Duration of labor contractions is the average length of contractions from beginning to end. Assessing from the beginning of one contraction to the beginning of the next is the frequency. The strongest intensity of each contraction is the strength or intensity. The interval of the contraction phase is the time of uterine relaxation between two contractions.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 314 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

7. The nurse teaching a prenatal class explains that which is the best indicator of true labor?
   a. Bloody show
   b. Cervical dilation and effacement
   c. Fetal descent into the pelvic inlet
   d. Uterine contractions every 7 minutes

ANS: B
The conclusive distinction between true and false labor is that contractions of true labor cause progressive change in the cervix. Bloody show can occur before true labor. Fetal descent can occur before true labor. False labor may have contractions that occur this frequently, but it is usually inconsistent.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 298 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

8. The student nurse learns that which factor ensures that the smallest anterior-posterior diameter of the fetal head enters the pelvis?
   a. Descent
   b. Engagement
   c. Flexion
   d. Station

ANS: C
Flexion of the fetal head allows the smallest head diameters to pass through the pelvis. Descent is the moving of the fetus through the birth canal. Engagement occurs when the largest diameter of the fetal presenting part has passed the pelvic inlet. Station is the relationship of the fetal presenting part to the level of the ischial spines.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 299 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

9. What results from the adaptation of the fetus to the size and shape of the pelvis?
   a. Lightening
   b. Lie
   c. Molding
   d. Presentation

ANS: C

The sutures and fontanels allow the bones of the fetal head to move slightly, changing the shape of the fetal head so it can adapt to the size and shape of the pelvis. Lightening is the descent of the fetus toward the pelvic inlet before labor. Lie is the relationship of the long axis of the fetus to the long axis of the mother. Presentation is the fetal part that first enters the pelvic inlet.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 293 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

10. The nurse assesses a patient whose cervix is dilated to 5 cm. What phase of labor does the nurse recognize the woman to be in?
    a. Latent phase
    b. Active phase
    c. Second stage
    d. Third stage

    ANS: B
    The active phase of labor is characterized by cervical dilation of 4 to 6 cm. The latent phase is from the beginning of true labor until 3 cm of cervical dilation. The second stage of labor begins when the cervix is completely dilated until the birth of the baby. The third stage of labor is from the birth of the baby until the expulsion of the placenta.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 299 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

11. To teach and support the woman in labor, the nurse explains that the strongest part of a labor contraction is the
    a. increment.
    b. acme.
    c. decrement.
    d. interval.

    ANS: B
    The acme is the peak or period of greatest strength during the middle of a contraction cycle. The increment is the beginning of the contractions until it reaches the peak. The decrement occurs after the peak until the contraction ends. The interval is the period between the end of the contraction and the beginning of the next.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 289 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

12. What assessment finding does the nurse expect in a woman with cervical dilation and effacement?
    a. Bloody show
    b. False labor
    c. Lightening
    d. Bladder distention

    ANS: A

As the cervix begins to soften, dilate, and efface, expulsion of the mucous plug that sealed the cervix during pregnancy occurs. This causes rupture of small cervical capillaries, leading to bloody show. Cervical dilation and effacement do not occur with false labor. Lightening is the descent of the fetus toward the pelvic inlet before labor. Bladder distention occurs when the bladder is not emptied frequently. It may slow down the decent of the fetus during labor.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: Table 16.2 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

13. The nurse is caring for a woman whose fetus has a breech presentation. What complication does the nurse prepare to assist with?
    a. Umbilical cord compression
    b. More rapid labor
    c. A high risk of infection
    d. Maternal perineal trauma

ANS: A
The umbilical cord can be compressed between the fetal body and the maternal pelvis when the body has been born but the head remains within the pelvis. Breech presentation is not associated with a more rapid labor. There is no higher risk of infection or perineal trauma with a breech birth.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 295 OBJ: Nursing Process: Planning
MSC: Client Needs: Health Promotion and Maintenance

14. The primary difference between the labor of a nullipara and that of a multipara is the
    a. amount of cervical dilation.
    b. total duration of labor.
    c. level of pain experienced.
    d. sequence of labor mechanisms.

ANS: B
Multiparas usually labor more quickly than nulliparas, making the total duration of their labor shorter. Cervical dilation and the sequence of labor mechanisms is the same for all labors. Level of pain is individual to the woman, not to the number of labors she has experienced.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: Table 16.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

15. Which maternal factor may inhibit fetal descent and require further nursing interventions?
    a. Decreased peristalsis
    b. A full bladder
    c. Reduction in internal uterine size
    d. Rupture of membranes

ANS: B

A full bladder may inhibit fetal descent because it occupies space in the pelvis needed by the fetal presenting part. Peristalsis does not influence fetal descent. Contractions will reduce the internal uterine size in order to assist fetal descent. Rupture of membranes will assist in the fetal descent.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 326 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

16. Leopold's maneuvers are used by practitioners to determine
    a. the best location to assess the fetal heart rate (FHR).
    b. cervical dilation and effacement.
    c. whether the fetus is in the posterior position.
    d. if the woman needs an amniotomy.

ANS: A
Leopold's maneuvers are often performed before assessing the FHR. These maneuvers help identify the best location to obtain the FHR. Dilation and effacement are best determined by vaginal examination. Assessment of fetal position is more accurate with vaginal examination. Leopold's maneuvers are not used to determine if the woman needs an amniotomy.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 305 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

17. Which comfort measure should the nurse use to assist the laboring woman?
    a. Keep the room lights lit so that the patient and her coach can see everything.
    b. Offer warm, wet cloths to use on the patient's face and neck.
    c. Palpate her bladder every 15 minutes to assess for distention.
    d. Recommend frequent position changes.

ANS: D
Frequent maternal position changes reduce the discomfort from constant pressure and promote fetal descent. Soft, indirect lighting is more soothing than irritating bright lights. Women in labor become hot and perspire. Cool cloths are much better. A full bladder intensifies labor pain. The bladder should be emptied every 2 hours.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 316 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

18. Which assessment finding could indicate hemorrhage in the postpartum patient?
    a. Firm fundus at the midline
    b. Saturation of one perineal pad in the hour after birth
    c. Elevated blood pressure
    d. Elevated pulse rate

ANS: D

An increasing pulse rate is an early sign of excessive blood loss. A firm fundus indicates that the uterus is contracting and compressing the open blood vessels at the placental site. Saturation of one pad within the first hour is the maximum normal amount of lochial flow. If the blood volume were diminishing, the blood pressure would decrease. However, this is a later finding.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 326 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

19. What nursing intervention is the priority when caring for a laboring woman?
    a. Helping the woman find ways to manage the pain
    b. Eliminating the pain associated with labor
    c. Sharing personal experiences regarding labor and delivery
    d. Providing the woman food to restore her energy

    ANS: A
    Helping a woman manage the pain is an essential part of nursing care, because pain is an expected part of normal labor and cannot be fully relieved. Labor pain cannot be fully relieved. Sharing experiences can sometimes be appropriate, but managing the pain is the priority. Some women may want food during labor, and some may not, but this is not the priority.

    PTS: 1 DIF: Cognitive Level: Application REF: p. 288
    OBJ: Nursing Process: Planning MSC: Client Needs: Health Promotion and Maintenance

20. A woman at 40 weeks of gestation calls the OB triage nurse to report a trickle of fluid from her vagina. What action by the nurse is most appropriate?
    a. Instruct the woman to come to the hospital.
    b. Ask her to time her contractions.
    c. Tell her if she saturates two pads in an hour to come to the hospital.
    d. Reassure her that she has plenty of time before delivery.

    ANS: A
    A trickle of fluid from the vagina may indicate rupture of the membranes requiring evaluation for infection or cord compression. Timing the contractions, waiting until she saturates two pads in an hour, and telling her there is plenty of time before she delivers are inappropriate actions and could lead to complications.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 305 | Patient-Centered Teaching Box
    OBJ: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

21. The nurse is answering phone calls in the OB triage area. Which patient should the nurse advise to come to the hospital soonest after labor begins?
    a. Gravida 2 para 1 who lives 10 minutes away
    b. Gravida 1 para 0 who lives 40 minutes away
    c. Gravida 3 para 2 whose longest previous labor was 4 hours
    d. Gravida 2 para 1 whose first labor lasted 16 hours

    ANS: C

Multiparous women usually have shorter labors than do nulliparous women. The woman described in option c is multiparous with a history of rapid labors, increasing the likelihood that her infant might be born in uncontrolled circumstances. The other women probably have more time.

PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
REF: p. 305 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

22. A primigravida at 39 weeks of gestation is observed for 2 hours in the intrapartum unit. The fetal heart rate has been normal. Contractions are 5 to 9 minutes apart, 20 to 30 seconds in duration, and of mild intensity. Cervical dilation is 1 to 2 cm and unchanged from admission. Membranes are intact. What action by the nurse is most appropriate?
    a. Prepare the woman for a cesarean birth.
    b. Admit the woman for extended observation.
    c. Discharge the woman with a sedative so she can rest.
    d. Provide discharge teaching on signs of true labor.

    ANS: D
    The situation describes a woman with normal assessments who is probably in false labor and will probably not deliver rapidly once true labor begins. There is no need to prepare her for a cesarean birth, admit her, or send her home with sedation.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 298 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

23. The nurse auscultates the fetal heart rate (FHR) and determines a rate of 152. Which nursing intervention is most appropriate?
    a. Document the findings in the chart.
    b. Reassess the FHR every 5 minutes.
    c. Report the FHR to the provider or nurse-midwife immediately.
    d. Apply oxygen and turn the mother on her left side.

    ANS: A
    The FHR is within the expected range; no further action is necessary at this point other than documenting the findings in the chart.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: Table 16.2 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

24. A laboring woman is lying in the supine position. The most appropriate nursing action is to
    a. ask her to turn to one side.
    b. elevate her feet and legs.
    c. take her blood pressure.
    d. let her stay in a position of comfort.

    ANS: A
    The woman’s supine position may cause the heavy uterus to compress her inferior vena cava, reducing blood return to her heart and reducing placental blood flow. This problem is relieved by having her turn onto her side. The other actions will not prevent this from happening.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 315 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

25. What finding should the nurse recognize as being associated with fetal compromise?
    a. Active fetal movements
    b. Contractions lasting 90 seconds
    c. FHR in the 140s
    d. Meconium-stained amniotic fluid

    ANS: D
    When fetal oxygen is compromised, relaxation of the rectal sphincter allows passage of meconium into the amniotic fluid. Active fetal movement is an expected occurrence. The fetus should be able to tolerate contractions lasting 90 seconds if the resting phase is sufficient to allow for a return of adequate blood flow. Expected FHR range is from 110 to 160.

    PTS: 1 DIF: Cognitive Level: Knowledge REF: p. 315 | Safety Alert Box
    OBJ: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

26. During the active phase of labor, the FHR of a low-risk patient should be assessed every
    a. 10 to 15 minutes.
    b. 15 to 30 minutes.
    c. 30 to 45 minutes.
    d. 1 hour.

    ANS: B
    For the fetus at low risk for complications, guidelines for frequency of assessments are at least every 15 to 30 minutes during the active phase of labor.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 310 | Table 16.2 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

27. Which nursing assessment indicates that a woman who is in second-stage labor is almost ready to give birth?
    a. The fetal head is felt at 0 station during vaginal examination.
    b. Bloody mucous discharge increases.
    c. The vulva bulges and encircles the fetal head.
    d. The membranes rupture during a contraction.

    ANS: C
    A bulging vulva that encircles the fetal head describes crowning, which occurs shortly before birth. Birth of the head occurs when the station is +4. A 0 station indicates engagement. Bloody show occurs throughout the labor process and is not an indication of an imminent birth. Rupture of membranes can occur at any time during the labor process and does not indicate an imminent birth.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 300 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

28. During labor, a vaginal examination should be performed only when necessary because of the risk of
    a. fetal injury.
    b. discomfort.
    c. infection.
    d. perineal trauma.

    ANS: C
    Vaginal examinations increase the risk of infection by carrying vaginal microorganisms upward toward the uterus. Properly performed vaginal examinations should not cause fetal injury. Vaginal examinations may be uncomfortable for some women in labor, but that is not the main reason for limiting them. A properly performed vaginal examination should not cause perineal trauma.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 313 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Safe and Effective Care Environment

29. A 25-year-old primigravida is in the first stage of labor. She and her husband have been holding hands and breathing together through each contraction. Suddenly the woman pushes her husband's hand away and shouts, "Don't touch me!" What action by the nurse is most appropriate?
    a. Reassure the husband this is normal in the transition phase.
    b. Ask the woman if she needs some pain medication.
    c. Call the anesthesia provider for an epidural block.
    d. Ask the husband to leave the room for a few minutes.

    ANS: A
    The transition phase of labor is often associated with an abrupt change in behavior, including increased anxiety and irritability. The woman may or may not need pain medication or an epidural, but the husband should be reassured. There is no need for the husband to be asked to leave.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 299 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

30. At 1 minute after birth, the nurse assesses the newborn to assign an Apgar score. The apical heart rate is 110 bpm, and the infant is crying vigorously with the limbs flexed. The infant's trunk is pink, but the hands and feet are blue. What is the Apgar score for this infant?
    a. 7
    b. 8
    c. 9
    d. 10

    ANS: C
    The baby received 2 points for each of the categories except color. Since the infant's hands and feet were blue this category is given a grade of 1.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 326 | Table 16.3 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

31. Thirty minutes after birth, the nurse assesses a woman's fundus as soft and boggy. What action by the nurse takes priority?
    a. Take the blood pressure.
    b. Massage the fundus.
    c. Notify the provider or nurse-midwife.
    d. Place the woman in the Trendelenburg position.

    ANS: B
    The nurse's first response should be to massage the fundus to stimulate contraction of the uterus to compress open blood vessels at the placental site, limiting blood loss. Blood pressure is important but not the priority. Notification should occur after all nursing measures have been attempted with no favorable results. The Trendelenburg position is contraindicated for this woman at this point. This position does not allow for appropriate vaginal drainage of lochia. The lochia remaining in the uterus would clot and produce further bleeding.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 327 | Table 16.4 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

32. Thirty minutes after giving birth a woman's uterus feels boggy to the nurse. The nurse massages the fundus without change. What action does the nurse take next?
    a. Notify the provider or nurse-midwife immediately.
    b. Assess the woman for a full bladder.
    c. Prepare to administer oxytocin.
    d. Take a full set of vital signs.

    ANS: B
    After massaging the uterus, without result, the nurse should assess the woman to see if a full bladder is contributing to the uterine atony. The woman can then be catheterized to empty the bladder. None of the other actions is needed.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 327 | Table 16.4 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Safe and Effective Care Environment

33. The nurse thoroughly dries the infant immediately after birth primarily to
    a. stimulate crying and lung expansion.
    b. remove maternal blood from the skin surface.
    c. reduce heat loss from evaporation.
    d. increase blood supply to the hands and feet.

    ANS: C
    Infants are wet with amniotic fluid and blood at birth, which accelerates evaporative heat loss. Drying the infant with help maintain a normal temperature. Rubbing the infant does stimulate crying, but it is not the main reason for drying the infant. Removing maternal blood is also not the main reason for this action. It does not increase blood supply to the hands and feet.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 325 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

34. The nurse notes that a woman who has given birth 1 hour ago is touching her infant with the fingertips and talking to him softly in high-pitched tones. On the basis of this observation, the nurse should
    a. document this evidence of normal early maternal-infant attachment behavior.
    b. observe for other signs that the mother may not be accepting of the infant.
    c. request a social service consult for psychosocial support.
    d. determine whether the mother is too fatigued to interact normally with her infant.

    ANS: A
    These are signs of normal attachment behavior; no other assessment or intervention is necessary at this point.

    PTS: 1 DIF: Cognitive Level: Comprehension REF: p. 329
    OBJ: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

35. When assessing the fetus using Leopold maneuvers, the nurse feels a round, firm, movable fetal part in the fundal portion of the uterus and a long, smooth surface in the mother's right side close to midline. What is the likely position of the fetus?
    a. ROA
    b. LSP
    c. RSA
    d. LOA

    ANS: C
    Fetal position is denoted with a three-letter abbreviation. The first letter indicates the presenting part in either the right or left side of the maternal pelvis. The second letter indicates the anatomic presenting part of the fetus. The third letter stands for the location of the presenting part in relation to the anterior, posterior, or transverse portion of the maternal pelvis. This fetus is positioned anteriorly in the right side of the maternal pelvis with the sacrum as the presenting part. RSA is the correct three-letter abbreviation to indicate this fetal position. ROA denotes a fetus that is positioned anteriorly in the right side of the maternal pelvis with the occiput as the presenting part. LSP describes a fetus that is positioned posteriorly in the left side of the pelvis with the sacrum as the presenting part. A fetus that is LOA would be positioned anteriorly in the left side of the pelvis with the occiput as the presenting part.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: pp. 295-296 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

36. The registered nurse tells the nursing student that which stage of labor varies most in length?
    a. First
    b. Second
    c. Third
    d. Fourth

    ANS: A
    The first stage is much longer than the second and third stages combined. In a first pregnancy, the first stage of labor can take up to 20 hours. However, there is great variability in length of time depending on many factors, including parity.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 302 | Table 16.1 OBJ: Nursing Process: Planning
MSC: Client Needs: Health Promotion and Maintenance

37. A pregnant woman is at 38 weeks of gestation. She wants to know if any signs indicate "labor is getting closer to starting." The nurse informs the woman that which of the following is a sign that labor may begin soon?
    a. Weight gain of 1.5 to 2 kg (3 to 4 lb)
    b. Increase in fundal height
    c. Urinary retention
    d. Surge of energy

    ANS: D
    Women speak of having a burst of energy before labor. The woman may lose 0.5 to 1.5 kg, the result of water loss caused by electrolyte shifts, which in turn are caused by changes in the estrogen and progesterone levels. When the fetus descends into the true pelvis (called lightening), the fundal height may decrease. Urinary frequency may return before labor.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 298 OBJ: Nursing Process: Planning
    MSC: Client Needs: Health Promotion and Maintenance

38. At hand-off report the off-going nurse states that the patient demonstrated clonus on her last assessment. What action by the on-coming nurse takes priority?
    a. Repeat the woman's vital signs.
    b. Institute seizure precautions.
    c. Prepare for cesarean delivery.
    d. Assess for pain.

    ANS: B
    Clonus (repeated tapping when the foot is dorsiflexed) is usually associated with pregnancy-induced hypertension and may precede a seizure. The nurse should place the woman on seizure precautions. Vital signs should be assessed frequently, but this is not the priority. There is no need at this point for cesarean delivery, although that is possible. Assessing for pain is important but does not take priority over a safety measure.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: Table 16.2 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Safe and Effective Care Environment

39. The labor and delivery nurse is evaluating a newly admitted woman's lab and notes a hemoglobin of 9.1 mg/dL and hematocrit of 31%. What action by the nurse takes priority?
    a. Document the findings on the woman's chart.
    b. Notify the provider or nurse-midwife immediately.
    c. Assess for response to blood loss during and after birth.
    d. Place the patient on bedrest during labor.

    ANS: C

The normal values for a woman about to deliver are 10.5 mg/dL and 33%. Values lower than this indicate the maternal reserves may not be adequate for the normal blood loss in delivery. The nurse should use astute assessments during and after delivery to assess her response to the loss of blood. Documentation and notification should occur, but that is not the priority action. There is no indication that the woman should be restricted to bed during labor.

PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
REF: Table 16.2 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

MULTIPLE RESPONSE

1. The nurse who elects to practice in the area of obstetrics learns about the "four Ps." What are the "four Ps"?
   a. Powers
   b. Passage
   c. Position
   d. Passenger
   e. Psyche

   ANS: A, B, D, E
   Powers: the two powers of labor are uterine contractions and pushing efforts. During the first stage of labor through full cervical dilation, uterine contractions are the primary force moving the fetus through the maternal pelvis. At some point after full dilation, the woman adds her voluntary pushing efforts to propel the fetus through the pelvis. *Passage:* the passage for birth of the fetus consists of the maternal pelvis and its soft tissues. The bony pelvis is more important to the successful outcome of labor, because bones and joints do not yield as readily to the forces of labor. *Passenger:* this is the fetus plus the membranes and placenta. Fetal lie, attitude, presentation, and position are all factors that affect the fetus as passenger. *Psyche:* the psyche is a crucial part of childbirth. Marked anxiety, fear, or fatigue decreases the woman's ability to cope. Position is not one of the "four Ps."

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 291 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

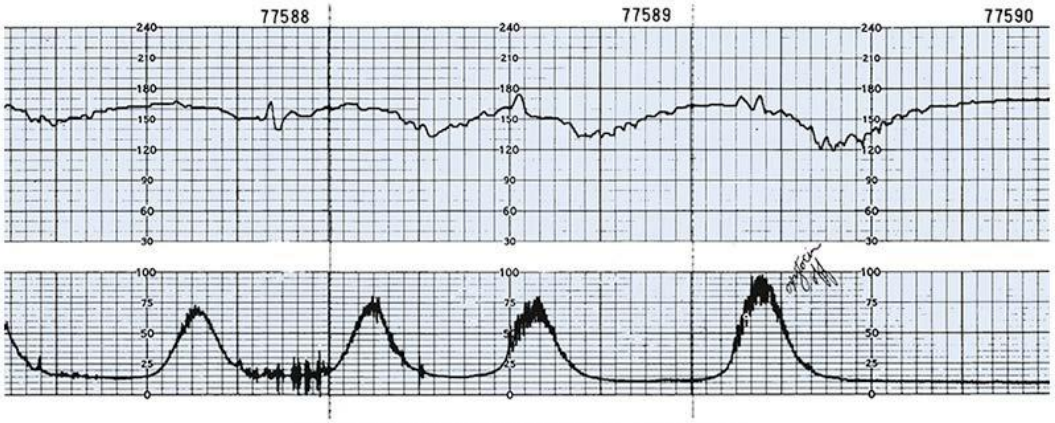
2. A woman who is gravida 3 para 2 enters the intrapartum unit. Which nursing assessments take priority at this time? (*Select all that apply.*)
   a. Fetal heart rate
   b. Maternal vital signs
   c. The woman's nearness to birth
   d. Contraction patterns
   e. Last food and water intake

   ANS: A, B, C
   All options describe relevant intrapartum nursing assessments, but the focused assessment has priority. If the maternal and fetal conditions are normal and birth is not imminent, other assessments can be performed in an unhurried manner.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 305 OBJ: Nursing Process: Assessment

MULTIPLE CHOICE

1. The nurse sees this pattern on the fetal monitor.



Courtesy Corometrics Medical Systems, Inc., Wallingford, CT.

What action by the nurse is most appropriate?
a. Apply oxygen via face mask, and position the woman on her left side.
b. Document the findings in the chart along with maternal vital signs.
c. Prepare to start an infusion of oxytocin per unit protocol.
d. Decrease the rate of the woman's IV maintenance fluids.

ANS: A
This tracing shows a late deceleration. The mother should be given oxygen and positioned on her left side. The findings should be documented, but only after interventions have occurred. Oxytocin would increase uterine activity (and increase stress on the fetus) so should not be started, or if already running, discontinued. IV fluids should be increased.

PTS: 1 DIF: Cognitive Level: Analysis REF: Figure 17.10
OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

2. Which maternal condition is considered a contraindication for the application of internal monitoring devices?
a. Unruptured membranes
b. Cervix is dilated to 4 cm
c. External monitors are currently being used
d. Fetus has a known heart defect

ANS: A
To apply internal monitoring devices, the membranes must be ruptured. Cervical dilation of 4 cm permits the insertion of fetal scalp electrodes and intrauterine catheter. The external monitor can be discontinued after the internal ones are applied. A compromised fetus should be monitored with the most accurate monitoring devices.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 338 OBJ: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

3. The nursing student is planning to assess a fetal heart rate. The registered nurse reminds the student to get gel. Which method of assessing the fetal heart rate is the student planning on conducting?
   a. Fetoscope
   b. Tocodynamometer
   c. Doppler
   d. Scalp electrode

   ANS: C
   Doppler is the only listed method involving ultrasonic transmission of fetal heart rates; it requires use of a gel.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 338 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

4. A nurse manager plans staffing for the Labor and Delivery unit. How does the available staff influence the selection of either continuous electronic or intermittent auscultation as the fetal monitoring method?
   a. There must be a 1:1 nurse-to-patient ratio regardless of the method used.
   b. Staffing patterns do not influence fetal monitoring choices.
   c. Use of intermittent auscultation requires a lower nurse-to-patient ratio.
   d. More nurses are needed when electronic fetal monitoring is used.

   ANS: A
   A one-to-one ratio is needed during the second stage of labor or if a high-risk condition exists, regardless of the monitoring method used. Intermittent auscultation is more staff-intensive. Less nursing time is needed with electronic monitoring, giving the nurse more time for teaching and supporting the laboring woman.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 336 OBJ: Nursing Process: Planning
   MSC: Client Needs: Safe and Effective Care Environment

5. A student nurse is placing a tocotransducer on a woman for electronic fetal monitoring. What action by the student indicates to the registered nurse that the student understands the procedure?
   a. Places the tocotransducer over the uterine fundus
   b. Prepares sterile field for fetal scalp electrode placement
   c. Positions the tocotransducer on the woman’s upper arm
   d. Attaches the tocotransducer to the woman’s lower abdomen

   ANS: A
   The tocotransducer monitors uterine activity and should be placed over the fundus, where the most intensive uterine contractions occur. No sterile field is needed. The tocotransducer is not placed on the upper arm or lower abdomen.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: p. 338 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Health Promotion and Maintenance

6. A student nurse is preparing to administer misoprostol (Cytotec). What action by the student seen by the registered nurse demonstrates adequate knowledge about this medication?
   a. Assesses maternal blood pressure 30 minutes after administration
   b. Assesses fetal heart tones prior to administering the medication
   c. Documents the drug administration in the woman's chart
   d. Takes and records an apical pulse for 1 minute prior to administration

   ANS: B
   Fetal heart tones should be assessed prior to giving cervical ripening agents such as misoprostol. It is not necessary to assess maternal blood pressure afterward or an apical pulse prior to administering the medication. Documentation of all medications is a legal requirement but is not related specifically to this drug.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: Box 17.2 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Physiologic Integrity

7. A woman has a history of hypertension during pregnancy. What method of intrapartum fetal monitoring does the nurse initiate?
   a. Continuous auscultation with a fetoscope
   b. Continuous electronic fetal monitoring
   c. Intermittent assessment with a Doppler transducer
   d. Intermittent electronic fetal monitoring for 15 minutes each hour

   ANS: B
   Maternal hypertension may reduce placental blood flow through vasospasm of the spiral arteries. Reduced placental perfusion is best assessed with continuous electronic fetal monitoring to identify patterns associated with this condition. It is not practical to provide continuous auscultation with a fetoscope. This fetus needs continuous monitoring because it is at high risk for complications.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 333 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

8. Why is continuous electronic fetal monitoring usually used when oxytocin is administered?
   a. The mother may become hypotensive.
   b. Uteroplacental exchange may be compromised.
   c. Maternal fluid volume deficit may occur.
   d. Fetal chemoreceptors are stimulated.

   ANS: B
   The uterus may contract more firmly, and the resting tone may be increased with oxytocin use. This response reduces entrance of freshly oxygenated maternal blood into the intervillous spaces, depleting fetal oxygen reserves. Hypotension is not a common side effect of oxytocin. All laboring women are at risk for fluid volume deficit; oxytocin administration does not increase the risk. Oxytocin affects the uterine muscles.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 333 OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

9. The nurse-midwife is concerned that a woman's uterine activity is too intense and that her obesity is preventing accurate assessment of the actual intrauterine pressure. On the basis of this information, the nurse should obtain a(n)
   a. tocotransducer.
   b. scalp electrode.
   c. intrauterine pressure catheter.
   d. Doppler transducer.

   ANS: C
   An intrauterine pressure catheter can measure actual intrauterine pressure. The tocotransducer measures the uterine pressure externally; this not be accurate with obesity. A scalp electrode measures the fetal heart rate (FHR). A Doppler auscultates the FHR.

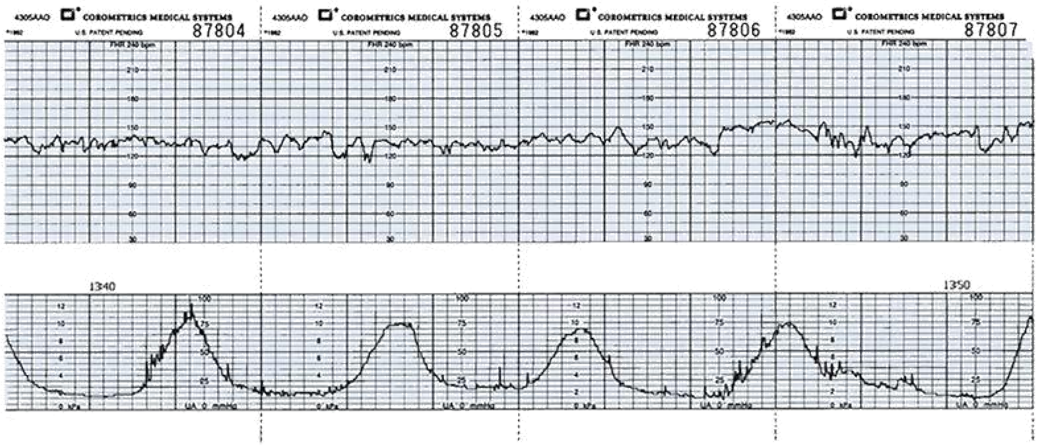
   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 339 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

10. In which situation is a baseline fetal heart rate of 160 to 170 beats per minute considered a normal finding?
   a. The fetus is at 28 weeks of gestation.
   b. The mother has been given an epidural block.
   c. The mother has a history of fast labors.
   d. The mother has mild preeclampsia but is not in labor.

   ANS: A
   The normal preterm fetus may have a baseline rate slightly higher than the term fetus because of an immature parasympathetic nervous system that does not yet exert a slowing effect on the fetal heart rate (FHR). Any change in the FHR with an epidural is not considered an expected outcome. Fast labors should not alter the FHR normally. Preeclampsia should not cause a normal elevation of the FHR.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 340 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

11. The nurse assesses the fetal monitor and sees the following strip. What action by the nurse is most appropriate?



Courtesy Corometrics Medical Systems, Inc., Wallingford, CT.

a. Administer oxygen by nasal cannula.
b. Reposition the woman.
c. Apply a fetal scalp electrode.
d. Record this reassuring pattern.

ANS: D
This is a reassuring pattern and no intervention is necessary beyond documentation.

PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
REF: Figure 17.6 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

12. When the mother's membranes rupture during active labor, the fetal heart rate should be observed for the occurrence of which periodic pattern?
a. Increase in baseline variability
b. Nonperiodic accelerations
c. Early decelerations
d. Variable decelerations

ANS: D
When the membranes rupture, amniotic fluid may carry the umbilical cord to a position where it will be compressed between the maternal pelvis and the fetal presenting part, resulting in a variable deceleration pattern. This is not an expected occurrence after the rupture of membranes. Accelerations are considered reassuring; they are not a concern after rupture of membranes. Early declarations are considered reassuring; they are not a concern after rupture of membranes.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 343 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

13. The fetal heart rate baseline increases 15 beats per minute after vibroacoustic stimulation. What action by the nurse is most appropriate?
a. Reassure the family the finding is normal.
b. Prepare to assist with obtaining cord blood gases.
c. Position the woman on her left side.
d. Administer oxygen at 4 L via nasal cannula.

ANS: A
The fetus with adequate reserve for the stress of labor will usually respond to vibroacoustic stimulation with a temporary increase in the fetal heart rate (FHR) over baseline of 15 bpm for 15 seconds or more. The nurse reassures the family that this finding is normal. The other actions are not warranted.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 346 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

14. The nurse notes a nonreassuring pattern of the fetal heart rate. The mother is already lying on her left side. What nursing action is indicated?
    a. Lower the head of the bed.
    b. Place the mother in a Trendelenburg position.
    c. Change her position to the right side.
    d. Place a wedge under the left hip.

ANS: C
Repositioning on the opposite side may relieve compression on the umbilical cord and improve blood flow to the placenta. The other actions are not warranted.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 347 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

15. The nurse notes a pattern of late decelerations on the fetal monitor. The most appropriate action is to
    a. continue observation of this reassuring pattern.
    b. notify the physician or nurse-midwife.
    c. give the woman oxygen by face mask.
    d. place the woman in a Trendelenburg position.

ANS: C
Late decelerations are associated with reduced placental perfusion. Giving the laboring woman oxygen increases the oxygen saturation in her blood, making more oxygen available to the fetus. This is not a reassuring pattern; interventions are needed. Nursing interventions should be initiated before notifying the health care provider. The Trendelenburg position will not increase the placental perfusion.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 342 | p. 344 | Safety Alert Box OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

16. The nurse explains to the student that increasing the infusion rate of non-additive intravenous fluids can increase fetal oxygenation primarily by
    a. maintaining normal maternal temperature.
    b. preventing normal maternal hypoglycemia.
    c. increasing the oxygen-carrying capacity of the maternal blood.
    d. expanding maternal blood volume.

ANS: D

Filling the mother's vascular system makes more blood available to perfuse the placenta and may correct hypotension. Increasing fluid volume may alter the maternal temperature only if she is dehydrated. Most intravenous fluids for laboring women are isotonic and do not improve hypoglycemia. Oxygen-carrying capacity is increased by adding more red blood cells.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 344 | Safety Alert Box OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

17. Which nursing action is correct when initiating electronic fetal monitoring?
    a. Lubricate the tocotransducer with an ultrasound gel.
    b. Inform the patient that she should remain in the semi-Fowler's position.
    c. Securely apply the tocotransducer with a strap or belt.
    d. Determine the position of the fetus before attaching the electrode.

    ANS: C
    The tocotransducer should fit snugly on the abdomen to monitor uterine activity accurately. The tocotransducer does not need gel to operate appropriately. The patient should be encouraged to move around during labor. The tocotransducer should be placed at the fundal area of the uterus.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 338 | Procedure Box OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

18. Which statement correctly describes the nurse's responsibility related to electronic monitoring?
    a. Teach the woman and her support person about the monitoring equipment, and discuss any questions they have.
    b. Report abnormal findings to the physician before initiating corrective actions.
    c. Inform the support person that the nurse will be responsible for all comfort measures when the electronic equipment is in place.
    d. Document the frequency, duration, and intensity of contractions measured by the external device.

    ANS: A
    Teaching is an essential part of the nurse's role. Corrective actions should be initiated first in order to correct abnormal findings as quickly as possible. The support person should be encouraged to assist with the comfort measures. Electronic monitoring will record the contractions and FHR response.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 347 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

19. The precepting nurse explains to the newly hired nurse that when using IA for FHR which situation is unit protocol?
    a. The nurses can be expected to cover only two or three patients when IA is the primary method of fetal assessment.
    b. The best course is to use the descriptive terms associated with EFM when

documenting results.

c. If the heartbeat cannot be found immediately, a shift must be made to electronic monitoring.
d. Ultrasound can be used to find the fetal heartbeat and reassure the mother if initial difficulty was a factor.

ANS: D
Locating fetal heartbeats often takes time. Mothers can be reassured verbally and by the ultrasound pictures if that device is used to help locate the heartbeat. When used as the primary method of fetal assessment, auscultation requires a nurse-to-patient ratio of one to one. Documentation should use only terms that can be numerically defined; the usual visual descriptions of EFM are inappropriate. Electronic monitoring is not needed at this point.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 335 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

20. The new nurse learns that which condition related to decreased variability is considered benign?
a. A periodic fetal sleep state
b. Extreme prematurity
c. Fetal hypoxemia
d. Preexisting neurologic injury

ANS: A
When the fetus is temporarily in a sleep state there is minimal variability present. Periodic fetal sleep states usually last no longer than 30 minutes. The other conditions would be considered conducive to abnormal variability.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 340 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

21. A nurse might be called on to stimulate the fetal scalp
a. as part of fetal scalp blood sampling.
b. in response to tocolysis.
c. in preparation for fetal oxygen saturation monitoring.
d. to elicit an acceleration in the FHR.

ANS: D
The scalp can be stimulated using digital pressure during a vaginal examination, which should cause an increase in FHR. Stimulating the fetal scalp is not part of blood sampling, assessing the response to tocolysis, or in preparation for oxygen saturation monitoring.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 345 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

22. In the low-risk patient assessments for variability and periodic changes if using the fetal monitor should be done how often?
a. Every 15 to 30 minutes
b. Every 5 to 15 minutes

c. Every 30 to 60 minutes
d. Only before and after ambulation

ANS: A
During the active first stage of labor, FHR should be assessed every 15 to 30 minutes just after a contraction.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 385 | Box 17.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Safe and Effective Care Environment

23. A new nurse notes a fetal heart rate pattern of late deceleration with minimal variability in a laboring woman with vaginal bleeding. Which action by the new nurse warrants intervention by the charge nurse?
a. Assesses maternal blood pressure
b. Assesses for a prolapsed cord
c. Prepares to administer terbutaline
d. Discontinues oxytocin

ANS: B
Assessing for a prolapsed cord requires a vaginal examination, which is contraindicated when the woman has active vaginal bleeding. The other actions are appropriate.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 344 | Safety Alert Box OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. A Labor and Delivery nurse knows that four of the five fetal factors that interact to regulate the heart rate are which of the following? (*Select all that apply.*)
a. Uterine activity
b. Autonomic nervous system
c. Baroreceptors
d. Chemoreceptors
e. Adrenal glands

ANS: B, C, D, E
The sympathetic and parasympathetic branches of the autonomic nervous system are balanced forces that regulate FHR. Sympathetic stimulation increases the heart rate, while parasympathetic responses, through stimulation of the vagus nerve, reduce the FHR and maintain variability. The baroreceptors stimulate the vagus nerve to slow the FHR and decrease the blood pressure. These are located in the carotid arch and major arteries. The chemoreceptors are cells that respond to changes in oxygen, carbon dioxide, and pH. They are found in the medulla oblongata and the aortic and carotid bodies. The adrenal medulla secretes epinephrine and norepinephrine in response to stress, causing an acceleration in FHR. Uterine activity is a maternal factor.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 333 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

2. The labor nurse is evaluating the patient's most recent 10-minute segment on the monitor strip and notes a late deceleration. This is likely to be caused by which physiologic alterations? (*Select all that apply.*)
   a. Spontaneous fetal movement
   b. Compression of the fetal head
   c. Placental abruption
   d. Cord around the baby's neck
   e. Maternal supine hypotension

   ANS: C, E
   Late decelerations are almost always caused by uteroplacental insufficiency. Insufficiency is caused by uterine tachysystole, maternal hypotension, epidural or spinal anesthesia, IUGR, intraamniotic infection, or placental abruption. Spontaneous fetal movement, vaginal examination, fetal scalp stimulation, fetal reaction to external sounds, uterine contractions, fundal pressure, and abdominal palpation are all likely to cause accelerations of the FHR. Early decelerations are most often the result of fetal head compression and may be caused by uterine contractions, fundal pressure, vaginal examination and placement of an internal electrode. A variable deceleration is likely caused by umbilical cord compression. This may happen when the cord is around the baby's neck, arm, leg or other body part, a short cord, a knot in the cord, or a prolapsed cord.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: Table 17.1 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

3. A new nurse to Labor and Delivery learns about the three categories of fetal heart rate patterns. Which characteristics of the fetal heart belong in Category III? (*Select all that apply.*)
   a. Baseline rate of 110 to 160 bpm
   b. Tachycardia
   c. Absent baseline variability NOT accompanied by recurrent decelerations
   d. Variable decelerations with other characteristics such as shoulders or overshoots
   e. Absent baseline variability with recurrent variable decelerations
   f. Bradycardia

   ANS: B, D, E, F
   These characteristics are all considered non-reassuring or abnormal and belong in Category III. A fetal heart rate of 110 to 160 bpm is considered normal and belongs in Category I. Absent baseline variability *not* accompanied by recurrent decelerations is a Category II characteristic.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 344 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

4. Which of the following factors place the intrapartum woman at risk for complications during labor and delivery? (*Select all that apply.*)
   a. Prolonged rupture of membranes
   b. Chorioamnionitis
   c. Fever
   d. History of stillbirth

e. Drug use

ANS: A, B, C
Prolonged rupture of membranes, Chorioamnionitis, and fever are specific to the intrapartum period. Stillbirths and drug use are problems found in the antepartum period.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: Box 17.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE CHOICE

1. Childbirth preparation can be considered successful if the outcome is described as follows:
   a. Labor and delivery were pain-free.
   b. The woman's partner participated eagerly.
   c. The woman rehearsed labor and practiced skills to master pain.
   d. Only nonpharmacologic methods for pain control were used.

   ANS: C
   Preparation allows the woman to rehearse for labor and to learn new skills to cope with the pain of labor and the expected behavioral changes. Childbirth preparation does not guarantee a pain-free labor. A woman should be prepared for pain and anesthesia/analgesia realistically. The partner's role and participation level should be established by the couple. Women will not always achieve their desired level of pain control by using nonpharmacologic methods alone.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: p. 356 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Psychosocial Integrity

2. In order to help patients manage discomfort and pain during labor, nurses should be aware that
   a. the predominant pain of the first stage of labor is the *visceral pain* located in the lower portion of the abdomen.
   b. somatic pain is the extreme discomfort between contractions.
   c. the somatic pain of the second stage of labor is more generalized and related to fatigue.
   d. pain during the third stage is a somewhat milder version of the second stage.

   ANS: A
   This pain comes from cervical changes, distention of the lower uterine segment, and uterine ischemia. Somatic pain is a faster, sharp pain. Somatic pain is most prominent during late first-stage labor and during second-stage labor as the descending fetus puts direct pressure on maternal tissues. Second-stage labor pain is intense, sharp, burning, and localized. Third-stage labor pain is similar to that of the first stage.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 355 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

3. The nurse caring for women in labor understands that childbirth pain is different from other types of pain in that it is
   a. more responsive to pharmacologic management.
   b. associated with a physiologic process.
   c. designed to make one withdraw from the stimulus.
   d. less intense.

   ANS: B

Childbirth pain is part of a normal process, whereas other types of pain usually signify an injury or illness. Childbirth pain is not more or less responsive to medication. The pain with childbirth is a normal process; it is not caused by the type of injury when withdrawal from the stimuli is seen. Childbirth pain is not less intense than other types of pain.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 354 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

4. Excessive anxiety in labor heightens the woman's sensitivity to pain by increasing
   a. muscle tension.
   b. blood flow to the uterus.
   c. the pain threshold.
   d. rest time between contractions.

ANS: A
Anxiety and fear increase muscle tension, diverting oxygenated blood to the woman's brain and skeletal muscles. Prolonged tension results in general fatigue, increased pain perception, and reduced ability to use coping skills. It can also decrease blood flow to the uterus, the pain threshold, and the amount of rest the mother gets between contractions.

PTS: 1 DIF: Cognitive Level: Knowledge REF: p. 356
OBJ: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

5. When providing labor support, the nurse knows that which fetal position might cause the laboring woman more back discomfort?
   a. Right occiput anterior
   b. Left occiput anterior
   c. Right occiput transverse
   d. Left occiput posterior

ANS: D
In the left occiput posterior position, each contraction pushes the fetal head against the mother's sacrum, which results in intense back discomfort. The other fetal positions do not cause more back discomfort.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 358 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

6. The nurse working with a pregnant woman explains that a major advantage of nonpharmacologic pain management is that
   a. more complete pain relief is possible.
   b. no side effects or risks to the fetus are involved.
   c. the woman remains fully alert at all times.
   d. a more rapid labor is likely.

ANS: B

Because nonpharmacologic pain management does not include analgesics, adjunct drugs, or anesthesia, it is harmless to the mother and the fetus. There is less pain relief with nonpharmacologic pain management during childbirth. The woman's alertness is not altered by medication, but the increase in pain will decrease alertness. Pain management may or may not alter the length of labor. At times when pain is decreased, the mother relaxes and labor progresses at a quicker pace.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 356 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

7. The best time to teach nonpharmacologic pain control methods to an unprepared laboring woman is during which phase?
   a. Latent phase
   b. Active phase
   c. Transition phase
   d. Second stage

   ANS: A
   The latent phase of labor is the best time for intrapartum teaching, because the woman is usually anxious enough to be attentive, yet comfortable enough to understand the teaching. During the active phase, the woman is focused internally and unable to concentrate on teaching. During transition, the woman is focused on keeping control; she is unable to focus on anyone else or learn at this time. During the second stage, the woman is focused on pushing. She normally handles the pain better at this point because she is active in doing something to hasten the delivery.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 357 OBJ: Nursing Process: Planning
   MSC: Client Needs: Health Promotion and Maintenance

8. The nurse providing newborn stabilization must be aware that the primary side effect of maternal narcotic analgesia in the newborn is
   a. respiratory depression.
   b. bradycardia.
   c. acrocyanosis.
   d. tachypnea.

   ANS: A
   An infant delivered within 5 hours of maternal analgesic administration (timing depends on drug used) is at risk for respiratory depression from the sedative effects of the opioid. Bradycardia, acrocyanosis, and tachypnea are not anticipated side effects of maternal analgesics.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 365 | Table 18.1 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

9. A woman received 50 mcg of fentanyl intravenously 1 hour before delivery. What drug should the nurse have readily available?
   a. Promethazine (Phenergan)

b. Nalbuphine (Nubain)
c. Butorphanol (Stadol)
d. Naloxone (Narcan)

ANS: D
Naloxone reverses narcotic-induced respiratory depression, which may occur with administration of narcotic analgesia. Phenergan is normally given for nausea. Nubain and Stadol are analgesics that can be given to women in labor.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 372 | Table 18.2 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

10. The nerve block used in labor that provides anesthesia to the lower vagina and perineum is called a(n)
a. epidural.
b. pudendal.
c. local.
d. spinal block.

ANS: B
A pudendal block anesthetizes the lower vagina and perineum to provide anesthesia for an episiotomy and use of low forceps if needed. An epidural provides anesthesia for the uterus, perineum, and legs. A local provides anesthesia for the perineum at the site of the episiotomy. A spinal block provides anesthesia for the uterus, perineum, and down the legs.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 372 | Table 18.2 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

11. A laboring woman has been given an injection of epidural anesthesia. Which assessment by the nurse takes priority?
a. Urinary output
b. Contraction pattern
c. Maternal blood pressure
d. Intravenous infusion rate

ANS: C
Epidural anesthesia may produce maternal hypotension due to vasodilation so the priority assessment by the nurse is maternal blood pressure. The other assessments are important for this woman but are not directly related to the anesthetic injection.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 372 | Table 18.2 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

12. Which statement is true about the physiologic effects of pain in labor?
a. It usually results in a more rapid labor.
b. It is considered to be a normal occurrence.
c. It may result in decreased placental perfusion.
d. It has no effect on the outcome of labor.

ANS: C
When experiencing excessive pain, the woman may react with a stress response that diverts blood flow from the uterus and the fetus. Excessive pain may prolong the labor due to increased anxiety in the woman. Pain is considered normal for labor, however; this statement does not explain the physiologic effects. Pain may affect the outcome of the labor depending on the cause and the effect on the woman.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 354 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

13. Which woman will most likely have increased anxiety and tension during her labor?
    a. Gravida 1 who did not attend prepared childbirth classes
    b. Gravida 2 who refused any medication
    c. Gravida 2 who delivered a stillborn baby last year
    d. Gravida 3 who has two children younger than 3 years

ANS: C
If a previous pregnancy had a poor outcome, the woman will probably be more anxious during labor and delivery. The woman is not prepared for labor and will have increased anxiety during labor. However, the woman with a poor previous outcome is more likely to experience more anxiety, and good teaching by the nurse will diminish some of the anxiety. A gravida 2 has previous experience and can anticipate what to expect. By refusing any medication, she is taking control over her situation and will have less anxiety. This gravida 3 has previous experience and is aware of what to expect.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 356 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

14. Which method of pain management does the nurse plan for a gravida 3 para 2 admitted at 8-cm cervical dilation?
    a. Epidural anesthesia
    b. Narcotics
    c. Spinal block
    d. Breathing and relaxation techniques

ANS: D
Nonpharmacologic methods of pain management may be the best option for a woman in advanced labor. There is probably not enough remaining time to administer epidural anesthesia or spinal anesthesia. A narcotic given at this time may reach its peak about the time of birth and result in respiratory depression in the newborn.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 357 OBJ: Nursing Process: Planning
MSC: Client Needs: Health Promotion and Maintenance

15. The laboring woman who imagines her body opening to let the baby out is using a mental technique called
    a. dissociation.
    b. effleurage.

c. imagery.
d. distraction.

ANS: C
Imagery is a technique of visualizing images that will assist the woman in coping with labor. Dissociation helps the woman learn to relax all muscles except those that are working. Effleurage is self-massage. Distraction can be used in the early latent phase by having the woman involved in another activity.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 359 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

16. The registered nurse explains to the student that when giving a narcotic to a laboring woman, the nurse should inject the medication at the beginning of a contraction so that
a. full benefit of the medication is received during that contraction.
b. less medication will be transferred to the fetus.
c. the medication will be rapidly circulated.
d. the maternal vital signs will not be adversely affected.

ANS: B
Injecting at the beginning of a contraction, when blood flow to the placenta is normally reduced, limits transfer to the fetus. The full benefit will be received by the woman; however, it will decrease the amount reaching the fetus. It will not increase the circulation of the medication. It will not alter the vital signs any more than giving it at another time.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 367 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

17. The method of anesthesia in labor considered the safest for the fetus is the
a. pudendal block.
b. epidural block.
c. spinal (subarachnoid) block.
d. local infiltration.

ANS: D
Local infiltration of the perineum rarely has any adverse effects on either the mother or the fetus. The fetus can be affected by maternal side effects of the other types of anesthesia.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 362 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

18. A woman received an epidural anesthetic and now her blood pressure is 88/64 mm Hg. What action by the nurse takes priority?
a. Turn the woman to the left side.
b. Place a wedge under the woman’s right hip.
c. Call the provider or nurse-anesthetist immediately.
d. Decrease the intravenous infusion rate.

ANS: B

If hypotension occurs after administration of an epidural, turn the patient to the left lateral side-lying position, and infuse intravenous crystalloids. These actions will improve placental blood flow. Oxygen administration is also recommended, but placing the patient on the left side takes priority. The providers should be notified after corrective actions have occurred.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 373 | Table 18.2 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

19. The priority nursing intervention for the patient who has received an epidural narcotic is
    a. monitoring respiratory rate hourly.
    b. administering analgesics as needed.
    c. monitoring blood pressure every 4 hours.
    d. assessing the level of anesthesia.

    ANS: A
    The possibility of respiratory depression exists for up to 24 hours after administration of an epidural narcotic. The nurse should monitor the woman's respiratory rate hourly during this time frame. Epidural narcotic should be enough pain relief that further medication is not necessary. Administering any other narcotic may cause an overdose. The patient's blood pressure needs to be monitored. However, that is not the major concern with this medication. The epidural narcotic should provide pain relief but not anesthesia.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 367 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

20. One of the greatest risks to the mother during administration of general anesthesia is
    a. respiratory depression.
    b. uterine relaxation.
    c. inadequate muscle relaxation.
    d. aspiration of stomach contents.

    ANS: D
    Aspiration of acidic gastric contents and possible airway obstruction is a potentially fatal complication of general anesthesia. Respirations can be altered during general anesthesia, and the anesthesiologist will take precautions to maintain proper oxygenation. Uterine relaxation can occur with some anesthesia, but this can be monitored and prevented. Inadequate muscle relaxation can be altered. This is not the greatest risk for the mother.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 367 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

21. The student nurse is working with a laboring woman. What action by the student requires the registered nurse to intervene?
    a. Placing the woman in a supine position
    b. Assisting the woman to a sitting position
    c. Turning the woman to a side-lying position
    d. Providing safety while the woman labors while standing

    ANS: A

The supine position allows the heavy uterus to compress the inferior vena cava and can reduce placental blood flow, compromising fetal oxygen supply. The nurse should intervene to position the woman in any of the other positions, which are all appropriate for labor if no contraindications exist.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 363 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

22. A woman had spinal anesthesia for delivery. Now she complains of a pounding headache rated 7/10. What action by the nurse is most appropriate?
    a. Prepare to assist with a blood patch procedure.
    b. Give the woman IV opioid pain medications.
    c. Increase the rate of her nonadditive IV fluids.
    d. Place a cool cloth on her forehead and dim the room lights.

    ANS: A
    The subarachnoid block may cause a postspinal headache due to loss of cerebrospinal fluid from the puncture in the dura. When blood is injected into the epidural space in the area of the dural puncture ("blood patch"), it forms a seal over the hole to stop leaking of cerebrospinal fluid. The spinal anesthesia makes further narcotic administration inadvisable at this time. Increasing IV fluid rate is not needed for headache. A cool cloth and dim lights may be very comforting but will not eliminate this severe headache.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 373 | Table 18.2 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

23. The nurse teaching a childbirth preparation class teaches the participants that the first type of breathing technique used in labor is called
    a. slow-paced.
    b. modified-paced.
    c. patterned-paced.
    d. pant-blow.

    ANS: A
    Breathing for the first stage of labor consists of a cleansing breath and various breathing techniques known as paced breathing. The first type used in labor is the slow-paced. Modified-paced breathing is used when the slow-paced breathing is no longer effective Patterned-paced breathing is used later in the labor and has the woman focusing on a pattern of breathing. Pant-blow breathing can be used to prevent pushing before the cervix is completely dilated.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 359 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

24. When instructing the woman in early labor, the nurse teaches her that an important aspect of proper breathing technique is
    a. breathing no more than three times the normal rate.
    b. beginning and ending with a cleansing breath.

c. holding the breath no longer than 10 seconds.
d. adhering exactly to the techniques as they were taught.

ANS: B
The cleansing breath helps the woman clear her mind to focus on relaxing and signals the coach that the contraction is beginning or ending. It is important to prevent hyperventilation; however, the cleansing breaths are the most important aspect of the breathing techniques. The woman should hold her breath for no more than 6 to 8 seconds. The woman needs to be flexible and change her breathing techniques as needed to keep her comfortable.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 359 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Psychosocial Integrity

25. Which patient is most likely to experience pain during labor?
a. Gravida 2 who has not attended childbirth preparation classes
b. Gravida 2 who is anxious because her last labor was difficult
c. Gravida 1 whose fetus is in a breech presentation
d. Gravida 3 who is using Lamaze breathing techniques

ANS: B
Anxiety affects a woman's perception of pain. Tension during labor causes tightening of abdominal muscles, impeding contractions and increasing pain by stimulation of nerve endings. The gravida 2 has previous experience, and this will decrease anxiety. This woman will have more pain than if the infant is in vertex. Also, there is an increased likelihood that she will have a cesarean section and not go through labor. The gravida 3 has previous experience and has prepared herself for the labor.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 356 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

26. Which type of cutaneous stimulation involves massage of the abdomen?
a. Thermal stimulation
b. Imagery
c. Mental stimulation
d. Effleurage

ANS: D
Effleurage is massage usually performed on the abdomen during contractions. Thermal stimulation is the use of warmth to provide comfort, such as showers and baths. Imagery involves the woman creating a relaxing mental scene and dissociating herself from the painful aspects of labor. Mental stimulation occupies the woman's mind and competes with pain stimuli.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 357 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

27. A woman is experiencing most of her labor pain in her back. What action by the nurse is best?
a. Positioning the woman lying supine with head slightly elevated
b. Showing the support person how to apply firm pressure to the sacrum

c. Assisting the woman to sit upright with the legs straight
d. Massaging her upper back during a contraction

ANS: B
Firm pressure against the sacrum may be helpful in relieving the discomfort associated with back labor. The nurse can provide this action, but including the support person (if desired) is beneficial. The woman should not lie on her back. Sitting up with legs straight would put more pressure onto the lower back area. The massage should be in the lower back where the pain is located.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 358 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

28. Which technique could the support person use when the laboring woman appears to be losing control?
a. Have the nurse take over the role of support.
b. Tell the woman that she is causing stress to her baby and herself.
c. Wait for the contraction to end and discuss the problem with her.
d. Make eye contact with the woman and breathe along with her.

ANS: D
Making eye contact and breathing along with the laboring woman to help pace her breathing will assist her in remaining calm. The woman already has a trusting relationship with the support person so they should stay in that position if possible. Telling the woman she is stressing herself and the baby is very uncaring and will not be helpful. A woman who has lost control will not be able to engage in a productive discussion.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 371 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

29. A nurse admits a woman to the labor and delivery unit who has a history of IV drug abuse. In planning care for this patient, the nurse explains to the student that which pain control plan is contraindicated for this woman?
a. Epidural anesthesia
b. Bolus administration of butorphanol (Stadol)
c. Promethazine (Phenergan) for opioid-induced nausea
d. Naloxone (Narcan) if needed for respiratory depression

ANS: B
Women who are opiate-dependent should not receive analgesics having mixed agonist and antagonist actions (butorphanol and nalbuphine) . Epidural anesthesia not using these drugs is appropriate as are promethazine and naloxone if needed.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: Table 18.2 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

30. A woman has received an epidural block. What action by the nurse takes priority?
a. Instruct her to call for help when getting out of bed.
b. Assess the woman for a post-procedure headache.

c. Determine type and time of last oral intake.
d. Administer metoclopramide within the first hour.

ANS: A
Due to variable leg strength and sensation with an epidural block, the woman who is able to get out of bed needs to call for assistance for safety. Post-procedure headaches are associated with subarachnoid blocks. Oral intake and pro-motility agents are important for the woman having general anesthesia.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: Table 18.2 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

31. What statement by the woman after a childbirth education class demonstrates that she needs more information?
a. "I'm having a pudendal block so control my labor pain."
b. "I may get a headache after a subarachnoid block."
c. "I don't want IV opioids as they may cause breathing problems."
d. "Some anesthetic agents may cause itching but it can be treated."

ANS: A
A pudendal block numbs the lower vagina and perineum for vaginal birth. There is no relief of labor pain because it is done just before birth. This woman needs further education. The other statements are all accurate.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: Table 18.2 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

32. A woman had an epidural place an hour ago and is now complaining of severe itching. What action by the nurse is most appropriate?
a. Discontinue the epidural infusion at once.
b. Notify the anesthesia provider.
c. Prepare to administer diphenhydramine (Benedryl).
d. Prepare to administer promethazine (Phenergan).

ANS: C
Pruritis (itching) is a common side effect of epidural medications. The nurse should be prepared to administer diphenhydramine. There is no need to discontinue the epidural infusion or notify the anesthesia provider. Promethazine is used for nausea.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: Table 18.1 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. While developing an intrapartum care plan for the patient in early labor, it is important that the nurse recognize that psychosocial factors may influence a woman's experience of pain. These include (*Select all that apply.*)
a. culture.

b. anxiety and fear.
c. previous experiences with pain.
d. intervention of caregivers.
e. support systems.

ANS: A, B, C, E
Culture: a woman's sociocultural roots influence how she perceives, interprets, and responds to pain during childbirth. Some cultures encourage loud and vigorous expressions of pain, whereas others value self-control. The nurse should avoid praising some behaviors (stoicism) while belittling others (noisy expression) . Anxiety and fear: extreme anxiety and fear magnify sensitivity to pain and impair a woman's ability to tolerate it. Anxiety and fear increase muscle tension in the pelvic area, which counters the expulsive forces of uterine contractions and pushing efforts. Previous experiences with pain: fear and withdrawal are a natural response to pain during labor. Learning about these normal sensations ahead of time helps a woman suppress her natural reactions of fear regarding the impending birth. If a woman previously had a long and difficult labor, she is likely to be anxious. She may also have learned ways to cope and may use these skills to adapt to the present labor experience. Support systems: an anxious partner is less able to provide help and support to a woman during labor. A woman's family and friends can be an important source of support if they convey realistic and positive information about labor and delivery. Although this may be necessary for the well-being of the woman and her fetus, some interventions add discomfort to the natural pain of labor (i.e., fetal monitor straps).

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 356 OBJ: Nursing Process: Planning
MSC: Client Needs: Psychosocial Integrity

2. The nurse is caring for a laboring patient who develops a fever after she has had her epidural initiated. What actions by the nurse are appropriate? (*Select all that apply.*)
a. Palpate the woman's bladder distention.
b. Assess the woman's blood pressure.
c. Observe the woman for shivering.
d. Check the skin for color and warmth.
e. Prepare to assist with a blood patch.

ANS: C, D
Heat dissipation is reduced as a result of decreased hyperventilation, sweating, and activity after the onset of pain relief. Vasodilation redistributes heat from the core to the periphery of the body, where it is lost to the environment. Assessing the skin will demonstrate findings consistent with vasodilation. Shivering often occurs with sympathetic blockade accompanied by a dissociation between warm and cold sensations. In essence, the body believes that the temperature is lower than it actually is and turns up the "thermostat." Bladder distention is an anticipated effect of having an epidural. A woman's bladder fills quickly because of the large quantity of IV solution, yet her sensation to void is reduced. Maternal hypotension is an expected side effect of epidural initiation. The nurse should assess the bladder and blood pressure, but these actions are not related to the fever. A blood patch procedure is not warranted for this patient.

PTS: 1 DIF: Cognitive Level: Application REF: p. 364
OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

COMPLETION

1. A newborn infant weighing 8 lb needs naloxone (Narcan). This infant should receive approximately _____ mg.

   ANS:
   0.36

   The dose of naloxone is 0.1 mg/kg. This baby weighs 3.6 kg, so 0.1 × 3.6 = 0.36 mg.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: Table 18.1 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. The nurse knows that a urinary catheter is added to the instrument table if a forceps-assisted birth is anticipated. What is the correct rationale for this intervention?
   a. Spontaneous release of urine might contaminate the sterile field.
   b. An empty bladder provides more room in the pelvis.
   c. A sterile urine specimen is needed preoperatively.
   d. A Foley catheter prevents the membranes from spontaneously rupturing.

   ANS: B
   Catheterization provides room for the application of the forceps blades and limits bladder trauma. Urine is sterile. A clean- catch urinalysis is usually sufficient for preoperative treatment. The membranes must be ruptured and the cervix completely dilated for a forceps-assisted birth.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 385 | Box 17.2 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

2. After a forceps-assisted birth, the mother is observed to have continuous bright red lochia but a firm fundus. What other finding is important to correlate with these data?
   a. Mild, intermittent perineal pain
   b. Edema and discoloration of the labia and perineum
   c. Lack of an episiotomy
   d. Lack of pain in the perineal area

   ANS: B
   Edema and discoloration of the labia and perineum along with continuous bright red lochia and firm fundus are correlated with a vaginal wall hematoma. Perineal pain, lack of episiotomy, and lack of pain are not correlated with a hematoma.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 386 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. Prior to cesarean birth, the nurse places the indwelling catheter and tubing in which manner?
   a. Placed on the floor on a sterile drape
   b. Placed near the head of the table
   c. Clamped during the cesarean section
   d. Positioned at the foot of the bed

   ANS: B
   The anesthesia clinician must monitor urine output during the surgery so the catheter and tubing are placed near the head of the table. They are not placed on the floor, even on a sterile drape. The catheter is not clamped because urinary output must be monitored continuously. An early sign of hypovolemia is a decreasing urinary output.

   PTS: 1 DIF: Cognitive Level: Application/Applying

REF: p. 393 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

4. The nurse understands that which condition is a contraindication for an amniotomy?
   a. Dilation less than 3 cm
   b. Cephalic presentation
   c. –2 station
   d. Right occiput posterior position

   ANS: C
   A prolapsed cord can occur if the membranes artificially rupture when the presenting part is not engaged. Engagement is assumed at zero station. The other conditions are not contraindications to this procedure.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 376 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

5. A nursing faculty member explains to students that which patient status is an acceptable indication for serial oxytocin induction of labor?
   a. Past 42 weeks' gestation
   b. Multiple fetuses
   c. Polyhydramnios
   d. History of long labors

   ANS: A
   Continuing a pregnancy past the normal gestational period is likely to be detrimental to fetal health. Multiple fetuses and polyhydramnios overdistend the uterus, making induction of labor high risk. History of rapid labors is a reason for induction of labor because of the possibility that the baby would otherwise be born in uncontrolled circumstances.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 378 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

6. The standard of care for obstetrics dictates that an internal version might be used to manipulate the
   a. fetus from a breech to a cephalic presentation before labor begins.
   b. fetus from a transverse lie to a longitudinal lie before cesarean birth.
   c. second twin from an oblique lie to a transverse lie before labor begins.
   d. second twin from a transverse lie to a breech presentation during vaginal birth.

   ANS: D
   Internal version is used only during vaginal birth to manipulate the second twin into a presentation that allows it to be born vaginally. For internal version to occur, the cervix needs to be completely dilated; the cervix is not dilated before labor begins. An internal version would not be done in the case of a cesarean birth.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 383 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

7. An indication for an episiotomy would be a woman who
   a. has a routine vaginal birth.
   b. has fetal shoulder dystocia.
   c. is delivering a preterm infant.
   d. has a history of rapid deliveries.

   ANS: B
   An episiotomy is indicated in the situation where the shoulder of the fetus becomes lodged under the mother's symphysis pubis during birth. The other situations are not indications for an episiotomy.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 387 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

8. The greatest risk to the newborn after an elective cesarean birth is
   a. trauma due to manipulation during delivery.
   b. tachypnea due to maternal anesthesia.
   c. prematurity due to miscalculation of gestation.
   d. tachycardia due to maternal narcotics.

   ANS: C
   Regardless of the many criteria used to determine gestational age, inadvertent preterm birth still occurs. There is reduced trauma with a cesarean birth. Maternal anesthesia may cause respiratory distress. Maternal narcotics may cause respiratory distress.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 389 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

9. The nurse practicing in a labor setting knows that the woman most at risk for a uterine rupture is a gravida
   a. 3 who has had two low-segment transverse cesarean births.
   b. 2 who has had a low-segment vertical incision for delivery of a 10-pound infant.
   c. 5 who has had two vaginal births and two cesarean births.
   d. 4 who has had four cesarean births.

   ANS: D
   The risk of uterine rupture increases as the number of prior uterine incisions increases. More than two previous cesarean births places the woman at increased risk for uterine rupture. The other women are not high-risk candidates.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 388 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

10. The nurse caring for a woman in labor understands that the primary risk associated with an amniotomy is
    a. maternal infection.
    b. maternal hemorrhage.
    c. prolapse of the umbilical cord.
    d. separation of the placenta.

ANS: C
When the membranes are ruptured, the umbilical cord may come downward with the flow of amniotic fluid and become trapped in front of the presenting part. Infection is a risk of amniotomy but not the primary concern. Maternal hemorrhage is not associated with amniotomy. Separation of the placenta may occur if the uterus is overdistended before the amniotomy, but it is not the major concern.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 376 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

11. Before the physician performs an external version, the nurse should expect an order for a
    a. tocolytic drug.
    b. contraction stress test (CST).
    c. local anesthetic.
    d. indwelling catheter.

ANS: A
A tocolytic drug will relax the uterus before and during version, making manipulation easier. A contraction stress test, local anesthetics, and indwelling catheters are not needed.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 383 OBJ: Nursing Process: Planning
MSC: Client Needs: Health Promotion and Maintenance

12. A maternal indication for the use of vacuum extraction is
    a. a wide pelvic outlet.
    b. maternal exhaustion.
    c. a history of rapid deliveries.
    d. failure to progress past 0 station.

ANS: B
A mother who is exhausted will be unable to assist with the expulsion of the fetus and is a candidate for vacuum extraction. With a wide pelvic outlet and rapid delivery, vacuum extraction is not necessary. A station of 0 is too high for a vacuum extraction.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 384 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

13. After an amniotomy, which action by the nurse takes priority?
    a. Assess the color of the amniotic fluid.
    b. Change the patient’s gown.
    c. Estimate the amount of amniotic fluid.
    d. Assess the fetal heart rate.

ANS: D
The fetal heart rate must be assessed immediately after the rupture of the membranes to determine whether cord prolapse or compression has occurred. Assessing the amniotic fluid color, changing the patient’s gown, and estimating the amount of amniotic fluid lost are all appropriate interventions but not the priority.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 376 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

14. For which patient should the oxytocin (Pitocin) infusion be discontinued immediately?
    a. A woman in active labor with contractions every 31 minutes lasting 60 seconds each
    b. A woman in transition with contractions every 2 minutes lasting 90 seconds each
    c. A woman in active labor with contractions every 2 to 3 minutes lasting 70 to 80 seconds each
    d. A woman in early labor with contractions every 5 minutes lasting 40 seconds each

    ANS: B
    This woman's contraction pattern represents hyperstimulation, and inadequate resting time occurs between contractions to allow placental perfusion. The other women can continue to use the oxytocin at this point.

    PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
    REF: p. 378 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

15. The priority nursing care associated with an oxytocin (Pitocin) infusion is
    a. measuring urinary output.
    b. increasing infusion rate every 30 minutes.
    c. monitoring uterine response.
    d. evaluating cervical dilation.

    ANS: C
    Because of the risk of hyperstimulation, which could result in decreased placental perfusion and uterine rupture, the nurse's priority intervention is monitoring uterine response. Monitoring urinary output and cervical dilation is appropriate but not the priority. The infusion rate may be increased but only after proper assessment determines that it is appropriate.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 380 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Safe and Effective Care Environment

16. Which event indicates a complication of an external version?
    a. Maternal pulse rate of 100 bpm
    b. Fetal bradycardia persisting 10 minutes after the version
    c. Fetus returning to the original position
    d. Increased maternal anxiety after the version

    ANS: B
    Fetal bradycardia after a version may indicate that the umbilical cord has become compressed, and the fetus is having hypoxia. There are few risks to the woman during an external version. The fetus may return to the original position, but this is not a complication of the version. Anxiety may occur before the version but should decrease after the procedure is completed.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering

REF: p. 383 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

17. Immediately after the forceps-assisted birth of an infant, which action by the nurse is next?
    a. Assess the infant for signs of trauma.
    b. Give the infant prophylactic antibiotics.
    c. Apply a cold pack to the infant's scalp.
    d. Measure the circumference of the infant's head.

    ANS: A
    Forceps delivery can result in local irritation, bruising, or lacerations of the fetal scalp. Prophylactic antibiotics are not necessary with a forceps delivery. This would put the infant at risk for cold stress and would be contraindicated. Measuring the circumference of the head is part of the initial nursing assessment.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 386 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

18. When preparing a woman for a cesarean birth, the nurse's care should include
    a. injection of narcotic preoperative medications.
    b. full perineal shave preparation.
    c. straight catheterization to empty the bladder.
    d. administration of an oral antacid.

    ANS: D
    General anesthesia may be needed unexpectedly for cesarean birth. An oral antacid neutralizes gastric acid and reduces potential lung injury if the woman vomits and aspirates gastric contents during anesthesia. A narcotic at this point would put the fetus at high risk for respiratory distress. Perineal preparation is not necessary for a cesarean section. Some agencies will do an abdominal prep just before the surgery. The catheterization should be indwelling in order to keep the bladder small during the surgery.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 389 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

19. Surgical, medical, or mechanical methods may be used for labor induction. Which technique is considered a mechanical method of induction?
    a. Amniotomy
    b. Intravenous Pitocin
    c. Transcervical catheter
    d. Vaginal insertion of prostaglandins

    ANS: C
    Placement of a balloon-tipped Foley catheter into the cervix is a mechanical method of induction. Other methods to expand and gradually dilate the cervix include *Laminaria* tents, Dilapan, and Lamicel. Amniotomy is a surgical method of augmentation and induction. Intravenous Pitocin is a medical method of induction. Insertion of prostaglandins is a medical method of induction.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering

REF: p. 378 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

20. What is an appropriate response to a woman's comment that she is worried about having a cesarean birth?
    a. "Don't worry. Everything will be okay."
    b. "What are your feelings about having a cesarean birth?"
    c. "I know you're worried, but this is a routine procedure."
    d. "Patients commonly worry about surgery."

    ANS: B
    Allowing the patient to express her feelings is the most appropriate nursing response. The nurse should never provide the patient with false reassurance or disregard or belittle her feelings, which is what the other options do.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 391 | Nursing Care Plan
    OBJ: Integrated Process: Communication and Documentation
    MSC: Client Needs: Psychosocial Integrity

21. While assisting with a vacuum extraction birth, what should the nurse immediately report to the provider?
    a. Persistent fetal bradycardia below 100 bpm
    b. Maternal pulse rate of 100 bpm
    c. Maternal blood pressure of 120/70 mm Hg
    d. Decrease in intensity of uterine contractions

    ANS: A
    Fetal bradycardia may indicate fetal distress and may require immediate intervention. Maternal pulse rate may increase due to the pushing process. This blood pressure is within expected norms for this stage of labor. The birth is imminent at this point.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 384 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

22. To monitor for potential hemorrhage in the woman who has just had a cesarean birth, what action by the recovery room nurse is most appropriate?
    a. Maintain an intravenous infusion at 100 mL/hr.
    b. Assess the abdominal dressings for drainage.
    c. Assess the uterus for firmness every 15 minutes.
    d. Monitor her urinary output.

    ANS: C
    Maintaining contraction of the uterus is important in controlling bleeding from the placental site. Maintaining proper fluid balance will not control hemorrhage. Assessing abdominal dressings is an important assessment, but hemorrhage will first be noted vaginally. Urinary output typically drops in hemorrhage, but this is a later finding.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 393 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

23. A new graduate nurse is preparing to hang oxytocin for a woman to augment her labor. What action by the new nurse warrants intervention from the preceptor?
    a. Adds oxytocin to the IV as a piggyback
    b. Programs the IV pump for a primary infusion
    c. Assesses FHR and uterine activity prior to starting the infusion
    d. Attaches the infusion line to the proximal port

    ANS: B
    Oxytocin is run as a secondary infusion on a pump. When the new nurse programs it as the primary infusion, the preceptor should intervene. Oxytocin should be added to the most proximal IV port. FHR and uterine activity should be assessed prior to starting the infusion.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 379 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

24. A woman is receiving oxytocin to augment labor. The nurse notes that the Montevideo units are measured at 560 and the fetus is showing late decelerations. What action by the nurse takes priority?
    a. Notify the charge nurse of the situation.
    b. Document the findings in the chart.
    c. Increase the rate of oxytocin slowly.
    d. Stop the oxytocin infusion.

    ANS: D
    This woman is showing signs of uterine tachysystole. The nurse first turns the oxytocin infusion off. Notifying the charge nurse and documentation are important but not the priority. The nurse would not increase the rate of the infusion.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 382 | Safety Alert Box OBJ: Nursing Process: Implementation
    MSC: Client Needs: Safe and Effective Care Environment

25. A woman is going to have a vaccum extraction delivery. What nursing intervention is most important to prevent complications?
    a. Empty the woman’s bladder.
    b. Apply cold packs to the perineum.
    c. Assess vital signs after the procedure.
    d. Monitor the woman’s temperature.

    ANS: A
    The nurse should empty the woman’s bladder prior to vacuum extraction delivery. Ice packs can help with pain and prevent or limit the size of hematomas, but that is not the most important safety measure. Assessing vital signs will not prevent complications from occurring but will help identify them when they occur.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 386 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Safe and Effective Care Environment

MULTIPLE RESPONSE

1. The labor and delivery nurse must be cognizant of the specific conditions appropriate for labor induction, including which of the following? (*Select all that apply.*)
   a. Rupture of membranes at or near term
   b. Convenience of the woman or her physician
   c. Chorioamnionitis
   d. Postterm pregnancy
   e. Fetal death

   ANS: A, C, D, E
   Rupture of membranes at or near term, chorioamnionitis, postterm pregnancy, and fetal death are all appropriate indications for induction of labor. Convenience is not.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: pp. 377-378 OBJ: Nursing Process: Planning
   MSC: Client Needs: Health Promotion and Maintenance

2. The labor and delivery nurse learns that recommendations from ACOG related to VBAC risks include which of the following? (*Select all that apply.*)
   a. Immediate availability of the obstetric provider
   b. Delivery at a tertiary care center
   c. Availability of anesthesia personnel
   d. Personnel who can assist with the cesarean birth
   e. Use of misoprostol for cervical ripening

   ANS: A, C, D
   A VBAC delivery should only be attempted with the obstetric provider in house and anesthesia along with operative personnel readily available to perform a cesarean birth. VBAC deliveries may be done in community hospitals if appropriate policies and guidelines for care are in place. Misoprostol administration is contraindicated in a patient with a previous uterine scar.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 388 | Box 19.1 OBJ: Nursing Process: Planning
   MSC: Client Needs: Health Promotion and Maintenance

COMPLETION

1. A nurse assesses a woman and gathers the following data:
   Dilation: 4 cm
   Effacement: 60%
   Fetal station: 0
   Cervical consistency: medium
   Cervical position: middle
   Calculate this woman's Bishop score _____

   ANS:
   8

This scoring system evaluates the woman’s cervix and how easily labor can be induced. The individual components are: 2-2-2-1-1 = 8.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: Table 19.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE CHOICE

1. A postpartum woman overhears the nurse tell the obstetrics clinician that she has a positive Homans sign and asks what it means. The nurse's best response is
   a. "You have pitting edema in your ankles."
   b. "You have deep tendon reflexes rated 2+."
   c. "You have calf pain when I flexed your foot."
   d. "You have a 'fleshy' odor to your vaginal drainage."

   ANS: C
   Discomfort in the calf with sharp dorsiflexion of the foot may indicate a deep vein thrombosis. It does not indicate edema, rate deep tendon reflexes, or describe the odor of lochia.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 404 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

2. Which woman is most likely to have severe afterbirth pains and request a narcotic analgesic?
   a. Gravida 5, para 5
   b. Woman who is bottle-feeding her first child
   c. Primipara who delivered a 7-lb boy
   d. Woman who has started to breastfeed

   ANS: A
   The discomfort of after pains is more acute for multiparas because repeated stretching of muscle fibers leads to loss of uterine muscle tone. After pains are particularly severe during breastfeeding, not bottle-feeding. The uterus of a primipara tends to remain contracted. The breastfeeding woman may have increased pain due to engorgement, but the multipara probably will have the most severe afterbirth pains.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 396 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. Which maternal event is abnormal in the early postpartum period?
   a. Diuresis and diaphoresis
   b. Flatulence and constipation
   c. Extreme hunger and thirst
   d. Lochial color changes from rubra to alba

   ANS: D

For the first 3 days after childbirth, lochia is mostly red and is termed rubra. Lochia serosa follows, and then at about 11 days, the discharge becomes clear, colorless, or white. The body rids itself of increased plasma volume after birth. Urine output of 3000 mL/day is common for the first few days after delivery and is facilitated by hormonal changes in the mother. Bowel tone remains sluggish for days after birth, leading to flatulence and constipation. The new mother is hungry and thirsty because of energy used in labor and thirsty because of fluid restrictions during labor.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 396 | Table 20.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

4. Which finding 12 hours after birth requires further assessment?
   a. The fundus is palpable two fingerbreadths above the umbilicus.
   b. The fundus is palpable at the level of the umbilicus.
   c. The fundus is palpable one fingerbreadth below the umbilicus.
   d. The fundus is palpable two fingerbreadths below the umbilicus.

   ANS: A
   The fundus rises to the umbilicus after delivery and remains there for about 24 hours. A fundus that is above the umbilicus may indicate uterine atony or urinary retention. The nurse needs to make further assessments. The other findings are within normal limits for the time period.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 395 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

5. If the patient's white blood cell (WBC) count is 25,000/mm^3 on her second postpartum day, the nurse should
   a. tell the physician immediately.
   b. have the laboratory draw blood for reanalysis.
   c. recognize that this is an acceptable range at this point.
   d. begin antibiotic therapy immediately.

   ANS: C
   Marked leukocytosis occurs with WBC counts increasing to as high as 30,000/mm^3 during labor and the immediate postpartum period. The WBC falls to normal within 6 days postpartum. No action is necessary.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 397 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

6. Postpartal overdistention of the bladder and urinary retention can lead to which complication?
   a. Postpartum hemorrhage and eclampsia
   b. Fever and increased blood pressure
   c. Postpartum hemorrhage and urinary tract infection
   d. Urinary tract infection and uterine rupture

   ANS: C

Incomplete emptying and overdistention of the bladder can lead to urinary tract infection. Overdistention of the bladder displaces the uterus and prevents contraction of the uterine muscle. There is no correlation between bladder distention and eclampsia, blood pressure, or fever. The risk of uterine rupture decreases after the birth.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 398 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

7. A postpartum patient asks, “Will these stretch marks go away?” The nurse’s best response is
   a. “They will fade and be gone by your 6-week checkup.”
   b. “No, unfortunately they will never fade away.”
   c. “Yes, eventually they will totally disappear.”
   d. “They will fade to silvery lines but won’t disappear completely.”

   ANS: D
   The stretch marks will fade to silvery lines but will not disappear completely.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 399 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

8. A pregnant patient asks when the dark line on her abdomen (linea nigra) will go away. The nurse knows the pigmentation will decrease after delivery because of
   a. increased estrogen.
   b. increased progesterone.
   c. decreased melanocyte-stimulating hormone.
   d. decreased human placental lactogen.

   ANS: C
   Melanocyte-stimulating hormone increases during pregnancy and is responsible for changes in skin pigmentation; the amount decreases after delivery. The linea nigra will eventually fade away for most women. Estrogen and progesterone levels decrease after delivery. Human placental lactogen production continues to aid in lactation. However, it does not affect pigmentation.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 399 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

9. If the fundus is palpated on the right side of the abdomen above the expected level, the nurse should suspect that the patient has
   a. been lying on her right side too long.
   b. a distended bladder.
   c. stretched ligaments that are unable to support the uterus.
   d. a normal involution.

   ANS: B
   The presence of a full bladder will displace the uterus. This finding does not signify a problem with positioning or ligaments, nor is it an expected finding.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering

REF: p. 403 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

10. A woman gave birth vaginally to a 9-pound, 12-ounce girl yesterday. Her primary health care provider has written orders for perineal ice packs, use of a sitz bath tid, and a stool softener. What information is most closely correlated with these orders?
    a. The woman is a gravida 2, para 2.
    b. The woman had a vacuum-assisted birth.
    c. The woman received epidural anesthesia.
    d. The woman has an episiotomy.

    ANS: D
    These orders are typical interventions for a woman who has had an episiotomy, lacerations, and hemorrhoids. A multiparous classification is not an indication for these orders. A vacuum-assisted birth may be used in conjunction with an episiotomy, which indicates these interventions, but that is not the only situation in which an episiotomy would be used, so this is not the best answer. Use of epidural anesthesia has no correlation with these orders.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 397 OBJ: Nursing Process: Planning
    MSC: Client Needs: Health Promotion and Maintenance

11. Rh_o immune globulin will be ordered postpartum if which situation occurs?
    a. Mother Rh–, baby Rh+
    b. Mother Rh–, baby Rh–
    c. Mother Rh+, baby Rh+
    d. Mother Rh+, baby Rh–

    ANS: A
    An Rh– mother delivering an Rh+ baby may develop antibodies to fetal cells that entered her bloodstream when the placenta separated. The Rho immune globulin works to destroy the fetal cells in the maternal circulation before sensitization occurs. The other blood type combinations would not necessitate the use of Rhogam.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 400 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

12. If rubella vaccine is indicated for a postpartum patient, instructions to the patient should include
    a. drinking plenty of fluids to prevent fever.
    b. no specific instructions.
    c. recommending that she stop breastfeeding for 24 hours after injection.
    d. explaining the risks of becoming pregnant within 1 month after injection.

    ANS: D
    Potential risks to the fetus can occur if pregnancy results within 28 days after rubella vaccine administration. Drinking fluids will not prevent a fever. Small amounts of the vaccine do cross the breast milk, but it is believed that there is no need to discontinue breastfeeding.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 400 OBJ: Nursing Process: Implementation

MSC: Client Needs: Health Promotion and Maintenance

13. Which nursing action is most appropriate to correct a boggy uterus that is displaced above and to the right of the umbilicus?
    a. Notify the provider of an impending hemorrhage.
    b. Assess the blood pressure and pulse.
    c. Evaluate the lochia.
    d. Assist the patient in emptying her bladder.

    ANS: D
    Urinary retention can cause overdistention of the urinary bladder, which lifts and displaces the uterus. Nursing actions need to be implemented before notifying the provider. Blood pressure, pulse, and lochia are important to assess, but first the nurse assesses the bladder so corrective action can be taken if needed.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 402 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

14. When caring for a newly delivered woman, the nurse is aware that the best measure to prevent abdominal distention after a cesarean birth is
    a. rectal suppositories.
    b. early and frequent ambulation.
    c. tightening and relaxing abdominal muscles.
    d. providing carbonated beverages.

    ANS: B
    Activity can aid the movement of accumulated gas in the gastrointestinal tract so early, and frequent ambulation is the best option. Rectal suppositories can be helpful after distention occurs but do not prevent it. Tightening and relaxing the abdominal muscles is not related. Carbonated beverages may increase distention.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 406 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

15. What documentation on a woman’s chart on postpartum day 14 indicates a normal involution process?
    a. Moderate bright red lochial flow
    b. Breasts firm and tender
    c. Fundus below the symphysis and not palpable
    d. Episiotomy slightly red and puffy

    ANS: C
    The fundus descends 1 cm/day, so by postpartum day 14 it is no longer palpable. The lochia should be changed by this day to serosa. Breasts are not part of the involution process. The episiotomy should not be red or puffy at this stage.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 395 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

16. To assess fundal contraction 6 hours after cesarean delivery, the nurse should
    a. palpate forcefully through the abdominal dressing.
    b. gently palpate, applying the same technique used for vaginal deliveries.
    c. place hands on both sides of the abdomen and press downward.
    d. rely on assessment of lochial flow rather than palpating the fundus.

    ANS: B
    Assessment of the fundus is the same for both vaginal and cesarean deliveries; however, palpation should be gentle due to increased discomfort caused by the uterine incision. Forceful palpation should never be used. The top of the fundus, not the sides, should be palpated and massaged. The fundus should be palpated and massaged to prevent bleeding.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 403 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

17. The mother-baby nurse is able to recognize reciprocal attachment behavior. What does this refer to?
    a. The positive feedback an infant exhibits toward parents during the attachment process
    b. Behavior during the sensitive period when the infant is in the quiet alert stage
    c. Unidirectional behavior exhibited by the infant, initiated and enhanced by eye contact
    d. Behavior by the infant during the sensitive period to elicit feelings of “falling in love” from the parents

    ANS: A
    In this definition, reciprocal refers to the feedback from the infant during the attachment process.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 412 | Nursing Quality Alert Box OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

18. The postpartum woman who continually repeats the story of her labor, delivery, and recovery experiences is
    a. providing others with her knowledge of events.
    b. making the birth experience “real.”
    c. taking hold of the events leading to her labor and delivery.
    d. accepting her response to labor and delivery.

    ANS: B
    Reliving the birth experience makes the event real and helps the mother realize that the pregnancy is over and that the infant is born and is now a separate individual. She is in the taking-in phase, trying to make the birth experience seem real. This process meets her needs, not those of others.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 413 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

19. During which stage of role attainment do the parents become acquainted with their baby and combine parenting activities with cues from the infant?
    a. Anticipatory
    b. Formal
    c. Informal
    d. Personal

    ANS: B
    A major task of the formal stage of role attainment is getting acquainted with the infant. The anticipatory stage begins during the pregnancy when the parents choose a physician and attend childbirth classes. The informal stage begins once the parents have learned appropriate responses to their infant's cues. The personal stage is attained when parents feel a sense of harmony in their role.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 413 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

20. A nurse observes a mother on her first postpartum day sitting in bed while her newborn lies awake in the bassinet. What action by the nurse is best?
    a. Realize that this situation is perfectly acceptable.
    b. Offer to hand the baby to the woman.
    c. Hand the baby to the woman.
    d. Explain "taking in" to the woman.

    ANS: C
    During the "taking-in" phase of maternal adaptation, in which the mother may be passive and dependent, the nurse should encourage bonding when the infant is in the quiet alert stage. This is done best by simply giving the baby to the mother. While acceptable, the nurse can still facilitate infant bonding. The woman is dependent and passive at this stage and may have difficulty making a decision so offering her the baby is not the best option. Women learn best in the taking-hold phase.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 413 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Psychosocial Integrity

21. A nurse is observing a family. The mother is holding the baby she delivered less than 24 hours ago. Her husband is watching his wife and asking questions about newborn care. The 4-year-old brother is punching his mother on the back. What action by the nurse is best?
    a. Report the incident to the social services department.
    b. Advise the parents that the toddler needs to be reprimanded.
    c. Report to oncoming staff that the mother is not a good disciplinarian.
    d. Realize that this is a normal family adjusting to family change.

    ANS: D
    The observed behaviors are normal variations of families adjusting to change. The nurse could provide suggestions on managing the adjustments. There is no need to report this one incident. The child does not need to be reprimanded, however; when the family is receptive the nurse could provide anticipatory guidance for this situation and help them problem solve. The nurse should avoid labeling the parents.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 416 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

22. What is the best way for the nurse to promote and support the maternal-infant bonding process?
    a. Help the mother identify her positive feelings toward the newborn.
    b. Encourage the mother to provide all newborn care.
    c. Assist the family with rooming-in.
    d. Return the newborn to the nursery during sleep periods.

    ANS: C
    Close and frequent interaction between mother and infant, which is facilitated by rooming-in, is important in the bonding process. This is often referred to as the mother -baby care or couplet care. Having the mother express her feelings is important, but it is not the best way to promote bonding. The mother needs time to rest and recuperate; she should not be expected to do all of the care. The mother needs to observe the infant during all stages so she will be aware of what to expect when they go home.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 419 OBJ: Nursing Process: Planning
    MSC: Client Needs: Psychosocial Integrity

23. During which phase of maternal adjustment will the mother relinquish the baby of her fantasies and accept the real baby?
    a. Letting go
    b. Taking hold
    c. Taking in
    d. Taking on

    ANS: A
    Accepting the real infant and relinquishing the fantasy infant occurs during the letting-go phase of maternal adjustment. During the taking-hold phase the mother assumes responsibility for her own care and shifts her attention to the infant. In the taking-in phase the mother is primarily focused on her own needs. There is no taking-on phase of maternal adjustment.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 419 | Table 20.3 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

24. A 25-year-old gravida 1 para 1 who had an emergency cesarean birth 3 days ago is scheduled for discharge. As the nurse prepares her for discharge, she begins to cry. What action should the nurse take first?
    a. Assess her for pain.
    b. Point out how lucky she is to have a healthy baby.
    c. Explain that she is experiencing postpartum blues.
    d. Allow her time to express her feelings.

    ANS: D

Many women experience transient postpartum blues and need assistance in expressing their feelings. This condition affects 70% to 80% of new mothers. The nurse should allow time for the new mother to express herself. The nurse should not assume she is in pain at this point. Pointing out how lucky she is belittles her feelings. Patient teaching can be done later.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: pp. 415-416 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

25. A man calls the nurse's station stating that his wife, who delivered 2 days ago, is happy one minute and crying the next. The man says, "She was never like this before the baby was born." What response by the nurse is best?
    a. Tell him to ignore the mood swings, as they will go away.
    b. Reassure him that this behavior is normal.
    c. Advise him to get immediate psychological help for her.
    d. Instruct him in the signs, symptoms, and duration of postpartum blues.

    ANS: B
    Before providing further instructions, inform family members of the fact that postpartum blues are a normal process to allay anxieties and increase receptiveness to learning. Telling him the mood swings will go away is belittling his concerns. Postpartum blues are a normal process that is short lived; no medical intervention is needed. Client teaching is important; however, his anxieties need to be allayed before he will be receptive to teaching.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: pp. 415-416 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Psychosocial Integrity

26. To promote bonding and attachment immediately after delivery, what action by the nurse is most important?
    a. Allow the mother quiet time with her infant.
    b. Assist the mother in assuming an *en face* position with her newborn.
    c. Teach the mother about the concepts of bonding and attachment.
    d. Assist the mother in feeding her baby.

    ANS: B
    Assisting the mother in assuming an en face position with her newborn will support the bonding process. Quiet time with the infant is helpful but not as important as *en face* positioning. The mother has just delivered and is more focused on the infant; she will not be receptive to teaching at this time. This is a good time to initiate breastfeeding, but this is not as specific to bonding and attachment as the *en face* position.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 420 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

27. In providing support to a new mother who must return to full-time employment 6 weeks after a vaginal delivery, which action by the nurse is best?
    a. Allow her to express her positive and negative feelings freely.
    b. Reassure her that she'll get used to leaving her baby.
    c. Discuss child care arrangements with her.

d. Allow her to solve the problem on her own.

ANS: A
Allowing the patient to express feelings will provide positive support in her process of maternal adjustment. Simply reassuring the mother blocks further communication and belittles her feelings. Discussing child care arrangements should wait until she has expressed herself. She should be instrumental in solving the problem; however, allowing her time to express her feelings and talk the problem over will assist her in making this decision.

PTS: 1 DIF: Cognitive Level: Application/Application
REF: p. 415 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

28. A new father states, “I know nothing about babies,” but he seems to be interested in learning. What action by the nurse is best?
a. Continue to observe his interaction with the newborn.
b. Tell him when he does something wrong.
c. Show no concern, as he will learn on his own.
d. Include him in teaching sessions.

ANS: D
The nurse must be sensitive to the father’s needs and include him whenever possible. As fathers take on care new role, the nurse should praise every attempt even if his early care is awkward. It is important to note the bonding process of the mother and the father, but that does not satisfy the expressed needs of the father. He should be encouraged by pointing out the correct procedures he does. Criticizing him will discourage him. The nurse should be sure to include him in all teaching sessions.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 422 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

29. A 25-year-old multiparous woman gave birth to an infant boy 1 day ago. Today her husband brings a large container of brown seaweed soup to the hospital. When the nurse enters the room, the husband asks for help with warming the soup so that his wife can eat it. The nurse’s most appropriate response is to ask the woman
a. “Didn’t you like your lunch?”
b. “Does your doctor know that you are planning to eat that?”
c. “What is that anyway?”
d. “I’ll warm the soup in the microwave for you.”

ANS: D
This statement shows cultural sensitivity to the dietary preferences of the woman and is the most appropriate response. Cultural dietary preferences must be respected. Women may request that family members bring favorite or culturally appropriate foods to the hospital. Asking if the provider knows she is eating this soup is insensitive.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 418 OBJ: Integrated Process: Culture and Spirituality
MSC: Client Needs: Psychosocial Integrity

30. A postpartum woman is unable to empty her bladder. What intervention would the nurse try last?
    a. Pouring water from a squeeze bottle over the woman's perineum
    b. Providing hot tea
    c. Asking the physician to prescribe analgesics
    d. Inserting a sterile catheter

    ANS: D
    Invasive procedures usually are the last to be tried, especially with so many other simple methods available. Pouring water over the perineum may stimulate voiding. It is easy, noninvasive, and should be tried early on. Hot tea or other fluids ad lib is an easy, noninvasive strategy that should be tried early on. If the woman is anticipating pain from voiding, pain medications may be helpful. Other nonmedical means could be tried first, but medications still come before insertion of a catheter.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 405 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

31. The nurse caring for the postpartum woman understands that breast engorgement is caused by
    a. overproduction of colostrum.
    b. accumulation of milk in the lactiferous ducts and glands.
    c. hyperplasia of mammary tissue.
    d. congestion of veins and lymphatics.

    ANS: D
    Breast engorgement is caused by the temporary congestion of veins and lymphatics, not overproduction of colostrum, accumulation of milk, or hyperplasia.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 404 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

32. Which hormone remains elevated in the immediate postpartum period of the breastfeeding woman?
    a. Estrogen
    b. Progesterone
    c. Prolactin
    d. Human placental lactogen

    ANS: C
    Prolactin levels in the blood increase progressively throughout pregnancy. In women who breastfeed, prolactin levels remain elevated into the sixth week after birth. Estrogen and progesterone levels decrease markedly after expulsion of the placenta, reaching their lowest levels 1 week into the postpartum period. Human placental lactogen levels dramatically decrease after expulsion of the placenta.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 400 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

33. The nurse explains to the nursing student that one mechanism for the diaphoresis and diuresis experienced during the early postpartum period is which of the following?
    a. Elevated temperature caused by postpartum infection
    b. Increased basal metabolic rate after giving birth
    c. Loss of increased blood volume associated with pregnancy
    d. Increased venous pressure in the lower extremities

    ANS: C
    Within 12 hours of birth, women begin to lose the excess tissue fluid that has accumulated during pregnancy. One mechanism for reducing these retained fluids is the profuse diaphoresis that often occurs, especially at night, for the first 2 or 3 days after childbirth. Postpartal diuresis is another mechanism by which the body rids itself of excess fluid. An elevated temperature causes chills and may cause dehydration, not diaphoresis and diuresis. Diaphoresis and diuresis are not caused by an increase in the basal metabolic rate. Postpartal diuresis may be caused by the removal of increased venous pressure in the lower extremities.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 397 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

34. Which condition seen in the postpartum period is likely to require careful medical assessment?
    a. Varicosities of the legs
    b. Carpal tunnel syndrome
    c. Periodic numbness and tingling of the fingers
    d. Headaches

    ANS: D
    Headaches in the postpartum period can have a number of causes, some of which deserve medical attention. Varicosities are common. Carpal tunnel syndrome is relieved in childbirth when the compression on the median nerve is lessened. Periodic numbness of the fingers usually disappears after birth unless carrying the baby aggravates the condition.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 399 OBJ: Nursing Process: Evaluation
    MSC: Client Needs: Physiologic Integrity

35. A nurse has taught a woman how to do Kegel exercises. What statement by the patient shows good understanding?
    a. “I contract my thighs, buttocks, and abdomen.”
    b. “I do 10 of these exercises every day.”
    c. “I stand while practicing this new exercise routine.”
    d. “I pretend that I am trying to stop the flow of urine midstream.”

    ANS: D

The woman can pretend that she is attempting to stop the passing of gas, or the flow of urine midstream. This will replicate the sensation of the muscles drawing upward and inward. Each contraction should be as intense as possible without contracting the abdomen, buttocks, or thighs. Guidelines suggest that these exercises should be done 24 to 100 times per day. Positive results are shown with a minimum of 24 to 45 repetitions per day. The best position to learn Kegel exercises is to lie supine with knees bent. A secondary position is on the hands and knees.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 407 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Health Promotion and Maintenance: Self-Care

36. A nurse is examining a woman 2 months after delivery. The woman has lost 25 pounds. What action by the nurse is best?
    a. Counsel her on other weight loss measures.
    b. Ask her for a dietary recall for 3 days.
    c. Instruct her on exercises for faster loss.
    d. Explain that her weight loss is affecting her breast milk.

    ANS: B
    This woman has lost too much weight for being 8 weeks postpartum. Gradual weight loss is recommended, so the nurse should first assess the woman's eating habits by conducting a nutrition history. From that information the nurse can help the woman plan a safer weight loss plan. She does not need to lose weight faster, so counseling her on weight loss measures or more exercise is not beneficial. Telling her she is harming her baby is not therapeutic and may make her less likely to listen to the nurse.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 415 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

37. A nurse has taught a woman and partner about measures to improve sexuality after childbirth. Which statement by the partner demonstrates a need for further teaching?
    a. "We will use water-soluble lubricant before intercourse."
    b. "We can try having sex in the morning when we are rested."
    c. "Breastfeeding before sex will increase vaginal lubrication."
    d. "My wife will be more comfortable if she is on top."

    ANS: C
    Breastfeeding just prior to intercourse may allow uninterrupted time while the baby sleeps afterward, although it will not increase vaginal lubrication. It also decreases the chance of leaking milk. The other statements show good understanding.

    PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
    REF: p. 409 OBJ: Nursing Process: Evaluation
    MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. Nurses must be aware of the conditions that increase the risk of hemorrhage, one of the most common complications of the puerperium. What are these conditions? (*Select all that apply.*)

a. Primipara
b. Rapid or prolonged labor
c. Overdistention of the uterus
d. Uterine fibroids
e. Preeclampsia

ANS: B, C, D, E
Rapid or prolonged labor, overdistention of the uterus, uterine fibroids, and preeclampsia are all risk factors for postpartum hemorrhage. Being a primipara is not a risk factor.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 401 | Safety Alert Box OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

2. Many women given up smoking during pregnancy to protect the health of the fetus. The majority of women resumed smoking within the first 6 months postpartum. Factors that increase the likelihood of relapse include (*Select all that apply.*)
a. living with a smoker.
b. returning to work.
c. weight concerns.
d. successful breastfeeding.
e. failure to breastfeed.

ANS: A, C, E
Living with a smoker, weight concerns, and failure to breastfeed are all associated with a higher relapse rate after smoking cessation during pregnancy.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 415 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

3. The nurse assesses a woman's episiotomy or perineal laceration using the acronym REEDA. What factors does this include? (*Select all that apply.*)
a. Redness
b. Edema
c. Approximation
d. Depth
e. Discharge

ANS: A, B, C, E
The acronym REEDA indicates *redness*, *edema*, *ecchymosis* or bruising, *discharge*, and *approximation.* Depth is not a consideration with this acronym.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 402 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

4. A woman's chart indicates she has a second-degree laceration. When assessing this patient, the nurse plans to observe which of the following structures? (*Select all that apply.*)
a. Vaginal mucosa
b. Perineal skin
c. Peritoneal muscle

d. Anus
e. Rectum

ANS: A, B, C
A second- degree perineal laceration includes vaginal mucosa, perineal skin, and peritoneal muscle. A third-degree laceration involves the anus, while a fourth-degree laceration includes the rectum.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: Box 20.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE CHOICE

1. A nursing student is helping the nursery nurses with morning vital signs. A baby born 10 hours ago via cesarean section is found to have moist lung sounds. What is the best interpretation of these data?
   a. The nurse should notify the pediatrician stat for this emergency situation.
   b. The neonate must have aspirated surfactant.
   c. If this baby was born vaginally, it could indicate a pneumothorax.
   d. The lungs of a baby delivered by cesarean section may sound moist for 24 hours after birth.

   ANS: D
   The condition will resolve itself within a few hours. For this common condition of newborns, surfactant acts to keep the expanded alveoli partially open between respirations. In vaginal births, absorption of remaining lung fluid is accelerated by the process of labor and delivery. Remaining lung fluid will move into interstitial spaces and be absorbed by the circulatory and lymphatic systems. There is no need to notify the pediatrician. Surfactant is produced by the lungs, so aspiration is not a concern. Pneumothorax is also not a concern.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 425 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

2. After giving birth the nurse suggests that the woman place the infant to her breast within 15 minutes. The nurse knows that breastfeeding is effective during the first 30 minutes after birth because this is the
   a. transition period.
   b. first period of reactivity.
   c. organizational stage.
   d. second period of reactivity.

   ANS: B
   The first period of reactivity is the first phase of transition and lasts up to 30 minutes after birth. The infant is highly alert during this phase. The transition period is the phase between intrauterine and extrauterine existence. There is no such phase as the organizational stage. The second period of reactivity occurs roughly between 4 and 8 hours after birth, after a period of prolonged sleep.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 435 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

3. Nurses can prevent evaporative heat loss in the newborn by
   a. drying the baby after birth and wrapping the baby in a dry blanket.
   b. keeping the baby out of drafts and away from air conditioners.
   c. placing the baby away from the outside wall and the windows.
   d. warming the stethoscope and nurse’s hands before touching the baby.

ANS: A
Because the infant is wet with amniotic fluid and blood, heat loss by evaporation occurs quickly. Heat loss by convection occurs when drafts come from open doors and air currents created by people moving around. If the heat loss is caused by placing the baby near cold surfaces or equipment, it is termed a radiation heat loss. Conduction heat loss occurs when the baby comes in contact with cold objects or surfaces.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 427 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

4. A first-time dad is concerned that his 3-day-old daughter's skin looks "yellow." In the nurse's explanation of physiologic jaundice, what fact should be included?
   a. Physiologic jaundice occurs during the first 24 hours of life.
   b. Physiologic jaundice is caused by blood incompatibilities between the mother and infant blood types.
   c. The bilirubin levels of physiologic jaundice peak between the second and fourth days of life.
   d. This condition is also known as "breast milk jaundice."

   ANS: C
   Physiologic jaundice becomes visible when the serum bilirubin reaches a level of 5 mg/dL or greater, which occurs when the baby is approximately 3 days old. This finding is within normal limits for the newborn. Pathologic jaundice occurs during the first 24 hours of life. Pathologic jaundice is caused by blood incompatibilities, causing excessive destruction of erythrocytes, and must be investigated. Breast milk jaundice occurs in one third of breastfed infants at 2 weeks and is caused by an insufficient intake of fluids.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 433 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

5. The nurse understands that respirations are initiated at birth as a result of
   a. an increase in the PO_2 and a decrease in PCO_2.
   b. the continued functioning of the foramen ovale.
   c. chemical, thermal, sensory, and mechanical factors.
   d. drying off the infant.

   ANS: C
   A variety of these factors are responsible for initiation of respirations. The PO_2 decreases at birth and the PCO_2 increases. The foramen ovale closes at birth. Tactile stimuli aid in initiating respirations but are not the main cause.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 425 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

6. The student nurse learns that in fetal circulation, the pressure is greatest in the
   a. right atrium.
   b. left atrium.
   c. hepatic system.

d. pulmonary veins.

ANS: A
Pressure in fetal circulation is greatest in the right atrium, which allows a right-to-left shunting that aids in bypassing the lungs during intrauterine life. The pressure increases in the left atrium after birth and will close the foramen ovale. The liver does not filter the blood during fetal life until the end. It is functioning by birth. Blood bypasses the pulmonary vein during fetal life.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 426 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

7. Cardiovascular changes that cause the foramen ovale to close at birth are a direct result of
   a. increased pressure in the right atrium.
   b. increased pressure in the left atrium.
   c. decreased blood flow to the left ventricle.
   d. changes in the hepatic blood flow.

   ANS: B
   With the increase in the blood flow to the left atrium from the lungs, the pressure is increased, and the foramen ovale is functionally closed. The pressure in the right atrium decreases at birth. It is higher during fetal life. Blood flow increases to the left ventricle after birth. The hepatic blood flow changes, but that is not the reason for the closure of the foramen ovale.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 427 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

8. The nurse should alert the provider when
   a. the infant is dusky and turns cyanotic when crying.
   b. acrocyanosis is present at age 1 hour.
   c. the infant’s blood glucose is 45 mg/dL.
   d. the infant goes into a deep sleep at age 1 hour.

   ANS: A
   An infant who is dusky and becomes cyanotic when crying is showing poor adaptation to extrauterine life. The nurse needs to notify the provider. Acrocyanosis is an expected finding during the early neonatal life. A blood glucose of 45 mg/dL is within normal range for a newborn. Infants enter the period of deep sleep when they are about 1 hour old.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 452 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

9. While assessing the newborn, the nurse should be aware that the average expected apical pulse range of a full-term, quiet, alert newborn is _____ beats/min.
   a. 80 to 100
   b. 100 to 120
   c. 120 to 160
   d. 150 to 180

ANS: C
The average infant heart rate while awake is 120 to 160 beats/min.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: Box 21.3 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

10. What is a result of hypothermia in the newborn?
    a. Shivering to generate heat
    b. Decreased oxygen demands
    c. Increased glucose demands
    d. Decreased metabolic rate

ANS: C
In hypothermia, the basal metabolic rate (BMR) is increased in an attempt to compensate, thus requiring more glucose. Shivering is not an effective method of heat production for newborns. Oxygen demands increase with hypothermia. The metabolic rate increases with hypothermia.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 427 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

11. The nurse needs to assess infants for the development of high levels of bilirubin. Which baby can the nurse check last?
    a. Was bruised during a difficult delivery
    b. Developed a cephalhematoma
    c. Was born prematurely
    d. Breastfeeds during the first hour of life

ANS: D
The infant who is fed early will be less likely to retain meconium and reabsorb bilirubin from the intestines back into the circulation. Bruising, cephalhematomas, and prematurity increase the baby's risk of high bilirubin.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 432 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

12. A nurse is administering vitamin K to an infant shortly after birth. The parents ask why their baby needs a shot. The nurse explains that vitamin K is
    a. important in the production of red blood cells.
    b. necessary in the production of platelets.
    c. not initially synthesized because of a sterile bowel at birth.
    d. responsible for the breakdown of bilirubin and prevention of jaundice.

ANS: C
The bowel is initially sterile in the newborn, and vitamin K cannot be synthesized until food is introduced into the bowel. Vitamin K is vital for clotting, so without it the infant is at increased risk of bleeding problems. It is not needed to produce red blood cells, platelets, or break down bilirubin.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding

REF: p. 430 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

13. A meconium stool can be differentiated from a transitional stool in the newborn because the meconium stool is
    a. seen at age 3 days.
    b. the residue of a milk curd.
    c. passed in the first 12 hours of life.
    d. lighter in color and looser in consistency.

    ANS: C
    Meconium stool is usually passed in the first 12 hours of life, and 99% of newborns have their first stool within 48 hours. If meconium is not passed by 48 hours, obstruction is suspected. It is dark in color and sticky and develops from matter in the intestines during intrauterine life.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 431 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

14. When the newborn infant is fed, the most likely cause of regurgitation is
    a. placing the infant in a prone position after a feeding.
    b. the gastrocolic reflex.
    c. an underdeveloped pyloric sphincter.
    d. a relaxed cardiac sphincter.

    ANS: D
    The underlying cause of newborn regurgitation is a relaxed cardiac sphincter.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 430 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

15. The student nurse learns that the process in which bilirubin is changed from a fat-soluble product to a water-soluble product is known as
    a. enterohepatic circuit.
    b. conjugation of bilirubin.
    c. unconjugation of bilirubin.
    d. albumin binding.

    ANS: B
    Conjugation of bilirubin is the process of changing the bilirubin from a fat -soluble to a water-soluble product. The enterohepatic circuit is the route by which part of the bile produced by the liver enters the intestine, is reabsorbed by the liver, and then is recycled into the intestine. Unconjugated bilirubin is fat soluble. Albumin binding is to attach something to a protein molecule.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 431 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

16. Which statement is correct regarding the fluid balance in a newborn versus that in an adult? a. The infant has a smaller percentage of surface area to body mass.

b. The infant has a smaller percentage of water to body mass.
c. The infant has a greater percentage of insensible water loss.
d. The infant has a 50% more effective glomerular filtration rate.

ANS: C
Insensible water loss is greater in the infant due to the newborn's large body surface area and rapid respiratory rate. The infant's surface area is large compared to an adult's. Infants have a larger percentage of water to body mass. The filtration rate is less than in adults because the kidneys are immature in a newborn.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 434 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

17. An infant has an elevated immunoglobulin M (IgM) level. What action by the nurse is most appropriate?
a. Encourage the mother to breastfeed the baby.
b. Document the findings in the infant's chart.
c. Assess the infant for other signs of allergy.
d. Take a set of vital signs on the infant, and then notify the provider.

ANS: D
An elevated level of IgM is associated with exposure to infection in utero because IgM does not cross the placenta. The nurse should take a set of vital signs and notify the provider so further investigation can occur. It is not related to breastfeeding or allergies. The information should be documented, but this is not the most important action.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 434 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

18. In which infant behavioral state is bonding most likely to occur?
a. Drowsy
b. Active alert
c. Quiet alert
d. Crying

ANS: C
In the quiet alert state, the infant is interested in his or her surroundings and will often gaze at the mother or father or both. In the drowsy state the eyes may remain closed. If open they are unfocused. The infant is not interested in the environment at this time. In the active alert state infants are often fussy, restless, and not focused. During the crying state the infant does not respond to stimulation and cannot focus on parents.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 435 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

19. To prevent heat loss from convection in a newborn, which action by the nurse is best?
a. Place the baby in a warmer.
b. Dry the baby after a bath.
c. Move infant away from blowing fan.

d. Wrap the baby in warmed blankets.

ANS: C
Convection occurs when infants are exposed to cold air currents. Moving the baby out of the fan's air currents will reduce this loss. The warmer prevents heat loss from radiant heat loss. Drying the baby prevents evaporative heat loss. Warm blankets prevent conductive heat loss.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 427 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

20. The hips of a newborn are examined for developmental dysplasia. Which sign indicates an incomplete development of the acetabulum?
a. Negative Ortolani's sign
b. Asymmetric thigh and gluteal creases
c. Negative Barlow test
d. Equal knee heights

ANS: B
Asymmetric thigh and gluteal creases may indicate potential dislocation of the hip. Positive Ortolani's sign yields a "clunking" sensation and indicates a dislocated femoral head moving into the acetabulum. During a positive Barlow test, the examiner can feel the femoral head move out of the acetabulum. If the hip is dislocated, the knee on the affected side will be lower.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 444 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

21. Which newborn reflex is elicited by stroking the lateral sole of the infant's foot from the heel to the ball of the foot?
a. Babinski
b. Tonic neck
c. Stepping
d. Plantar grasp

ANS: A
The Babinski reflex causes the toes to flare outward and the big toe to dorsiflex. The tonic neck reflex (also called the fencing reflex) refers to the posture assumed by newborns when in a supine position. The stepping reflex occurs when infants are held upright with their heel touching a solid surface and the infant appears to be walking. The plantar grasp reflex is similar to the palmar grasp reflex: when the area below the toes are touched, the infant's toes curl over the nurse's finger.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 448 | Table 21.3 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

22. Infants in whom cephalhematomas develop are at increased risk for
a. infection.
b. jaundice.
c. caput succedaneum.

d. erythema toxicum.

ANS: B
Cephalhematomas are characterized by bleeding between the bone and its covering, the periosteum. Because of the breakdown of the red blood cells within a hematoma, the infants are at greater risk for jaundice. Cephalhematomas do not increase the risk for infection, caput, or erythema toxicum.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 451 | Box 21.5 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

23. A maculopapular rash with a red base and a small white papule in the center is
a. milia.
b. mongolian spots.
c. erythema toxicum.
d. café au lait spots.

ANS: C
This is a description of erythema toxicum, a normal rash in the newborn. Milia are minute epidermal cysts on the face of the newborn. Mongolian spots are bluish-black discolorations found on dark- skinned newborns, usually on the sacrum. Café au lait spots are pale tan (the color of coffee with milk) macules. Occasional spots occur normally in newborns, but they can indicate a genetic disorder.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 435 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

24. Plantar creases should be evaluated within a few hours of birth because
a. the newborn has to be footprinted.
b. as the skin dries, the creases will become more prominent.
c. heel sticks may be required.
d. creases will be less prominent after 24 hours.

ANS: B
As the infant's skin begins to dry, the creases will appear more prominent, and the infant's gestation could be misinterpreted. Footprinting will not interfere with the creases. Heel sticks will not interfere with the creases. The creases will appear more prominent after 24 hours.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 454 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

25. A newborn who is large for gestational age (LGA) is _____ percentile for weight.
a. below the 90th
b. less than the 10th
c. greater than the 90th
d. between the 10th and 90th

ANS: C

The LGA rating is based on weight and is defined as greater than the 90th percentile in weight. An infant between the 10th and 90th percentiles is average for gestational age. An infant in less than the 10th percentile is small for gestational age.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 458 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

26. A new mother asks, “Why are you doing a gestational age assessment on my baby? I delivered on time.” The nurse’s best response is
    a. “This must be done to meet insurance requirements.”
    b. “It helps us identify infants who are at risk for any problems.”
    c. “The gestational age determines how long the infant will be hospitalized.”
    d. “It was ordered by your doctor.”

    ANS: B
    The nurse should provide the mother with accurate information about various procedures performed on the newborn. A gestational age assessment helps identify at -risk infants. It is not done for insurance requirements or to determine hospital days. Assessing gestational age is a nursing assessment and does not have to be ordered.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 454 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

27. Which nursing action is designed to avoid unnecessary heat loss in the newborn?
    a. Place a blanket over the scale before weighing the infant.
    b. Maintain room temperature at 70° F.
    c. Undress the infant completely for assessments so they can be finished quickly.
    d. Take the rectal temperature every hour to detect early changes.

    ANS: A
    Padding the scale prevents heat loss from the infant to a cold surface by conduction. Room temperature should be appropriate to prevent heat loss from convection. Also, if the room is warm enough, radiation will assist in maintaining body heat. Undressing the infant completely will expose the child to cooler room temperatures and cause a drop in body temperature due to convection. Hourly assessments are not necessary for a normal newborn with a stable temperature. Rectal temperatures are usually not done on the newborn.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 428 | Figure 21.2 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

28. What characteristic shows the greatest gestational maturity?
    a. Few rugae on the scrotum and testes high in the scrotum
    b. Infant’s arms and legs extended
    c. Some peeling and cracking of the skin
    d. The arm can be positioned with the elbow beyond the midline of the chest

    ANS: C
    Peeling, cracking, dryness, and a few visible veins in the skin are signs of maturity in the newborn. The other signs are indicative of a younger gestational age.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 437 | Table 21.2 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

29. The nurse is concerned about an infection in a newborn. What finding does the nurse assess for?
    a. More than two soft stools per day
    b. Leukocytosis with a left shift
    c. Poor feeding behaviors
    d. An axillary temperature greater than 37.5° C

    ANS: D
    Due to their immature immune system, newborns often do not have fever and leukocytosis with infection. Signs of infection are subtler and include changes in activity, tone, feeding, and color. More than two stools is an expected finding.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 434 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

30. An African-American woman noticed some bruises on her newborn girl's buttocks. She asks the nurse who spanked her daughter. The nurse explains that these marks are called
    a. lanugo.
    b. vascular nevi.
    c. nevus flammeus.
    d. mongolian spots.

    ANS: D
    A mongolian spot is a bluish black area of pigmentation that may appear over any part of the exterior surface of the body. It is more commonly noted on the back and buttocks and most frequently is seen on infants whose ethnic origins are Mediterranean, Latin American, Asian, or African. Lanugo is the fine, downy hair seen on a term newborn. A vascular nevus, commonly called a strawberry mark, is a type of capillary hemangioma. A nevus flammeus, commonly called a port-wine stain, is most frequently found on the face.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 435 OBJ: Nursing Process: Diagnosis
    MSC: Client Needs: Health Promotion and Maintenance

31. What is the quickest and most common method to obtain neonatal blood for glucose screening 1 hour after birth?
    a. Puncture the lateral pad of the heel.
    b. Obtain a sample from the umbilical cord.
    c. Puncture a fingertip.
    d. Obtain a laboratory chemical determination.

    ANS: A

A drop of blood obtained by heel stick is the quickest method of glucose screening. The calcaneus bone should be avoided as osteomyelitis may result from injury to the foot. Most umbilical cords are clamped in the delivery room and are not available for routine testing. A neonate's fingertips are too fragile to use for this purpose. Laboratory chemical determination is the most accurate but the lengthiest method.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 449 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

32. A new mother states that her infant must be cold because the baby's hands and feet are blue. The nurse explains that this is a common and temporary condition called
    a. acrocyanosis.
    b. erythema neonatorum.
    c. harlequin color.
    d. vernix caseosa.

    ANS: A
    Acrocyanosis, or the appearance of slightly cyanotic hands and feet, is caused by vasomotor instability, capillary stasis, and a high hemoglobin level. Acrocyanosis is normal and appears intermittently over the first 7 to 10 days. Erythema toxicum (also called erythema neonatorum) is a transient newborn rash that resembles flea bites. The harlequin sign is a benign, transient color change in newborns. Half of the body is pale, and the other half is ruddy or bluish red with a line of demarcation. Vernix caseosa is a cheeselike, whitish substance that serves as a protective covering.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 428 | Figure 21.2 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

33. The parents of a newborn ask the nurse how much the newborn can see. The parents specifically want to know what types of visual stimuli they should provide for their newborn. The nurse responds to the parents by telling them
    a. "Infants can see very little until about 3 months of age."
    b. "Infants can track their parent's eyes and prefer complex patterns."
    c. "The infant's eyes must be protected. Infants enjoy looking at bright stripes."
    d. "It's important to shield the newborn's eyes. Overhead lights help them see better."

    ANS: B
    Infants can track their parents' faces, including eyes and prefer to look at complex patterns. Newborns seem to have clearest visual acuity at about 19 cm. Infants prefer complex patterns, regardless of color and also prefer low lighting.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 445 | p. 448 OBJ: Nursing Process: Planning
    MSC: Client Needs: Health Promotion and Maintenance

34. A first-time father is changing the diaper of his 1-day-old daughter. He asks the nurse, "What is this black, sticky stuff in her diaper?" The nurse's best response is
    a. "That's meconium, which is your baby's first stool. It's normal."

b. “That’s transitional stool.”
c. “That means your baby is bleeding internally.”
d. “Oh, don’t worry about that. It’s okay.”

ANS: A
This describes a meconium stool, which the nurse should educate the father about. It is not a transitional stool nor does it indicate bleeding. Telling the father not to worry about it is belittling and does not provide information.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 451 | Box 21.5 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

35. A nurse assesses a newborn’s lab values and notes a WBC of 31,000 mm^3. What action by the nurse is best?
a. Take a set of vital signs and notify the provider.
b. Document the findings in the infant’s chart.
c. Follow unit protocol to initiate a sepsis workup.
d. Perform a heel stick for a bedside blood glucose reading.

ANS: B
The leukocyte (white blood cell [WBC]) count at birth is 9100 to 34,000/mm^3. This is a normal finding so the only action required is to document these results.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 430 OBJ: Integrated Process: Communication and Documentation
MSC: Client Needs: Health Promotion and Maintenance

36. What information does the student learn about the newborn’s developing cardiovascular system?
a. The heart rate of a crying infant may rise to 120 beats/min.
b. Heart murmurs heard after the first few hours are cause for concern.
c. The point of maximal impulse (PMI) is on the third or fourth left intercostal space.
d. Persistent bradycardia may indicate respiratory distress syndrome (RDS).

ANS: C
The newborns’ PMI is found in the left third to fourth intercostal space. The normal heart rate for infants who are not sleeping is 120 to 160 beats/min. However, a crying infant temporarily could have a heart rate of 180 beats/min. Heart murmurs during the first few days of life have no pathologic significance; an irregular heart rate past the first few hours should be evaluated further. Persistent tachycardia may indicate RDS; bradycardia may be a sign of congenital heart blockage.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 436 | Table 21.2 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

37. The cheeselike, whitish substance that fuses with the epidermis and serves as a protective coating is called
a. vernix caseosa
b. surfactant
c. caput succedaneum

d. acrocyanosis

ANS: A
Vernix caseosa is a cheeselike substance on the skin. This protection is needed because the infant's skin is so thin. Surfactant is a protein that lines the alveoli of the infant's lungs. Caput succedaneum is the swelling of the tissue over the presenting part of the fetal head. Acrocyanosis is cyanosis of the hands and feet, resulting in a blue coloring.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 452 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

38. A nurse receives handoff report. Which newborn should the nurse assess first?
a. Temperature 97.7° F (36.5° C)
b. Pulse 144 beats/minute
c. Respiratory rate 78 breaths/minute
d. Glucose reading 58 mg/dL

ANS: C
A newborn's respiratory rate should be 30 to 60 breaths/minute, so the nurse needs to assess the infant with the high respiratory rate first. The other values are within normal limits.

PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
REF: p. 435 OBJ: Nursing Process: Assessment
MSC: Client Needs: Safe and Effective Care Environment

39. A nurse assesses a newborn and finds him to be jittery with a poor suck reflex. What action by the nurse takes priority?
a. Ensure the warmer is set to the correct temperature.
b. Obtain a heel stick for bedside glucose reading.
c. Listen to the newborn's heart and lungs.
d. Perform a gestational age assessment.

ANS: B
These are signs of possible hypoglycemia. The nurse should obtain blood for a glucose determination. Ensuring the warmer is set correctly and further assessing the baby are appropriate but not related to these findings. There would be no need to repeat the gestational age assessment.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 449 | Safety Alert Box OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

40. An infant has been exposed to cold stress. After taking measures to warm the infant, what action does the nurse perform next?
a. Obtain a blood glucose reading.
b. Listen to the infant's lungs.
c. Document the warming interventions.
d. Determine how the baby got cold.

ANS: A

In trying to maintain temperature, the infant expends a lot of energy, using glucose. The infant is at risk of hypoglycemia, so a glucose reading should be obtained. Documenting and investigating the incident are important but need to wait until the glucose is obtained and actions taken if needed. Listening to the lungs is not specifically needed in this case since there is no indication that the infant has respiratory distress. This action can occur later as well.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 429 | Box 21.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Safe and Effective Care Environment

41. A nurse is supervising a student nurse who is assessing an infant's rooting reflex. Which action by the student warrants further instruction by the nurse?
    a. Tells parents this reflex will disappear within 4 months
    b. Strokes face from side of mouth to cheek
    c. Notes normal findings when infant turns head toward touch
    d. Performs assessment on infant while sleeping

    ANS: D
    This reflex is difficult to assess on an infant just after feeding or when asleep. The other actions by the student are correct.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 448 | Table 21.3 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. What are modes of heat loss in the newborn? (*Select all that apply.*)
    a. Perspiration
    b. Convection
    c. Radiation
    d. Conduction
    e. Urination

    ANS: B, C, D
    Convection, radiation, evaporation, and conduction are the four modes of heat loss in the newborn. Perspiration and urination are not modes of heat loss in newborns.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 427 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

2. The nurse explains to parents that which organs are nonfunctional during fetal life? (*Select all that apply.*)
    a. Kidneys
    b. Lungs
    c. Liver
    d. Gastrointestinal system
    e. Adrenal glands

ANS: B, C
Most of the fetal blood flow bypasses the nonfunctional lungs and liver. The other organs are functional during fetal life.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 426 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

COMPLETION

1. An infant was born weighing 7.2 pounds. Calculate this infant's oral intake needs. _____

ANS:
223.2-327 mL/day

This infant weighs 3.27 kg. The range of intake for the first 3 days is 60 to 100 mL/kg/day. This infant needs 223.2 to 327 mL/day of fluid intake.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 434 | Box 21.2 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. A yellow crust has formed over the circumcision site. The mother calls the hotline at the local hospital, 5 days after her son was circumcised. She is very concerned. On which rationale should the nurse base her reply?
   a. After circumcision, the diaper should be changed frequently and fastened snugly.
   b. This yellow crust is an early sign of infection.
   c. The yellow crust should not be removed.
   d. Discontinue the use of petroleum jelly to the tip of the penis.

   ANS: C
   Crust is a normal part of healing and should not be removed. The diaper should be fastened loosely to prevent rubbing or pressure on the incision site. The normal yellowish exudate that forms over the site should be differentiated from the purulent drainage of infection. The only contraindication for petroleum jelly is the use of a PlastiBell.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 472 | Patient-Centered Teaching Box
   OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

2. A new father wants to know what medication was put into his infant's eyes and why it is needed. The nurse explains to the father that the purpose of the ophthalmic ointment is to
   a. destroy an infectious exudate caused by *Staphylococcus* that could make the infant blind.
   b. prevent gonorrheal and chlamydial infection of the infant's eyes potentially acquired from the birth canal.
   c. prevent potentially harmful exudate from invading the tear ducts of the infant's eyes, leading to dry eyes.
   d. prevent the infant's eyelids from sticking together and help the infant see.

   ANS: B
   The ointment is used to prevent potential gonorrheal and chlamydial infection of the infant's eyes.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 462 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

3. When instructing parents on the correct use of a bulb syringe it is important include what information?
   a. Avoid suctioning the nares.
   b. Insert the compressed bulb into the center of the mouth.
   c. Suction the mouth first.
   d. Remove the bulb syringe from the crib when finished.

   ANS: C

The mouth should be suctioned first to prevent the infant from inhaling pharyngeal secretions by gasping as the nares are suctioned. The nasal passages should be suctioned one nostril at a time. The mouth should always be suctioned first. After compression of the bulb it should be inserted into one side of the mouth. If it is inserted into the center of the mouth, the gag reflex is likely to be initiated. The bulb syringe should remain in the crib so that it is easily accessible if needed again.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 463 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

4. In providing and teaching cord care, what is an important principle?
   a. Cord care is done only to control bleeding.
   b. Alcohol is the only agent used for cord care.
   c. It takes a minimum of 24 days for the cord to separate.
   d. The process of keeping the cord dry will decrease bacterial growth.

   ANS: D
   Bacterial growth increases in a moist environment, so keeping the umbilical cord dry impedes bacterial growth. Cord care is to prevent infection and add in the drying of the cord. No agents are necessary to facilitate drying of the cord. The cord will fall off within 10 to 14 days.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 468 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

5. The nurse's initial action when caring for an infant with a slightly decreased temperature is to
   a. notify the physician immediately.
   b. place a cap on the infant’s head.
   c. Keep the infant in the nursery for the next 4 hours.
   d. Assess for other signs of inaccurate gestational age.

   ANS: B
   A cap will prevent further heat loss from the head, and having the mother place the infant skin-to-skin should increase the infant’s temperature. Nursing actions are needed first to correct the problem. If the problem persists after interventions, notification may then be necessary. A slightly decreased temperature can be treated in the mother’s room. This would be an excellent time for parent teaching on prevention of cold stress. There is no need for another gestational age assessment.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 464 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

6. When teaching parents about mandatory newborn screening, it is important for the nurse to explain that the main purpose is to
   a. keep the state records updated.
   b. allow accurate statistical information.

c. document the number of births.
d. recognize and treat newborn disorders early.

ANS: D
Early treatment of disorders will prevent morbidity associated with inborn errors of metabolism or other genetic conditions. Keeping and updating records are not the reasons for the testing.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 476 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

7. What action by the nurse is most important to prevent the kidnapping of newborns from the hospital?
   a. Instruct the mother not to give her infant to anyone except the one nurse assigned to her that day.
   b. Question anyone who is seen walking in the hallways carrying an infant.
   c. Allow no visitors in the maternity area except those who have identification bracelets.
   d. Restrict the amount of time infants are out of the nursery.

   ANS: B
   Infants should be transported in the hallways only in their cribs. It is impossible for one nurse to be on call for one mother and baby for the entire shift, so the parents need to be able to identify the nurses who are working on the unit. Limiting visitors may cut the new family off from vital support. Infants should be with their parents the majority of the time.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 469 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Safe and Effective Care Environment

8. The nurse administers vitamin K to the newborn for what reason?
   a. Most mothers have a diet deficient in vitamin K, which results in the infant's being deficient.
   b. Vitamin K prevents the synthesis of prothrombin in the liver and must be given by injection.
   c. Bacteria that synthesize vitamin K are not present in the newborn's intestinal tract.
   d. The supply of vitamin K is inadequate for at least 3 to 4 months, and the newborn must be supplemented.

   ANS: C
   In order to promote clotting, vitamin K is necessary. However, the bacteria that synthesize vitamin K are not present in the newborn's intestinal tract, so the nurse administers it via injection. The maternal diet has no bearing on the amount of vitamin K found in the newborn. It is not involved in the synthesis of prothrombin. By day 8, normal newborns are able to produce their own vitamin K.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 462 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

9. The student nurse asks why gloves are needed when handling a newborn because the newborn "hasn't been exposed to anything." What response by the nurse is best?
   a. It is part of standard precautions.
   b. It is hospital policy.
   c. Amniotic fluid and maternal blood pose risks to us.
   d. We are protecting the infant from our bacteria.

   ANS: C
   With the possibility of transmission of viruses such as HBV and HIV through maternal blood and amniotic fluid, the newborn must be considered a potential contamination source until proved otherwise. As part of standard precautions, nurses should wear gloves when handling the newborn until blood and amniotic fluid are removed by bathing. While this may be policy and is part of standard precautions, simply stating these facts does not convey any detailed information. The nurses are not protecting the infant from themselves.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 462 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Safe and Effective Care Environment

10. With regard to lab tests and diagnostic tests in the hospital after birth, nurses should be aware that
    a. all states test for phenylketonuria (PKU), hypothyroidism, cystic fibrosis, and sickle cell diseases.
    b. federal law prohibits newborn genetic testing without parental consent.
    c. if genetic screening is done before the infant is 24 hours old, it should be repeated at age 1 to 2 weeks.
    d. hearing screening is now mandated by federal law.

    ANS: C
    If testing is done prior to 24 hours of age, genetic screening should be repeated when the infant is 1 to 2 weeks old. States all test for PKU and hypothyroidism, but other genetic defects are not universally covered. Federal law mandates newborn genetic screening; however, parents can decline testing. A waiver should be signed and a notation made in the infant's medical record. Federal law does not mandate screening for hearing problems; however, the majority of states have enacted legislation mandating newborn hearing screening. In the United States the majority (95%) of infants is screened for hearing loss prior to discharge from the hospital.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 476 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

11. Nurses can help parents deal with the issue and fact of circumcision if they explain
    a. the pros and cons of the procedure during the prenatal period.
    b. that the American Academy of Pediatrics (AAP) recommends that all newborn males be routinely circumcised.
    c. that circumcision is rarely painful and that any discomfort can be managed without medication.
    d. that the infant will likely be alert and hungry shortly after the procedure.

ANS: A

Parents need to make an informed choice regarding newborn circumcision based on the most current evidence and recommendations. Health care providers and nurses who care for childbearing families should provide factual, unbiased information regarding circumcision and give parents opportunities to discuss the risks and benefits of the procedure. The AAP and other professional organizations note the benefits but stop short of recommendation for routine circumcision. Circumcision is painful and must be managed with environmental, nonpharmacologic, and pharmacologic measures. Infants may or may not be alert and hungry after the procedure.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 471 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

12. A nurse is responsible for teaching new parents about the hygienic care of their newborn. What information does the nurse include?
    a. Avoid washing the head for at least 1 week to prevent heat loss.
    b. Sponge bathe only until the cord has fallen off.
    c. Cleanse the ears and nose with cotton-tipped swabs, such as Q-tips.
    d. Water temperature should be at least 38° C.

    ANS: D

    The ideal temperature of the bath water should be at least 38° C, or 100.4° F. The head can be washed. Tub baths may be initiated from birth. Ensure that the infant is fully immersed. Q-tips should not be used, because they may cause injury. A corner of a moistened washcloth should be twisted into shape so that it can be used to cleanse the ears and nose.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 467 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

13. An unfortunate but essential role of the nurse is protecting the infant from abduction. Which statement regarding the profile of a potential abductor is the most accurate?
    a. Male gender
    b. A young woman who has had a previous pregnancy loss
    c. A middle-aged woman past childbearing age
    d. A female with a number of children of her own

    ANS: B

    The woman is usually of childbearing age and may have had a previous pregnancy loss or has been unable to have a child of her own. She may want an infant to solidify the relationship with her husband or boyfriend and may have pretended to be pregnant. The women are usually familiar with the facility and its routines.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 469 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Safe and Effective Care Environment

14. When the nurse is in the process of health teaching it is very important that he or she consider the family's cultural beliefs regarding child care. One of these beliefs includes that
    a. Arab women are anxious to breastfeed while still in the hospital.
    b. it is important to complement Asian parents about their new baby.
    c. women from India tie a black thread around the infant's waist.
    d. in the Korean culture the patient's mother is the primary caregiver of the infant.

    ANS: C
    Women from India may tie a black thread around the infant's wrist, ankle, or waist to ward off evil spirits. This thread should not be removed by the nurse. Arab women are hesitant to breastfeed in the birth facility and wish to wait until they are home and their milk comes in. Asian parents may be uneasy when caregivers are too complementary about the baby or casually touch the infant's head. In the Korean culture, the husband's mother is the primary caregiver for the infant and the mother during the early weeks.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 475 OBJ: Integrated Process: Culture and Spirituality
    MSC: Client Needs: Psychosocial Integrity

15. Nursing follow-up care often includes home visits for the new mother and her infant. Which information related to home visits is correct?
    a. Ideally the visit is scheduled between 24 and 72 hours after discharge.
    b. Home visits are available in all areas.
    c. Visits are completed within a 30-minute time frame.
    d. Blood draws are not a part of the home visit.

    ANS: A
    The home visit is ideally scheduled during the first 24 to 72 hours after discharge. This timing allows early assessment and intervention for problems with feedings, jaundice, newborn adaptation, and maternal-infant interaction. Because home visits are expensive, they are not available in all geographic areas. Visits are usually 60 to 90 minutes in length to allow enough time for assessment and teaching. When jaundice is found, the nurse can discuss the implications and check the transcutaneous bilirubin level or draw blood for testing.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 477 OBJ: Nursing Process: Planning
    MSC: Client Needs: Health Promotion and Maintenance

16. A nurse is observing a student nurse apply erythromycin ophthalmic ointment. What action by the student requires the nurse to intervene?
    a. Applies ointment in thin ribbon
    b. Applies ointment from outer canthus to inner canthus.
    c. Holds the tube horizontally while applying ointment
    d. Wipes excess ointment away after 1 minute.

    ANS: B
    The ointment should be applied from inner to outer canthus. When the student does this incorrectly, the nurse should intervene. The other actions are appropriate.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 463 | Drug Guide OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

17. A student nurse is preparing an injection of vitamin K (aquaMEPHYTON). What action by the student shows good understanding of this procedure?
    a. Draws up 1.5 mg of solution
    b. Protects solution from light
    c. Finds landmark for subQ injection
    d. Administers directly after circumcision

    ANS: B
    The solution of vitamin K is light-sensitive, so it should be protected from light. The dose is 0.5 to 1 mg. It is given IM and should be administered prior to a circumcision.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 463 | Drug Guide OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. Nurses use many different nonpharmacologic methods of pain management. Examples of nonpharmacologic pain management techniques include which of the following? (*Select all that apply*.)
    a. Swaddling
    b. Nonnutritive sucking (pacifier)
    c. Skin-to-skin contact with the mother
    d. Sucrose
    e. Acetaminophen

    ANS: A, B, C, D
    These interventions are all appropriate nonpharmacologic techniques used to manage pain in neonates. Other interventions include soothing music, dim lighting and speaking to the infant in a quiet voice. Acetaminophen is a pharmacologic method of treating pain.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 471 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

2. The nurse should model and teach practices used to prevent sudden infant death syndrome. Which of the following do these include? (*Select all that apply*.)
    a. Fully supine position for all sleep
    b. Side-sleeping position as an acceptable alternative
    c. “Tummy time” for play
    d. Placing the infant’s crib in the parents’ room
    e. A soft mattress

    ANS: A, D

The back to sleep position is now recommended as the only position for every sleep period. Ideally the infant's crib should be placed in the parents' room. Side sleeping is not an acceptable alternative because of the possibility the infant will roll to the prone position. Tummy time helps develop muscles and reduces plagiocephaly. Mattresses in cribs should be firm.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 468 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

3. Auditory screening of all newborns within the first month of life is recommended by the American Academy of Pediatrics. Reasons for having this testing performed include (*Select all that apply.*)
   a. To prevent or reduce developmental delay
   b. Reassurance for concerned new parents
   c. Early identification and treatment
   d. To help the child communicate better
   e. To achieve one of the *Healthy People 2020* goals

   ANS: A, C, D, E
   These are all appropriate reasons for auditory screening of the newborn. Infants who do not pass should be rescreened. If they still do not pass the test, they should have a full audiologic and medical evaluation by 3 months of age. If necessary, the infant should be enrolled in early intervention by 6 months of age. New parents are often anxious about this test and the impending results; however, it is not the reason for the screening to be performed. Auditory screening is usually done before hospital discharge. It is important for the nurse to ensure that the infant receive the appropriate testing and that the test is fully explained to the parents. For infants who are referred for further testing and follow-up, it is important for the nurse to provide further explanation and emotional support.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 476 OBJ: Nursing Process: Diagnosis
   MSC: Client Needs: Health Promotion and Maintenance

4. The parents of a newborn are considering circumcision. What possible complications does the nurse teach them about? (*Select all that apply*.)
   a. Urinary retention
   b. Adhesions
   c. Necrosis of the site
   d. Kidney infection
   e. Unsatisfactory cosmetic result

   ANS: A, B, C, E
   Urinary retention, adhesions, necrosis, and unsatisfactory cosmetic results are possible complications of this procedure. Kidney infection is not.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 475 | Safety Alert Box OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. The breastfeeding mother should be taught a safe method to remove the breast from the baby's mouth. Which suggestion by the nurse is most appropriate?
   a. Slowly remove the breast from the baby's mouth when the infant has fallen asleep and the jaws are relaxed.
   b. Break the suction by inserting your finger into the corner of the infant's mouth.
   c. A popping sound occurs when the breast is correctly removed from the infant's mouth.
   d. Elicit the Moro reflex to wake the baby and remove the breast when the baby cries.

   ANS: B
   Inserting a finger into the corner of the baby's mouth between the gums to break the suction avoids trauma to the breast. The infant who is sleeping may lose grasp on the nipple and areola, resulting in "chewing" on the nipple, making it sore. A popping sound indicates improper removal of the breast from the baby's mouth and may cause cracks or fissures in the breast. Most mothers prefer the infant to continue to sleep after the feeding. Gentle wake-up techniques are recommended.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 488 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

2. A pregnant woman wants to breastfeed her infant; however, her husband is not convinced that there are any scientific reasons to do so. Which statement by the nurse is true? Bottle-feeding using commercially prepared infant formulas
   a. increases the risk that the infant will develop allergies.
   b. helps the infant sleep through the night.
   c. ensures that the infant is getting iron in a form that is easily absorbed.
   d. requires that multivitamin supplements be given to the infant.

   ANS: A
   Breastfeeding is less likely to cause allergies. Newborns should be fed through the night regardless of feeding method. Iron is better absorbed from breast milk than from formula. Commercial formulas are designed to meet the nutritional needs of the infant and to resemble breast milk. No supplements are necessary.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 482 | Box 23.2 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity; Basic Care and Comfort

3. How can the nurse help the mother who is breastfeeding and has engorged breasts?
   a. Suggest that she switch to bottled formula just for today.
   b. Assist her in removing her bra, making her more comfortable.
   c. Apply heat to her breasts between feeding and cold to the breasts just before feedings.

d. Instruct and assist the mother to massage her breasts.

ANS: D
Massage of the breasts causes release of oxytocin and increases the speed of milk release. Engorgement is more likely to increase if breastfeeding is delayed or infrequent. A well-fitting bra should be worn both day and night to support the breasts. Cold applications are used between feedings to reduce edema and pain. Heat is applied just before feedings to increase vasodilation.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 492 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

4. A new mother recalls that she should feed her newborn when she exhibits feeding readiness cues rather than waiting until her infant is crying frantically. Based on this information, this woman should feed her infant when she
   a. waves her arms in the air.
   b. makes sucking motions.
   c. has hiccups.
   d. stretches out her legs straight.

   ANS: B
   Sucking motions, rooting, mouthing, and hand- to-mouth motions are examples of feeding-readiness cues. The other observations are not feeding cues.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 485 | Box 23.3 OBJ: Nursing Process: Planning
   MSC: Client Needs: Health Promotion and Maintenance

5. Which type of formula is not diluted before being administered to an infant?
   a. Powdered
   b. Concentrated
   c. Ready-to-use
   d. Modified cow’s milk

   ANS: C
   Ready-to-use formula can be poured directly from the can into baby’s bottle and is good (but expensive) when a proper water supply is not available. Powdered and concentrated formulas should be well mixed to dissolve the powder and make it uniform. Cow’s milk is more difficult for the infant to digest and is not recommended, even if it is diluted.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 496 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

6. The student nurse learns that the hormone necessary for milk production is
   a. estrogen.
   b. prolactin.
   c. progesterone.
   d. lactogen.

ANS: B
Prolactin, secreted by the anterior pituitary, is a hormone that causes the breasts to produce milk. Estrogen decreases the effectiveness of prolactin and prevents mature breast milk from being produced. Progesterone decreases the effectiveness of prolactin and prevents mature breast milk from being produced. Human placental lactogen decreases the effectiveness of prolactin and prevents mature breast milk from being produced.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 484 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

7. To initiate the milk ejection reflex, the mother should
   a. wear a firm-fitting bra.
   b. drink plenty of fluids.
   c. place the infant to the breast
   d. apply cool packs to her breast.

   ANS: C
   Oxytocin, which causes the milk let -down reflex, increases in response to nipple stimulation. A firm bra is important to support the breast but will not initiate the let -down reflex. Drinking plenty of fluids is necessary for adequate milk production but will not initiate the let-down reflex. Cool packs to the breast will decrease the let-down reflex.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 484 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

8. What is the first step in assisting the breastfeeding mother?
   a. Provide instruction on the composition of breast milk.
   b. Discuss the hormonal changes that trigger the milk ejection reflex.
   c. Assess the woman’s knowledge of and feelings toward breastfeeding.
   d. Help her obtain a comfortable position and place the infant to the breast.

   ANS: C
   The nurse should first assess the woman’s knowledge and feedings toward breastfeeding to determine her teaching needs. Assessment should occur before instruction on positions and placing the infant to the breast. Education on hormonal changes and composition of breast milk also comes after assessment.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 483 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

9. A primiparous woman wants to begin breastfeeding as soon as possible. The nurse can facilitate the infant’s correct latch-on by helping the woman hold the infant
   a. with his arms folded together over his chest.
   b. curled up in a fetal position.
   c. with his head cupped in her hand.
   d. with his head and body in alignment.

ANS: D
The infant's head and body should be in correct alignment with the mother and the breast during latch-on and feeding. The other positions do not facilitate nursing.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 486 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

10. A postpartum woman telephones about her 4-day-old infant. She is not scheduled for a weight check until the infant is 10 days old, and she is worried about whether breastfeeding is going well. Effective breastfeeding is indicated by the newborn who
    a. sleeps for 6 hours at a time between feedings.
    b. has at least one breast milk stool every 24 hours.
    c. gains 1 to 2 ounces per week.
    d. has at least six to eight wet diapers per day.

    ANS: D
    After day 4, when the mother's milk comes in, the infant should have six to eight wet diapers every 24 hours. Typically infants sleep 2 to 4 hours between feedings, depending on whether they are being fed on a 2- to 3-hour schedule or cluster- fed. The infant should have a minimum of three bowel movements in a 24-hour period. The mother will not know what her child weighs until the appointment and so the nurse needs to provide her with other indicators of successful breastfeeding.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 489 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

11. To prevent breast engorgement, the new breastfeeding mother should be instructed to
    a. apply cold packs to the breast before feeding.
    b. breastfeed frequently and for adequate lengths of time.
    c. limit her intake of fluids for the first few days.
    d. feed her infant no more than every 4 hours.

    ANS: B
    Engorgement occurs when the breasts are not adequately emptied at each feeding or if feedings are not frequent enough. Warm packs should be applied to the breast before feedings. Fluid intake should not be limited with a breastfeeding mother; that will decrease the amount of breast milk produced. Breast milk moves through the stomach within 1.5 to 2 hours, so waiting 4 hours to feed is too long. Frequent feedings are important to empty the breast and to establish lactation.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 491 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

12. The difference between the aseptic and terminal methods of sterilization is that the
    a. aseptic method does not require boiling of the bottles.
    b. terminal method requires boiling water to be added to the formula.
    c. aseptic method requires a longer preparation time.

d. terminal method sterilizes the prepared formula at the same time it sterilizes the equipment.

ANS: D
In the terminal sterilization method, the formula is prepared in the bottles, which are loosely capped, and then the bottles are placed in the sterilizer, where they are boiled for 25 minutes. With the aseptic method, the bottles are boiled separate from the formula. This process takes about 5 minutes.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 496 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

13. How many ounces will a formula-fed infant who is on a 4-hour feeding schedule need to consume at each feeding to meet daily caloric needs?
a. 0.5 to 1
b. 1 to 2
c. 2 to 3
d. 4

ANS: C
The newborn requires approximately 2 to 3 ounces per feeding within 1 week after birth.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 496 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

14. A new mother is concerned because her 1-day-old newborn is taking only 1 ounce at each feeding. The nurse should explain that the
a. infant does not require as much formula in the first few days of life.
b. infant's stomach capacity is small at birth but will expand within a few days.
c. infant tires easily during the first few days but will gradually take more formula.
d. infant is probably having difficulty adjusting to the formula.

ANS: B
The infant's stomach capacity at birth is 10 to 20 mL and increases to 60 to 90 mL by the end of the first week. One ounce is 30 mL. The infant's requirements are the same, but the stomach capacity needs to increase before taking in adequate amounts. The infant's sleep patterns do change, but the infant should be awake enough to feed. There are other symptoms that occur if there is a formula intolerance.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 488 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

15. As the nurse assists a new mother with breastfeeding, she asks, "If formula is prepared to meet the nutritional needs of the newborn, what is in breast milk that makes it better?" The nurse's best response is that it contains
a. more calories.
b. essential amino acids.

c. important immunoglobulins.
d. more calcium.

ANS: C
Breast milk contains immunoglobulins that protect the newborn against infection. The calorie count of formula and breast milk is about the same. All of the essential amino acids are in both formula and breast milk. The concentrations may differ. Calcium levels are higher in formula than breast milk. This higher level can cause an excessively high renal solute load if the formula is not diluted properly.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 480 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

16. When responding to the question "Will I produce enough milk for my baby as she grows and needs more milk at each feeding?" the nurse should explain that
a. the breast milk will gradually become richer to supply additional calories.
b. as the infant requires more milk, feedings can be supplemented with cow's milk.
c. early addition of baby food will meet the infant's needs.
d. the mother's milk supply will increase as the infant demands more at each feeding.

ANS: D
The amount of milk produced depends on the amount of stimulation of the breast. Increased demand with more frequent and longer breastfeeding sessions results in more milk available for the infant. Mature breast milk will stay the same. The amounts will increase as the infant feeds for longer times. Supplementation will decrease the amount of stimulation of the breast and decrease the milk production. Solids should not be added until about 4 to 6 months, when the infant's immune system is more mature. This will decrease the chance of allergy formations.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 484 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

17. In order to prevent nipple trauma, the nurse should teach the new mother to
a. limit the feeding time to less than 5 minutes.
b. position the infant so the nipple is far back in the mouth.
c. assess the nipples before each feeding.
d. wash the nipples daily with mild soap and water.

ANS: B
If the infant's mouth does not cover as much of the areola as possible, the pressure during sucking will be applied to the nipple, causing trauma to the area. Stimulating the breast for less than 5 minutes will not produce the extra milk the infant may need. Assessing the nipples for trauma is important, but it will not prevent sore nipples. Soap can be drying to the nipples and should be avoided during breastfeeding.

PTS: 1 DIF: Cognitive Level: Application REF: p. 487
OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

18. A breastfeeding mother who was discharged yesterday calls to ask about a tender, hard area on her right breast. The nurse's first response should be
    a. "Try massaging the area and apply heat, as this is probably a plugged duct."
    b. "Stop breastfeeding because you probably have an infection."
    c. "Notify your doctor so he can start you on antibiotics."
    d. "This is a normal response in breastfeeding mothers."

    ANS: A
    A plugged lactiferous duct results in localized edema, tenderness, and a palpable hard area. Massage of the area followed by heat will cause the duct to open. This does not indicate an infection or a need for antibiotics. This is a normal deviation but requires intervention to prevent further complications.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 493 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

19. An important aspect about storage of breast milk is that it
    a. can be frozen for up to 2 months.
    b. should be stored only in glass bottles.
    c. can be thawed and refrozen.
    d. can be kept refrigerated for 48 hours.

    ANS: D
    If used within 48 hours after being refrigerated, breast milk will maintain its full nutritional value.

    PTS: 1 DIF: Cognitive Level: Knowledge REF: p. 496
    OBJ: Nursing Process: Assessment
    MSC: Client Needs: Safe and Effective Care Environment

20. The nurse should explain to new parents that the most serious consequence of propping an infant's bottle is
    a. dental caries.
    b. aspiration.
    c. ear infections.
    d. colic.

    ANS: B
    Propping the bottle increases the likelihood of choking and aspiration if regurgitation occurs. Dental caries become a problem when milk stays on the gums for a long period of time. This may cause a buildup of bacteria that will alter the growing teeth buds. However, this is not the most serious consequence. Ear infections can occur when the warm formula runs into the ear and bacterial growth occurs. However, this is not the most serious consequence. Colic can occur, but it is not the most serious consequence.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 497 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

21. Parents have been asked by the neonatologist to provide breast milk for their newborn son, who was born prematurely at 32 weeks of gestation. The nurse who instructs them about pumping, storing, and transporting the milk needs to assess their knowledge of lactation. What statement is valid?
    a. A premature infant more easily digests breast milk than formula.
    b. A glass of wine just before pumping will help reduce stress and anxiety.
    c. The mother should only pump as much as the infant can drink.
    d. The mother should pump every 2 to 3 hours, including during the night.

    ANS: A
    Human milk is the ideal food for preterm infants, with benefits that are unique in addition to those received by term, healthy infants. Greater physiologic stability occurs with breastfeeding compared with formula feeding. Consumption of alcohol during lactation is approached with caution. Excessive amounts can have serious effects on the infant and can adversely affect the mother's milk ejection reflex. It is generally taught that lactating mothers avoid it. To establish an optimal milk supply, the mother should be instructed to pump 8 to 10 times a day for 10 to 15 minutes on each breast. The mother should be instructed to pump 8 to 10 times a day for 10 to 15 minutes on each breast.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 480 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

22. A new mother asks if she should feed her newborn colostrum, because it is not "real milk." The nurse's best answer is that
    a. colostrum is high in antibodies, protein, vitamins, and minerals.
    b. colostrum is lower in calories than milk and should be supplemented by formula.
    c. giving colostrum helps the mother learn how to breastfeed.
    d. colostrum is unnecessary for newborns.

    ANS: A
    Colostrum is important because it has high levels of the nutrients needed by the neonate and helps protect against infection. Supplementation is not necessary. It will decrease stimulation to the breast and decrease the production of milk. It is important for the mother to feel comfortable in this role before discharge, but the importance of the colostrum to the infant is top priority. Colostrum provides immunities and enzymes necessary to clean the gastrointestinal system, among other things.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 480 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

23. What information about iron supplementation should the nurse teach a new mother?
    a. Start iron supplementation shortly after birth if the infant is breastfeeding exclusively.
    b. Iron-fortified formula will meet the infant's iron requirements.
    c. Iron supplements must be given when the infant begins teething.
    d. Infants need a multivitamin with iron every day.

ANS: B
Iron-fortified formula will meet the infant's initial iron requirements. Solid foods added to the diet maintain iron needs as formula intake decreases. Term infants who are exclusively breastfed have adequate iron stored until they are age 6 months. Iron supplements are not necessary for adequate teething. Vitamins and minerals are added to processed formulas and cereals. It should not be necessary for the child to receive a multivitamin with iron unless the infant is at risk for undernutrition.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 481 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

24. A new mother wants to be sure that she is meeting her daughter's needs while feeding her commercially prepared infant formula. The nurse determines that the mother meets her child's needs when she
    a. adds rice cereal to her formula at 2 weeks of age to ensure adequate nutrition.
    b. warms the bottles using a microwave oven.
    c. burps her infant during and after the feeding as needed.
    d. refrigerates any leftover formula for the next feeding.

    ANS: C
    Most infants swallow air when fed from a bottle and should be given a chance to burp several times during a feeding and after the feeding. Solid food should not be introduced to the infant for at least 4 to 6 months after birth. A microwave should never be used to warm any food to be given to an infant. The heat is not distributed evenly, which may pose a risk of burning the infant. Any formula left in the bottle after the feeding should be discarded, because the infant's saliva has mixed with it.

    PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
    REF: p. 496 OBJ: Nursing Process: Evaluation
    MSC: Client Needs: Health Promotion and Maintenance

25. According to the recommendations of the American Academy of Pediatrics (AAP) on infant nutrition
    a. Infants should be given only human milk for the first 6 months of life.
    b. Infants fed on formula should be started on solid food sooner than breastfed infants.
    c. If infants are weaned from breast milk before 12 months, they should receive cow's milk, not formula.
    d. After 6 months, mothers should shift from breast milk to cow's milk.

    ANS: A
    Breastfeeding/human milk should also be the sole source of milk for the second 6 months. Infants start on solids when they are ready, usually at 6 months, whether they start on formula or breast milk. If infants are weaned from breast milk before 12 months, they should receive iron-fortified formula, not cow's milk. Breastfeeding/human milk should also be the sole source of milk for the second 6 months.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 482 | Box 23.2 OBJ: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

26. The Baby Friendly Hospital Initiative was founded to encourage institutions to offer optimal levels of care for lactating mothers. Which is of the following is inconsistent with the nurse's knowledge about the "Ten Steps to Successful Breastfeeding for Hospitals"?
    a. Give newborns no food or drink other than breast milk.
    b. Have a written breastfeeding policy that is communicated to all staff.
    c. Help mothers initiate breastfeeding within one half-hour of birth.
    d. Give artificial pacifiers as necessary.

    ANS: D
    No artificial pacifiers should be given to breastfeeding infants. The other statements are consistent with the "Ten Steps to Successful Breastfeeding for Hospitals."

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 482 | Box 23.2 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

27. The best reason for recommending formula over breastfeeding is that
    a. the mother has a medical condition or is taking drugs that could be passed along to the infant via breast milk.
    b. the mother lacks confidence in her ability to breastfeed.
    c. other family members or care providers also need to feed the baby.
    d. the mother sees bottle-feeding as more convenient.

    ANS: A
    Breastfeeding is contraindicated when mothers have certain viruses, are undergoing chemotherapy, or are using/abusing drugs. Some women lack confidence in their ability to produce breast milk of adequate quantity or quality. The key to encouraging these mothers to breastfeed is anticipatory guidance beginning as early as possible in pregnancy. A major barrier for many women is the influence of family and friends. She may view formula feeding as a way to ensure that the father and other family members can participate. Each encounter with the family is an opportunity for the nurse to educate, dispel myths, and clarify information regarding the benefits of breastfeeding. Many women see bottle-feeding as more convenient and less embarrassing than breastfeeding. They may also see breastfeeding as incompatible with an active social life. There may be modesty issues related to feeding the infant in public. Although concerning, these are not legitimate reasons to formula-feed an infant. Often this decision is made without complete information regarding the benefits of breastfeeding.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 492 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

28. The nurse providing couplet care should understand that nipple confusion results when
    a. breastfeeding babies receive supplementary bottle feedings.
    b. the baby is weaned too abruptly.
    c. pacifiers are used before breastfeeding is established.
    d. twins are breastfed together.

ANS: A
Nipple confusion can result when babies go back and forth between bottles and breasts, especially before breastfeeding is established in 3 to 4 weeks, because the two require different skills. Abrupt weaning can be distressing to mother and/or baby but should not lead to nipple confusion. Pacifiers used before breastfeeding is established can be disruptive, but this does not lead to nipple confusion. Breastfeeding twins require some logistic adaptations, but this should not lead to nipple confusion.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 490 OBJ: Nursing Process: Planning
MSC: Client Needs: Health Promotion and Maintenance

29. The mother who is pumping for an occasional bottle would be most suited for which type of breast pump?
a. Manual or hand pump
b. Hospital-grade pump
c. Electric self-cycling double pumps
d. Smaller electric or battery-operated pump

ANS: A
These are the least expensive and can be the most appropriate choice for mothers pumping for the occasional bottle. Full-service electric or hospital-grade pumps most closely duplicate the sucking action of the breastfeeding infant. These are used when mother and baby (preterm or sick) are separated for long periods. Self-cycling pumps are easy to use, efficient, and designed for working mothers. Smaller pumps operated with a battery are typically used when pumping occasionally.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 495 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

30. The nurse notes a new mother is waiting until her newborn begins crying prior to breastfeeding her. What response by the nurse is best?
a. Praise the mother for her efforts to nurse.
b. Teach the mother signs of hunger in the newborn.
c. Inform the mother she is inhibiting bonding.
d. Demonstrate calming methods prior to feeding.

ANS: B
Crying is a late sign of hunger in the newborn. The nurse should teach the mother other signs of hunger so the baby will be more ready to eat when the mother attempts to feed the baby. Of course the nurse should praise all attempts at breastfeeding, but this is not the best response. Telling the mother she is inhibiting bonding will discourage her. The nurse should also demonstrate calming methods, but the goal is to feed the infant when he or she displays early signs of hunger.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 483 | Box 23.3 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

31. A woman wants to breastfeed, but her nipples are inverted and she is concerned it won't be possible. What does the nurse teach the woman about this condition?
    a. A woman with inverted nipples rarely is successful at breastfeeding.
    b. You can use a breast pump just prior to feeding to evert the nipples.
    c. Massage the breasts prior to feeding to allow milk let-down.
    d. Try changing the infant's position during feedings.

    ANS: B
    A breast pump can be used just prior to feeding. As soon as the suction everts the nipple, the woman needs to place the baby to the breast. Women with inverted nipples can breastfeed. Massage and changing the infant's position will not affect the inverted nipples.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 485 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

32. The nurse notices an infant has dimpling of the cheeks when breastfeeding. What action by the nurse is best?
    a. Tell the mother this is a sign of adequate feeding.
    b. Have the mother remove the baby from the breast and try again.
    c. Make a referral for a lactation consultation.
    d. Instruct the mother to feed for at least 15 minutes.

    ANS: B
    Dimpling the cheeks is a sign of an infant- derived problem during breastfeeding. The nurse should have the mother gently remove the baby from the breast, reposition the infant if needed, and try to get the baby to latch on correctly so she can try again. The nurse may need to call for a lactation consultant, but all mother -baby or labor and delivery nurses should be able to provide basic assistance first. This is not a sign of adequate feeding so the nurse should not encourage her to keep going for another 15 minutes.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 490 | Safety Alert Box OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. Some nipple conditions make it necessary to provide intervention before birth in the mother who plans to breastfeed. These include (*Select all that apply*.)
    a. Everted nipples
    b. Flat nipples
    c. Inverted nipples
    d. Nipples that contract when compressed
    e. Cracked nipples

    ANS: B, C, D

Flat nipples appear soft, like the areola, and do not stand erect unless stimulated by rolling them between the fingers. Inverted nipples are retracted into the breast tissue. These nipples appear normal; however, they will draw inward when the areola is compressed by the infant's mouth. Dome-shaped devices known as breast shells can be worn during the last weeks of pregnancy and between feedings after birth. The shells are placed inside the bra with the opening over the nipple. The shells exert slight pressure against the areola to help the nipples protrude. The helpfulness of breast shells is debated. A breast pump can be used to draw the nipples out before feedings after delivery. Everted nipples protrude and are normal. No intervention will be required. Cracked, blistered, and bleeding nipples occur after breastfeeding has been initiated and are the result of improper latch.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: pp. 484-485 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

2. Which are examples of appropriate techniques to wake a sleepy infant for breastfeeding? (*Select all that apply*.)
   a. Unwrap the infant.
   b. Change the diaper.
   c. Talk to the infant.
   d. Slap the infant's hands and feet.
   e. Apply a cold towel to the infant's abdomen.

   ANS: A, B, C
   Unwrapping the infant, changing the diaper, or talking to the infant are appropriate ways of waking the sleeping baby. Slapping the hands and feet and applying cold towels are not appropriate methods.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 493 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

3. A nurse is discussing the signs and symptoms of mastitis with a mother who is breastfeeding. What signs and symptoms should the nurse include in her discussion? (*Select all that apply*.)
   a. Breast tenderness
   b. Warmth in the breast
   c. An area of redness on the breast often resembling the shape of a pie wedge
   d. A small white blister on the tip of the nipple
   e. Fever and flulike symptoms

   ANS: A, B, C, E
   Signs and symptoms of mastitis include breast tenderness and warmth, an area of redness on the breast, and fever or flulike symptoms. A small white blister on the tip of the nipple is generally associated with a plugged milk duct.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 491 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

4. The student nurse learns that breastfed babies are less likely to develop certain health conditions as adults. Which conditions does this include? (*Select all that apply.*)
   a. Diabetes
   b. Asthma
   c. Obesity
   d. Kidney failure
   e. Some cancers

   ANS: A, B, C, E
   Breastfed infants are less likely to develop diabetes, asthma, obesity, and some cancers than bottle-fed infants. No difference is seen in the development of kidney failure.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 482 | Box 23.2 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

COMPLETION

1. A newborn weighs 8.7 pounds. How many kilocalories does this breastfed term infant require each day? _____

   ANS:
   336 to 395

   The breastfed baby needs 85 to 100 kcal/kg/day. This baby weighs 8.7 pounds (3.95 kg) so 85 × 3.95 = 85. 3.95 × 100 = 395.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 481 | Box 23.1 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. A pregnant woman who abuses cocaine admits to exchanging sex for her drug habit. This behavior puts her at a greater risk for which of the following?
   a. Depression of the central nervous system
   b. Hypotension and vasodilation
   c. Sexually transmitted diseases
   d. Postmature birth

   ANS: C
   Sex acts exchanged for drugs place the woman at increased risk for sexually transmitted diseases because of multiple partners and lack of protection. Cocaine is a central nervous system stimulant. Cocaine causes hypertension and vasoconstriction. Premature delivery of the infant is one of the most common problems associated with cocaine use during pregnancy.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 508 | Table 24.1 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

2. During which phase of the cycle of violence does the batterer become contrite and remorseful?
   a. Battering phase
   b. Honeymoon phase
   c. Tension-building phase
   d. Increased drug-taking phase

   ANS: B
   During the honeymoon phase, the battered person wants to believe that the battering will never happen again, and the batterer will promise anything to get back into the home. During the battering phase violence actually occurs, and the victim feels powerless. During the tension-building phase, the batterer becomes increasingly hostile, swears, threatens, throws things, and pushes the battered. Often the batterer increases the use of drugs during the tension-building phase; however, this is not an actual phase of the cycle.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 518 | Figure 24.5 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Psychosocial Integrity

3. What is a major barrier to health care for teen mothers?
   a. The hospital/clinic is within walking distance of the girl's home.
   b. The institution is open days, evenings, and Saturdays by special arrangement.
   c. The teen must be prepared to see a different nurse or doctor or both at every visit.
   d. The health care workers have a positive attitude.

   ANS: C

Whenever possible, the teen should be scheduled to see the same nurses and practitioners for continuity of care. If the hospital/clinic were within walking distance of the girl's home, it would prevent the teen from missing appointments because of transportation problems. If the institution were open days, evenings, and Saturdays by special arrangement, this availability would be helpful for teens who work, go to school, or have other time-of-day restrictions. Scheduling conflicts are a major barrier to health care. A negative attitude is unfortunate, because it discourages families who would benefit most from consistent prenatal care.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 503 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

4. Of adolescents who become pregnant, what percentage have had a previous birth?
   a. 10%
   b. 15%
   c. 17%
   d. 35%

   ANS: C
   Seventeen percent of pregnant adolescents have had one or more previous births.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 500 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

5. In counseling a patient who has decided to relinquish her baby for adoption, the nurse should do which of the following?
   a. Affirm her decision while acknowledging her maturity in making it.
   b. Question her about her feelings regarding adoption.
   c. Tell her she can always change her mind about adoption.
   d. Ask her if anyone is coercing her into the decision to relinquish her baby.

   ANS: A
   A supportive, affirming approach by the nurse will strengthen the patient's resolve and help her to appreciate the significance of the event. The teen needs help in coping with her feelings about this decision. It is important for the nurse to support and affirm the decision the patient has made. This will strengthen the patient's resolve to follow through. Later the patient should be given an opportunity to express her feelings. Telling her she can always change her mind should not be an option after the baby is born and placed with the adoptive parents. It is important that the teenager is treated as an adult, with the assumption that she is capable of making an important decision on her own.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 501 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Psychosocial Integrity

6. A woman who is older than 35 years may have difficulty achieving pregnancy, because
   a. personal risk behaviors influence fertility.
   b. she has used contraceptives for an extended time.

c. her ovaries may be affected by the aging process.
d. prepregnancy medical attention is lacking.

ANS: C
Once the mature woman decides to conceive, a delay in becoming pregnant may occur because of the normal aging of the ovaries. The older adult participates in fewer risk behaviors than the younger adult. The problem is the age of the ovaries, not the past use of contraceptives. Prepregnancy medical care is available and encouraged.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 505 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

7. What is most likely to be a concern for the older mother?
a. The importance of having enough rest and sleep
b. Information about effective contraceptive methods
c. Nutrition and diet planning
d. Information about exercise and fitness

ANS: A
The woman who delays childbearing may have unique concerns, one of which is having less energy than younger mothers. The older mother usually has more financial means to search out effective contraceptive methods. The older mother often is better off financially and can afford better nutrition. Information about exercise and fitness is readily available.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 506 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

8. What is the most dangerous effect on the fetus of a mother who smokes cigarettes while pregnant?
a. Genetic changes and anomalies
b. Extensive central nervous system damage
c. Fetal addiction to the substance inhaled
d. Intrauterine growth restriction

ANS: D
The major consequences of smoking tobacco during pregnancy are low-birth-weight infants, prematurity, and increased perinatal loss. Cigarettes normally will not cause genetic changes or extensive central nervous system damage. Addiction is not a normal concern with the neonate.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 508 | Table 24.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

9. A patient at 24 weeks of gestation says she has a glass of wine with dinner every evening. The nurse will counsel her to eliminate all alcohol intake. What is the best rationale provided by the nurse?
a. A daily consumption of alcohol indicates a risk for alcoholism.

b. She will be at risk for abusing other substances as well.
c. The fetus is placed at risk for altered brain growth.
d. The fetus is at risk for multiple organ anomalies.

ANS: C
The brain grows most rapidly in the third trimester and is most vulnerable to alcohol exposure during this time. A risk for alcoholism is not the major risk for the infant. Multiple organ anomalies are not a major concern.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 508 | Table 24.1 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

10. Which of these substances can lead to miscarriage, preterm labor, placental separation (abruption), and stillbirth?
a. Heroin
b. Alcohol
c. PCP
d. Cocaine

ANS: D
Cocaine is a powerful CNS stimulant. Effects on pregnancy associated with cocaine use include abruptio placentae, preterm labor, precipitous birth, and stillbirth. Heroin is an opiate. Its use in pregnancy is associated with preeclampsia, intrauterine growth restriction, miscarriage, premature rupture of membranes, infections, breech presentation, and preterm labor. The most serious effect of alcohol use in pregnancy is FAS. The major concerns regarding PCP use in pregnant women are its association with polydrug abuse and the neurobehavioral effects on the neonate.

PTS: 1 DIF: Cognitive Level: Comprehension
REF: p. 507 | Table 24.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

11. When helping the mother, father, and other family members actualize the loss of the infant, nurses should
a. use the words *lost* or *gone* rather than *dead* or *died*.
b. make sure the family understands that it is important to name the baby.
c. if the parents choose to visit the baby, apply lotion to the baby and wrap the infant in a pretty blanket.
d. set a firm time for ending the visit with the baby so that the parents know when to let go.

ANS: C
Presenting the baby in a nice way stimulates the parents' senses and provides pleasant memories of their baby. Nurses must use dead and died to assist the bereaved in accepting reality. Although naming the baby can be helpful, it is important not to create the sense that parents have to name the baby. In fact, some cultural taboos and religious rules prohibit the naming of an infant who has died. Parents need different time periods with their baby to say goodbye. Nurses need to be careful not to rush the process.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 514 OBJ: Nursing Process: Planning
MSC: Client Needs: Psychosocial Integrity

12. A woman has delivered twins. The first twin was stillborn, and the second is in the intensive care nursery and is recovering quickly from respiratory distress. The woman is crying softly and says, ”I wish my baby could have lived.” What is the most therapeutic response?
    a. “Don’t be sad. At least you have one healthy baby.”
    b. “How soon do you plan to have another baby?”
    c. “I have a friend who lost a twin and she’s doing just fine now ”
    d. “I am so sorry about your loss. Would you like to talk about it?”

    ANS: D
    The nurse should recognize the woman’s grief and its significance and allow her to express her feelings. The other three responses belittle the woman’s feelings.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 514 OBJ: Integrated Process: Communication and Documentation
    MSC: Client Needs: Psychosocial Integrity

13. Which of the following is an appropriate nursing measure when a baby has an unexpected anomaly?
    a. Remove the baby from the delivery area immediately.
    b. Tell the parents that the baby has to go to the nursery immediately.
    c. Inform the parents immediately that something is wrong.
    d. Explain the defect, and show the baby to the parents as soon as possible.

    ANS: D
    Parents experience less anxiety when they are told about the defect as early as possible and are allowed to touch and hold the baby. The parents should be both informed and able to touch and hold the baby as soon as possible.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 511 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Psychosocial Integrity

14. A woman who is 6 months pregnant has sought medical attention saying she fell down the stairs. What scenario would cause an emergency department nurse to suspect that the woman has been battered?
    a. The woman and her partner are having an argument that is loud and hostile.
    b. The woman has injuries on various parts of her body in different stages of healing.
    c. Examination reveals a fractured arm and fresh bruises. Her husband asks her about her pain.
    d. She loudly complains about having several injuries.

    ANS: B
    The battered woman often has multiple injuries in various stages of healing. Arguing may or may not be sign of battering; many times the batterer will be attentive and refuse to leave the woman’s side. A battered woman often has a flat affect or avoids eye contact and is vague about how the injuries occurred.

PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
REF: p. 519 | Critical to Remember Box OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

15. Which of the following items are inconsistent with the nurse's knowledge of symptoms of fetal alcohol syndrome?
    a. Respiratory conditions
    b. Impaired growth
    c. CNS abnormality
    d. Facial abnormalities

    ANS: A
    Respiratory difficulties are not a category of conditions that are related to FAS. Abnormalities related to FAS include impaired growth (intrauterine growth restriction), CNS abnormalities, and a constellation of typical facial features.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 508 | Table 24.1 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

16. When the nurse is alone with a battered patient, the patient seems extremely anxious and says, "It was all my fault. The house was so messy when he got home and I know he hates that." The best response by the nurse is
    a. "No one deserves to be hurt. It's not your fault. How can I help you?"
    b. "What else do you do that makes him angry enough to hurt you?"
    c. "He will never find out what we talk about. Don't worry. We're here to help you."
    d. "You have to remember that he is frustrated and angry so he takes it out on you."

    ANS: A
    The nurse should stress that the patient is not at fault and offer to help. Asking what else the woman does to make the partner angry or reminding her that he is frustrated is placing blame on the woman. Telling her "don't worry" is giving false reassurance.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 519 | Critical to Remember Box OBJ: Nursing Process: Implementation
    MSC: Client Needs: Psychosocial Integrity

17. In helping bereaved parents cope and move on, nurses should keep in mind that
    a. a perinatal or parental grief support group is more likely to be helpful if the needs of the parents are matched with the focus of the group.
    b. when pictures of the infant are taken for keepsakes, no close-ups should be taken of any congenital anomalies.
    c. no significant differences exist in grieving individuals from various cultures, ethnic groups, and religions.
    d. calling the hospital clergy for emergency baptism is always appropriate.

    ANS: A

The nurse should try when possible to match the recommended support resources to the parents. For example, a religious-based group may not work for nonreligious parents. Close-up pictures of the baby must be taken as the infant was, congenital anomalies and all. Although death and grieving are events shared by all people, mourning rituals, traditions, and taboos vary by culture, ethnicity, and religion. Differences must be respected. Parents may or may not want the newborn to be baptized; the nurse must assess the family for their religious wishes and facilitate them.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 512 OBJ: Nursing Process: Planning
MSC: Client Needs: Psychosocial Integrity

18. A common effect of both smoking and cocaine use on the pregnant woman is
    a. vasoconstriction.
    b. increased appetite.
    c. inactivates fetal hemoglobin.
    d. euphoria.

    ANS: A
    Both smoking and cocaine use cause vasoconstriction, which results in impaired placental blood flow to the fetus. Both smoking and cocaine use decrease the appetite. Smoking inactivates fetal hemoglobin. Euphoria can be seen with cocaine use.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 507 | Table 24.1 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

19. What information about caffeine in pregnancy does the nurse provide the prenatal class with?
    a. It stays in your body twice as long as when you are not pregnant.
    b. It causes vasoconstriction, which could keep the fetus from growing.
    c. Caffeine depresses your heart’s ability to pump and function.
    d. Severe diuresis can leave you at risk for dehydration during pregnancy.

    ANS: B
    Caffeine is a vasoconstrictor. Its half-life is 3 times as long in the pregnant woman. It stimulates cardiac function. It does cause mild but not severe diuresis.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 507 | Table 24.1 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

20. The student nurse learns that the most important reason marijuana should not be used during pregnancy is which of the following?
    a. Unknown effects, more research is needed
    b. Causes a higher rate of spontaneous abortions
    c. Leads to multiple organ dysfunction in the newborn
    d. Responsible for severe cognitive deficits

    ANS: A

Marijuana's effects on the fetus are largely unknown. More research is needed in this area.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 507 | Table 24.1 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

21. A nurse is interviewing a pregnant woman in the clinic. She seems hostile and answers many questions with "Whatever" and "I don't really know." At her last appointment she was late and disheveled. What action by the nurse is best?
    a. Ask the woman if this pregnancy was planned or is wanted.
    b. Call social services to come evaluate the situation.
    c. Ask the woman about drug use, including over the counter.
    d. Encourage the woman to be more forthright with answers.

    ANS: C
    This woman is displaying some signs of substance abuse. In a non- judgmental manner, the nurse should ask about all drugs and medications she is using. The questions will appear less confrontative if the nurse begins by asking about over-the-counter medications first. Asking if the pregnancy is planned or wanted is conveying disapproval to the woman for her choices and behavior. Social services may or may not need to be involved, but the nurse needs to assess the woman more completely first. Encouraging the woman to be more forthright implies that she is being dishonest and will not gain more cooperation.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 509 | Critical to Remember Box OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. Many teens wait until the second or even third trimester to seek prenatal care. The nurse should understand that the reasons behind this delay include which of the following? (*Select all that apply*.)
    a. Lack of realization that they are pregnant
    b. Uncertainty as to where to go for care
    c. Continuing to deny the pregnancy
    d. A desire to gain control over their situation
    e. Wanting to hide the pregnancy as long as possible

    ANS: A, B, C, E
    Not realizing they are pregnant, uncertainty over where to get care, denial, and wanting to hide the pregnancy are all reasons some teens delay prenatal care. Wanting to gain control over the situation does not lead to delaying care.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 502 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Psychosocial Integrity

2. Approximately 82% of teen pregnancies are unintended. Seventy percent of teens have had sex by their 19th birthday. Factors that contribute to an increased risk for teen pregnancy include which of the following? (*Select all that apply.*)
   a. High self-esteem
   b. Peer pressure
   c. Limited access to contraception
   d. Planning sexual activity
   e. Lack of role models

   ANS: B, C, E
   Peer pressure to begin sexual activity is a contributing factor toward teen pregnancy. Limited access to contraceptive devices and lack of accurate information about how to use these devices are also factors. Lack of appropriate role models, desire to alleviate or escape the present situation at home along with feelings of invincibility also contribute to teen pregnancy. Low self-esteem and the consequent inability to set limits on sexual activity place the adolescent at risk for teen pregnancy. Ambivalence toward sexuality and not planning intercourse are more likely to result in teen pregnancy.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 500 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Psychosocial Integrity

MULTIPLE CHOICE

1. The perinatal nurse is giving discharge instructions to a woman, status post suction and curettage secondary to a hydatidiform mole. The woman asks why she must take oral contraceptives for the next 12 months. The best response from the nurse is
   a. "If you get pregnant within 1 year, the chance of a successful pregnancy is very small. Therefore, if you desire a future pregnancy, it would be better for you to use the most reliable method of contraception available."
   b. "The major risk to you after a molar pregnancy is a type of cancer that can be diagnosed only by measuring the same hormone that your body produces during pregnancy. If you were to get pregnant, it would make the diagnosis of this cancer more difficult."
   c. "If you can avoid a pregnancy for the next year, the chance of developing a second molar pregnancy is rare. Therefore, to improve your chance of a successful pregnancy, it is better not to get pregnant at this time."
   d. "Oral contraceptives are the only form of birth control that will prevent a recurrence of a molar pregnancy."

   ANS: B
   Beta-hCG levels will be drawn for 1 year to ensure that the mole is completely gone. There is an increased chance of developing choriocarcinoma after the development of a hydatidiform mole. The goal is to achieve a "zero" hCG level. If the woman were to become pregnant, it may obscure the presence of the potentially carcinogenic cells. Any contraceptive method except an IUD is acceptable.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 528 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

2. Which maternal condition always necessitates delivery by cesarean section?
   a. Partial abruptio placentae
   b. Total placenta previa
   c. Ectopic pregnancy
   d. Eclampsia

   ANS: B
   In total placenta previa, the placenta completely covers the cervical os. The fetus would die if a vaginal delivery occurred. In a partial abruptio placentae, if the mother has stable vital signs and the fetus is alive, a vaginal delivery can be attempted. If the fetus has died, a vaginal delivery is preferred. The most common ectopic pregnancy is a tubal pregnancy, which is usually detected and treated in the first trimester. Labor can be safely induced if the eclampsia is under control.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 531 OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

3. The nursing student learns that spontaneous termination of a pregnancy is considered to be an abortion if
   a. the pregnancy is less than 20 weeks.
   b. the fetus weighs less than 1000 g.
   c. the products of conception are passed intact.
   d. no evidence exists of intrauterine infection.

   ANS: A
   An abortion is the termination of pregnancy before the age of viability (20 weeks). The weight of a fetus is not considered because some fetuses of an older age may have a low birth weight. A spontaneous abortion may be complete or incomplete. A spontaneous abortion may be caused by many problems, one being intrauterine infection.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 523 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

4. An abortion in which the fetus dies but is retained in the uterus is called _____ abortion.
   a. inevitable
   b. missed
   c. incomplete
   d. threatened

   ANS: B
   Missed abortion refers to a dead fetus being retained in the uterus. An inevitable abortion means that the cervix is dilating with the contractions. An incomplete abortion means that not all of the products of conception were expelled. With a threatened abortion the woman has cramping and bleeding but not cervical dilation.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 524 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

5. A placenta previa in which the placental edge just reaches the internal os is called
   a. total.
   b. partial.
   c. complete.
   d. marginal.

   ANS: D
   A placenta previa that does not cover any part of the cervix is termed marginal. With a total placenta previa the placenta completely covers the os. With a partial previa the lower border of the placenta is within 3 cm of the internal cervical os but does not completely cover the os. A complete previa is termed total. The placenta completely covers the internal cervical os.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 529 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

6. The student nurse is assessing a woman with abruptio placentae. The student reports to the registered nurse “I can’t really palpate her abdomen, it’s as hard as a board.” What action by the nurse is the priority?
   a. Tell the student to document the findings.
   b. Have the student teach the woman relaxation techniques.
   c. Assess the woman’s fundal height and vital signs.
   d. Administer a dose of opioid pain medication.

   ANS: C
   A hard, board- like abdomen in this setting is characteristic of concealed hemorrhage. The nurse assesses the woman’s fundal height (which will rise with bleeding) and vital signs to detect shock. Documentation occurs after interventions are complete. Relaxation techniques may help the woman cope with the situation, but anxiety is not the reason for the findings. The woman may or may not need pain medication, and if she is going to need surgery, she should not get opioids until consents are signed.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 532 | Safety Alert Box OBJ: Nursing Process: Assessment
   MSC: Client Needs: Safe and Effective Care Environment

7. The priority nursing intervention when admitting a pregnant woman who has experienced a bleeding episode in late pregnancy is to
   a. assess fetal heart rate (FHR) and maternal vital signs.
   b. perform a venipuncture for hemoglobin and hematocrit levels.
   c. place clean disposable pads to collect any drainage.
   d. monitor uterine contractions.

   ANS: A
   Assessment of the FHR and maternal vital signs will assist the nurse in determining the degree of the blood loss and its effect on the mother and fetus. The blood levels can be obtained later. It is important to assess future bleeding and provide for comfort, but the top priority is mother/fetal well-being. Monitoring uterine contractions is important but not the top priority.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 530 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

8. A pregnant woman has been diagnosed with gestational hypertension and is crying. She asks the nurse if this means she has to take blood pressure medicine for the rest of her life. What answer by the nurse is best?
   a. “Yes, you will have hypertension for the rest of your life.”
   b. “No, this always goes away after you deliver.”
   c. “Maybe, we have to wait and see at your 6-week postpartum checkup.”
   d. “I don’t know. But if you need medicine you should take it.”

   ANS: C

Gestational hypertension can last after delivery. If it has not resolved by postpartum week 6, it is considered chronic, and the woman will probably have to take medication. It may or may not resolve, but the nurse should not provide false reassurance or state that he or she does not know without finding more information. Telling the woman to take medicine if she needs it belittles her concerns.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 536 | Table 25.1 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

9. A woman with severe preeclampsia is being treated with bed rest and intravenous magnesium sulfate. The drug classification of this medication is
   a. tocolytic.
   b. anticonvulsant.
   c. antihypertensive.
   d. diuretic.

   ANS: B
   Anticonvulsant drugs act by blocking neuromuscular transmission and depress the central nervous system to control seizure activity. A tocolytic drug does slow the frequency and intensity of uterine contractions, but it is not used for that purpose in this scenario. Decreased peripheral blood pressure is a therapeutic response (side effect) of the anticonvulsant magnesium sulfate. Diuresis is a therapeutic response to magnesium sulfate.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 539 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

10. What is the only known cure for preeclampsia?
    a. Magnesium sulfate
    b. Antihypertensive medications
    c. Delivery of the fetus
    d. Administration of acetylsalicylic acid (ASA) every day of the pregnancy

    ANS: C
    If the fetus is viable and near term, delivery is the only known definitive treatment for preeclampsia. Magnesium sulfate is one of the medications used to treat but not to cure preeclampsia. Antihypertensive medications are used to lower the dangerously elevated blood pressures in preeclampsia and eclampsia. Low doses of ASA (81 mg) have been administered to women at high risk for developing preeclampsia.

    PTS: 1 DIF: Cognitive Level: Knowledge REF: p. 539
    OBJ: Nursing Process: Planning MSC: Client Needs: Physiologic Integrity

11. Which clinical sign is not included in the symptoms of preeclampsia?
    a. Hypertension
    b. Edema
    c. Proteinuria
    d. Glycosuria

ANS: D
Spilling glucose into the urine is not one of the three classic symptoms of preeclampsia. Hypertension is usually the first sign noted. Edema occurs but is considered a non-specific sign. Edema can lead to rapid weight gain. Proteinuria should be assessed through a 24-hour UA.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 537 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

12. A nurse is assessing a woman receiving magnesium sulfate. The nurse assesses her deep tendon reflexes at 0 and 1+. What action by the nurse is best?
    a. Hold the magnesium sulfate.
    b. Ask the provider to order a 24-hour UA.
    c. Assess the woman's temperature.
    d. Take the woman's blood pressure.

    ANS: A
    Absent or hypoactive deep tendon reflexes are indicative of magnesium sulfate toxicity. The nurse should hold the magnesium and notify the provider. There is no need for a 24- hour UA at this point. Temperature changes are not related to magnesium. Blood pressure can be assessed, but that is not the priority.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 542 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Safe and Effective Care Environment

13. The labor of a pregnant woman with preeclampsia is going to be induced. The nurse reviews the woman's latest laboratory test findings, which reveal a low platelet count, an elevated aspartate transaminase (AST) level, and a falling hematocrit. What action by the nurse is most important?
    a. Palpate the woman's abdomen for tenderness.
    b. Document findings and begin the Pitocin infusion.
    c. Instruct the woman to ask for help getting out of bed.
    d. Assess the woman's drinking history.

    ANS: C
    This woman has HELLP syndrome, with is characterized by low platelet counts and hepatic dysfunction. She is at risk for bleeding, so the nurse instructs her to call for assistance in getting in and out of bed. The nurse does not palpate the abdomen even though the woman may complain of abdominal pain because of possible rupture of a subcapsular hematoma. The findings should be documented but the nurse should intervene based on the abnormal findings. The liver enzymes are not elevated because of alcohol intake.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 544 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Safe and Effective Care Environment

14. The nurse is explaining how to assess edema to the nursing students working on the antepartum unit. Which score indicates edema of lower extremities, face, hands, and sacral area?
    a. +1 edema
    b. +2 edema
    c. +3 edema
    d. +4 edema

    ANS: C
    Edema of the extremities, face, and sacral area is classified as +3 edema. Edema classified as +1 indicates minimal edema of the lower extremities. Marked edema of the lower extremities is termed +2 edema. Generalized massive edema (+4) includes accumulation of fluid in the peritoneal cavity.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 537 | Table 25.2 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

15. The prenatal clinic nurse monitored women for preeclampsia. If all four women were in the clinic at the same time, which one should the nurse see first?
    a. Blood pressure increase to 138/86 mm Hg
    b. Weight gain of 0.5 kg during the past 2 weeks
    c. A dipstick value of 3+ for protein in her urine
    d. Pitting pedal edema at the end of the day

    ANS: C
    Proteinuria is defined as a concentration of 1+ or greater via dipstick measurement. A dipstick value of 3+ is indicative of severe preeclampsia and should alert the nurse that additional testing or assessment should be made. Generally, hypertension is defined as a BP of 140/90 or higher. Preeclampsia may be manifested as a rapid weight gain. Gaining 0.5 kg during the past 2 weeks does not qualify as rapid. Edema occurs in many normal pregnancies as well as in women with preeclampsia. Therefore, the presence of edema is no longer considered diagnostic of preeclampsia.

    PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
    REF: p. 538 | Table 25.3 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Safe and Effective Care Environment

16. A patient with pregnancy-induced hypertension is admitted complaining of pounding headache, visual changes, and epigastric pain. Nursing care is based on the knowledge that these signs indicate
    a. Anxiety due to hospitalization
    b. Worsening disease and impending seizure
    c. Effects of magnesium sulfate
    d. Gastrointestinal upset

    ANS: B
    Headache and visual disturbances are due to increased cerebral edema. Epigastric pain indicates distention of the hepatic capsules and often warns that a seizure is imminent. These sign are not due to anxiety or magnesium sulfate or related to gastrointestinal upset.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 538 | Table 25.3 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

17. Rh incompatibility can occur if the woman is Rh negative and her
    a. fetus is Rh positive.
    b. husband is Rh positive.
    c. fetus is Rh negative.
    d. husband and fetus are both Rh negative.

    ANS: A
    For Rh incompatibility to occur, the mother must be Rh negative and her fetus Rh positive. The husband's Rh factor is a concern only as it relates to the possible Rh factor of the fetus. If the fetus is Rh negative, the blood types are compatible and no problems should occur. If the fetus is Rh negative, the blood type with the mother is compatible. The husband's blood type does not enter into the problem.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 545 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

18. In which situation is a dilation and curettage (D&C) indicated?
    a. Complete abortion at 8 weeks
    b. Incomplete abortion at 16 weeks
    c. Threatened abortion at 6 weeks
    d. Incomplete abortion at 10 weeks

    ANS: D
    D&C is used to remove the products of conception from the uterus and can be used safely until week 14 of gestation. After that there is a greater risk of excessive bleeding, and this procedure may not be used. If all the products of conception have been passed (complete abortion), a D&C is not used. If the pregnancy is still viable (threatened abortion), a D&C is not used.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 525 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

19. What order should the nurse expect for a patient admitted with a threatened abortion?
    a. Abstinence from sexual activity
    b. Pitocin IV
    c. NPO
    d. Narcotic analgesia every 3 hours, prn

    ANS: A
    The woman may be counseled to avoid sexual activity with a threatened abortion. Activity restrictions were once recommended, but they have not shown effectiveness as treatment. Pitocin would be contraindicated. There is no reason for the woman to be NPO. In fact, hydration is important. Narcotic analgesia is not indicated.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 524 OBJ: Nursing Process: Planning
MSC: Client Needs: Health Promotion and Maintenance

20. What data on a patient's health history places her at risk for an ectopic pregnancy?
    a. Use of oral contraceptives for 5 years
    b. Recurrent pelvic infections
    c. Ovarian cyst 2 years ago
    d. Heavy menstrual flow of 4 days' duration

    ANS: B
    Infection and subsequent scarring of the fallopian tubes prevents normal movement of the fertilized ovum into the uterus for implantation. Oral contraceptives, ovarian cysts, and heavy menstrual flows do not increase risk.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 526 | Box 25.1 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

21. What finding on a prenatal visit at 10 weeks might suggest a hydatidiform mole?
    a. Complaint of frequent mild nausea
    b. Blood pressure of 120/80 mm Hg
    c. Fundal height measurement of 18 cm
    d. History of bright red spotting for 1 day, weeks ago

    ANS: C
    The uterus in a hydatidiform molar pregnancy is often larger than would be expected on the basis of the duration of the pregnancy. Many women have nausea in the first trimester. A woman with a molar pregnancy may have early-onset pregnancy-induced hypertension. The history of bleeding is normally described as being brownish.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 528 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

22. What routine nursing assessment is contraindicated in the patient admitted with suspected placenta previa?
    a. Monitoring FHR and maternal vital signs
    b. Observing vaginal bleeding or leakage of amniotic fluid
    c. Determining frequency, duration, and intensity of contractions
    d. Determining cervical dilation and effacement

    ANS: D
    Vaginal examination of the cervix may result in perforation of the placenta and subsequent hemorrhage and is therefore contraindicated. Monitoring FHR and maternal vital signs is a necessary part of the assessment for this woman. Monitoring for bleeding and rupture of membranes is not contraindicated in this woman. Monitoring contractions is not contraindicated in this woman.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 530 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

23. The primary symptom present in abruptio placentae that distinguishes it from placenta previa is
    a. vaginal bleeding.
    b. rupture of membranes.
    c. presence of abdominal pain.
    d. changes in maternal vital signs.

    ANS: C
    Pain in abruptio placentae occurs in response to increased pressure behind the placenta and within the uterus. Placenta previa manifests with painless vaginal bleeding, but both may have vaginal bleeding. Rupture of membranes may occur with both conditions. Maternal vital signs may change with both if bleeding is pronounced.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 529 | p. 532 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

24. Which laboratory marker is indicative of disseminated intravascular coagulation (DIC)?
    a. Positive KB test
    b. Presence of fibrin split products
    c. Thrombocytopenia
    d. Positive drug screen

    ANS: B
    Degradation of fibrin leads to the accumulation of multiple fibrin clots throughout the body's vasculature. The other lab tests are not indicative of DIC.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 525 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

25. A woman taking magnesium sulfate has respiratory rate of 10 breaths/min. In addition to discontinuing the medication, the nurse should
    a. vigorously stimulate the woman.
    b. instruct her to take deep breaths.
    c. administer calcium gluconate.
    d. increase her IV fluids.

    ANS: C
    Calcium gluconate reverses the effects of magnesium sulfate. Stimulation, instruction on taking deep breaths, and increasing her fluid rate will not increase the respirations.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 539 | Drug Guide Box OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

26. A 32-year-old primigravida is admitted with a diagnosis of ectopic pregnancy. Nursing care is based on the knowledge that
    a. bed rest and analgesics are the recommended treatment.
    b. she will be unable to conceive in the future.
    c. a D&C will be performed to remove the products of conception.
    d. hemorrhage is the major concern.

    ANS: D
    Severe bleeding occurs if the fallopian tube ruptures. The recommended treatment is to remove the pregnancy before hemorrhaging. If the tube must be removed, her fertility will decrease but she will not be infertile. A D&C is done on the inside of the uterine cavity. The ectopic pregnancy is located within the tubes.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 527 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

27. The nurse learns that which is the most common cause of spontaneous abortion?
    a. Chromosomal abnormalities
    b. Infections
    c. Endocrine imbalance
    d. Immunologic factors

    ANS: A
    Around 60% of pregnancy losses from spontaneous abortion in the first trimester result from chromosomal abnormalities that are incompatible with life. Maternal infection, endocrine imbalances, and immunologic factors may also be causes of early miscarriage.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 523 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

28. Methotrexate is recommended as part of the treatment plan for which obstetric complication?
    a. Complete hydatidiform mole
    b. Missed abortion
    c. Unruptured ectopic pregnancy
    d. Abruptio placentae

    ANS: C
    Methotrexate is an effective, nonsurgical treatment option for a hemodynamically stable woman whose ectopic pregnancy is unruptured and less than 3.5 cm in diameter. Methotrexate is not indicated or recommended as a treatment option for a complete hydatidiform mole, a missed abortion, or abruptio placentae.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 527 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

29. The nurse caring for a woman hospitalized for hyperemesis gravidarum should expect that initial treatment involves
    a. corticosteroids to reduce inflammation.
    b. IV therapy to correct fluid and electrolyte imbalances.
    c. an antiemetic, such as pyridoxine, to control nausea and vomiting.
    d. enteral nutrition to correct nutritional deficits.

    ANS: B
    Initially, the woman who is unable to down clear liquids by mouth requires IV therapy for correction of fluid and electrolyte imbalances. Corticosteroids are not the expected treatment for this disorder. Pyridoxine is vitamin B6, not an antiemetic. Promethazine, a common antiemetic, may be prescribed. In severe cases of hyperemesis gravidarum, enteral nutrition via a feeding tube may be necessary to correct maternal nutritional deprivation. This is not an initial treatment for this patient.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 535 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

30. A woman with preeclampsia has a seizure. What action by the nurse takes priority?
    a. Insert an oral airway.
    b. Suction the mouth to prevent aspiration.
    c. Administer oxygen by mask.
    d. Stay with the patient and call for help.

    ANS: D
    If a patient seizes, the nurse should stay with her and call for help. Nursing actions during a seizure are directed toward ensuring a patent airway and patient safety. Insertion of an oral airway during seizure activity is no longer the standard of care. The nurse should attempt to keep the airway patent by turning the patient's head to the side to prevent aspiration. Once the seizure has ended, it may be necessary to suction the patient's mouth. Oxygen may or may not be needed after the seizure has ended.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 544 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Safe and Effective Care Environment

31. A woman is in the emergency department with severe abdominal pain. When her pregnancy test comes back positive, she yells "I can't be pregnant! I had a tubal ligation two months ago!" What action by the nurse is the priority?
    a. Provide emotional support to the woman.
    b. Facilitate an ultrasound examination.
    c. Call the lab to have them repeat the test.
    d. Administer an opioid pain medication.

    ANS: B

A failed tubal ligation is a risk factor for ectopic pregnancy. After a blood pregnancy test, a transvaginal ultrasound is needed to look for a gestational sac within the uterus. Of course the nurse provides emotional support, but that is not the priority. There is no need to repeat the test. Pain medications may be contraindicated if surgery is needed and consents have not yet been signed.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: pp. 526-527 | Box 25.1 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

32. A woman who is 8 months pregnant is brought to the emergency department after a serious motor vehicle crash. Although she has no apparent injuries, she is admitted to the hospital. Her partner is upset and wants to know why she just can't come home. What response by the nurse is best?
    a. "This is standard procedure for all pregnant crash victims."
    b. "She needs to be monitored for some potential complications."
    c. "We may have to deliver the baby at any time now."
    d. "We are giving her medicine to keep her from laboring."

    ANS: B
    After serious trauma, a woman may be admitted and observed because an abruptio placentae may take up to 24 hours to become apparent. Not all motor vehicle crash patients will need to be admitted. The baby may or may not need to be delivered at any time, but this statement will frighten the partner. There is no indication the patient is in labor.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 532 | Safety Alert Box OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. The nurse who suspects that a patient has early signs of ectopic pregnancy should be observing her for which symptoms? (*Select all that apply*.)
    a. Pelvic pain
    b. Abdominal pain
    c. Unanticipated heavy bleeding
    d. Vaginal spotting or light bleeding
    e. Missed period

    ANS: A, B, D, E
    Early signs of ectopic pregnancy include pelvic pain, abdominal pain, spotting or light bleeding, and a woman's report of a "missed period." Heavy bleeding is a later sign and occurs after the tube has ruptured.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 526 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

2. What assessment findings indicate to the nurses that a woman's preeclampsia should now be considered severe? (*Select all that apply*.)
   a. Urine output 40 mL/hour for the past 2 hours
   b. Serum creatinine 3.1 mg/dL
   c. Seeing "sparkly" things in the visual field
   d. Crackles in both lungs
   e. Soft, non-tender abdomen

   ANS: B, C, D
   Signs of severe preeclampsia include elevated creatinine, seeing sparkles, and pulmonary edema (manifested by crackles). The urine output is above the minimum requirements, and a soft non-tender abdomen is a reassuring sign.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 538 | Table 25.3 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. A woman has several relatives who had gestational hypertension and wants to decrease her risk for it. What information does the nurse provide this woman? (*Select all that apply*.)
   a. There is no way to reduce risk factors for gestational hypertension.
   b. Losing weight before you get pregnant will help prevent it.
   c. Eating a diet high in protein and iron may help prevent it.
   d. The father contributes no risk factors for hypertension in pregnancy
   e. Waiting until you are 35 to get pregnant cuts the risk in half.

   ANS: B, C
   There are many risk factors for gestational hypertension, including obesity and anemia. The woman can take action to address these factors prior to becoming pregnant. The father's risks include the first baby and having fathered other preeclamptic pregnancies. Maternal age >35 increases the risk.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 536 | Box 25.2 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. Preconception counseling is critical to the outcome of diabetic pregnancies because poor glycemic control before and during early pregnancy is associated with
   a. frequent episodes of maternal hypoglycemia.
   b. congenital anomalies in the fetus.
   c. polyhydramnios.
   d. hyperemesis gravidarum.

   ANS: B
   Preconception counseling is particularly important because strict metabolic control before conception and in the early weeks of gestation is instrumental in decreasing the risks of congenital anomalies. Frequent episodes of maternal hypoglycemia may occur during the first trimester (not before conception) as a result of hormone changes and the effects on insulin production and usage. Hydramnios occurs about 10 times more often in diabetic pregnancies than in nondiabetic pregnancies. Typically, it is seen in the third trimester of pregnancy. Hyperemesis gravidarum may exacerbate hypoglycemic events as the decreased food intake by the mother and glucose transfer to the fetus contribute to hypoglycemia.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 550 OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

2. In assessing the knowledge of a pregestational woman with type 1 diabetes concerning changing insulin needs during pregnancy, the nurse recognizes that further teaching is warranted when the patient states
   a. “I will need to increase my insulin dosage during the first 3 months of pregnancy.”
   b. “Insulin dosage will likely need to be increased during the second and third trimesters.”
   c. “Episodes of hypoglycemia are more likely to occur during the first 3 months.”
   d. “Insulin needs should return to normal within 7 to 10 days after birth if I am bottle feeding.”

   ANS: A
   Insulin needs are reduced in the first trimester due to increased insulin production by the pancreas and increased peripheral sensitivity to insulin. Also the woman may be experiencing nausea, vomiting, and anorexia that would decrease her insulin needs. The other statements show good understanding of this topic.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: p. 553 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Physiologic Integrity

3. Screening at 24 weeks of gestation reveals that a pregnant woman has gestational diabetes mellitus (GDM). In planning her care, the nurse and the woman mutually agree that an expected outcome is to prevent injury to the fetus as a result of GDM. The nurse identifies that the fetus is at greatest risk for
   a. macrosomia.
   b. congenital anomalies of the central nervous system.
   c. preterm birth.
   d. low birth weight.

   ANS: A
   Poor glycemic control later in pregnancy increases the rate of fetal macrosomia. Poor glycemic control during the preconception time frame and into the early weeks of the pregnancy is associated with congenital anomalies. Preterm labor or birth is more likely to occur with severe diabetes and is the greatest risk in women with pregestational diabetes. Increased weight, or macrosomia, is the greatest risk factor for this woman.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 554 OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

4. In terms of the incidence and classification of diabetes, maternity nurses should know that
   a. type 1 diabetes is most common.
   b. type 2 diabetes often goes undiagnosed.
   c. there is only one type of gestational diabetes.
   d. type 1 diabetes may become type 2 during pregnancy.

   ANS: B
   Type 2 often goes undiagnosed, because hyperglycemia develops gradually and often is not severe. Type 2, previously called adult onset diabetes, is the most common. There are 2 subgroups of gestational diabetes. Type GDM A1 is diet-controlled whereas type GDM A2 is controlled by insulin and diet. People do not go back and forth between type 1 and type 2 diabetes.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 550 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

5. A nurse in labor and delivery learns about metabolic changes that occur throughout pregnancy in diabetes. What information does the nurse know?
   a. Insulin crosses the placenta to the fetus only in the first trimester, after which the fetus secretes its own.
   b. Women with insulin-dependent diabetes are prone to hyperglycemia during the first trimester, because they are consuming more sugar.
   c. During the second and third trimesters, pregnancy exerts a diabetogenic effect that ensures an abundant supply of glucose for the fetus.
   d. Maternal insulin requirements steadily decline during pregnancy.

   ANS: C

Pregnant women develop increased insulin resistance during the second and third trimesters. Insulin never crosses the placenta; the fetus starts making its own around the tenth week. As a result of normal metabolic changes during pregnancy, insulin-dependent women are prone to hypoglycemia. Maternal insulin requirements may double or quadruple by the end of pregnancy.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 549 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

6. Which major neonatal complication is carefully monitored after the birth of the infant of a diabetic mother?
   a. Hypoglycemia
   b. Hypercalcemia
   c. Hypobilirubinemia
   d. Hypoinsulinemia

   ANS: A
   The neonate is at highest risk for hypoglycemia because fetal insulin production is accelerated during pregnancy to metabolize excessive glucose from the mother. At birth, the maternal glucose supply stops and the neonatal insulin exceeds the available glucose, leading to hypoglycemia. Hypocalcemia is associated with preterm birth, birth trauma, and asphyxia, all common problems of the infant of a diabetic mother. Excess erythrocytes are broken down after birth, releasing large amounts of bilirubin into the neonate's circulation, which results in hyperbilirubinemia. Because fetal insulin production is accelerated during pregnancy, the neonate shows hyperinsulinemia.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 552 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

7. Which factor is known to increase the risk of gestational diabetes mellitus?
   a. Underweight before pregnancy
   b. Maternal age younger than 25 years
   c. Previous birth of large infant
   d. Previous diagnosis of type 2 diabetes mellitus

   ANS: C
   Previous birth of a large infant suggests gestational diabetes mellitus. Obesity (BMI of 30 or greater) creates a higher risk for gestational diabetes. A woman younger than 25 generally is not at risk for gestational diabetes mellitus. The person with type 2 diabetes mellitus already is a diabetic and will continue to be so during and after pregnancy.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 552 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

8. Glucose metabolism is profoundly affected during pregnancy because
   a. pancreatic function in the islets of Langerhans is affected by pregnancy.
   b. the pregnant woman uses glucose at a more rapid rate than the nonpregnant

woman.
c. the pregnant woman increases her dietary intake significantly.
d. placental hormones are antagonistic to insulin, resulting in insulin resistance.

ANS: D
Placental hormones, estrogen, progesterone, and human placental lactogen (HPL) create insulin resistance. Insulin also is broken down more quickly by the enzyme placental insulinase. Pancreatic functioning is not affected by pregnancy. The glucose requirements differ because of the growing fetus. The pregnant woman should increase her intake by 200 calories a day.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 553 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

9. To manage her diabetes appropriately and ensure a good fetal outcome, the pregnant woman with diabetes will need to alter her diet by doing which of the following?
a. Eating six small equal meals per day
b. Reducing carbohydrates in her diet
c. Eating her meals and snacks on a fixed schedule
d. Increasing her consumption of protein

ANS: C
Having a fixed meal schedule will provide the woman and the fetus with a steadier blood sugar level, provide better balance with insulin administration, and help prevent complications. It is more important to have a fixed meal schedule than equal division of food intake or increased protein intake. Approximately 45% of the food eaten should be in the form of carbohydrates.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 556 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

10. A pregnant diabetic woman is in the hospital and her blood glucose reading is 42 mg/dL. What action by the nurse is best?
a. Provide her with 15 grams of oral carbohydrate if she can swallow.
b. Administer a bolus of rapid-acting insulin.
c. Order the woman a meal tray from the cafeteria.
d. Notify the provider immediately.

ANS: A
This woman has hypoglycemia and needs to injest 15 grams of carbohydrate if she is able to swallow. Insulin would make the problem worse. The meal tray is a good idea but not as the first response as it will take too long. The provider should be notified but only after the nurse takes corrective action.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 556 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

11. Nursing intervention for the pregnant diabetic is based on the knowledge that the need for insulin
    a. increases throughout pregnancy and the postpartum period.
    b. decreases throughout pregnancy and the postpartum period.
    c. varies depending on the stage of gestation.
    d. should not change because the fetus produces its own insulin.

    ANS: C
    Insulin needs decrease during the first trimester, when nausea, vomiting, and anorexia are a factor. They increase during the second and third trimesters, when the hormones of pregnancy create insulin resistance in maternal cells.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 553 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

12. With regard to the association of maternal diabetes and other risk situations affecting mother and fetus, nurses should be aware that
    a. Diabetic ketoacidosis (DKA) can lead to fetal death at any time during pregnancy.
    b. Hydramnios rarely occurs in diabetic pregnancies.
    c. Infections occur about as often and are considered about as serious in diabetic and nondiabetic pregnancies.
    d. Women should not use insulin pumps during pregnancy.

    ANS: A
    Prompt treatment of DKA is necessary to save the fetus and the mother. Hydramnios is a potential complication for the diabetic pregnancy. Infections are more common and more serious in pregnant women with diabetes. Women who were treated with an insulin pump before pregnancy can continue this therapy.

    PTS: 1 DIF: Cognitive Level: Comprehension REF: p. 556
    OBJ: Nursing Process: Planning MSC: Client Needs: Physiologic Integrity

13. What form of heart disease in women of childbearing years usually has a benign effect on pregnancy?
    a. Cardiomyopathy
    b. Rheumatic heart disease
    c. Congenital heart disease
    d. Mitral valve prolapse

    ANS: D
    Mitral valve prolapse is a benign condition that is usually asymptomatic. Cardiomyopathy produces congestive heart failure during pregnancy. Rheumatic heart disease can lead to heart failure during pregnancy. Some congenital heart diseases will produce pulmonary hypertension or endocarditis during pregnancy.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 559 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

14. When teaching the pregnant woman with class II heart disease, what information should the nurse provide?
    a. Advise her to gain at least 30 lb.
    b. Explain the importance of a diet high in calcium.
    c. Instruct her to avoid strenuous activity.
    d. Inform her of the need to limit fluid intake.

    ANS: C
    Activity may need to be limited so that cardiac demand does not exceed cardiac capacity. Weight gain should be kept at a minimum with heart disease. Iron and folic acid intake is important to prevent anemia. Fluid intake should not be limited during pregnancy. She may also be put on a diuretic. Fluid intake is necessary to prevent fluid deficits.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 559 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

15. Prophylaxis of subacute bacterial endocarditis (SBE) is given before and after birth when a pregnant woman has
    a. valvular disease.
    b. congestive heart disease.
    c. dysrhythmias.
    d. postmyocardial infarction.

    ANS: A
    Prophylaxis for intrapartum endocarditis and pulmonary infection may be provided for women who have mitral valve prolapse. It is not indicated for congestive heart failure, dysrhythmias, or myocardial infarctions.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 559 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

16. The nurse understands that postpartum care of the woman with cardiac disease
    a. is the same as that for any pregnant woman.
    b. includes rest and monitoring of the effect of activity.
    c. includes ambulating frequently, alternating with active range of motion.
    d. includes limiting visits with the infant to once per day.

    ANS: B
    After delivery, the woman with cardiac disease should rest, and the nurse monitors her for the effect activity has on her cardiovascular status. Care of the woman with cardiac disease in the postpartum period is tailored to the woman's functional capacity. Although the woman may need help caring for the infant, breastfeeding and infant visits are not contraindicated.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 561 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

17. In caring for a pregnant woman with sickle cell anemia the nurse is aware that signs and symptoms of sickle cell crisis include
    a. anemia.
    b. endometritis.
    c. fever and pain.
    d. urinary tract infection.

    ANS: C
    Women with sickle cell anemia have recurrent attacks (crisis) of fever and pain, most often in the abdomen, joints, and extremities. These attacks are attributed to vascular occlusion when RBCs assume the characteristic sickled shape. Crises are usually triggered by dehydration, hypoxia, or acidosis. Signs of crisis do not include anemia, endometriosis, or UTI.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 562 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

18. With regard to anemia, nurses should be aware that
    a. it is the most common medical disorder of pregnancy.
    b. it can trigger reflex brachycardia.
    c. the most common form of anemia is caused by folate deficiency.
    d. thalassemia is a European version of sickle cell anemia.

    ANS: A
    Iron deficiency anemia causes 75% of anemias in pregnancy. It is difficult to meet the pregnancy needs for iron through diet alone. It does not cause bradycardia. Thalassemia is a distinct disease from sickle cell anemia.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 561 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

19. For which of the infectious diseases can a woman be immunized?
    a. Toxoplasmosis
    b. Rubella
    c. Cytomegalovirus
    d. Herpesvirus type 2

    ANS: B
    Rubella is the only infectious disease listed for which a vaccine is available.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 566 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

20. A woman who delivered her third child yesterday has just learned that her two school-age children have contracted chickenpox. What action by the nurse is best?
    a. Assess if the woman has had chickenpox or been vaccinated.
    b. Tell her that the baby has immunity from her and is not susceptible.

c. Advise her if she is non-immune, she will get vaccinated at her 2-week postpartum checkup.
d. The infant will receive prophylactic acyclovir before discharge.

ANS: A
The first thing the nurse should do is to determine the woman's susceptibility to this infection. If she is non-immune, she will get her first vaccination prior to discharge. The nurse does not know the baby's immune status without knowing the mother's. Acyclovir is not used to treat chickenpox.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 566 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

21. A woman has a history of drug use and is screened for hepatitis B during the first trimester. What is an appropriate action?
a. Provide a low-protein diet.
b. Offer the vaccine.
c. Discuss the recommendation to bottle-feed her baby.
d. Practice respiratory isolation.

ANS: B
A person who has a history of high-risk behaviors should be offered the hepatitis B vaccine. A low-protein diet will not prevent the infection. The first trimester is too early to discuss feeding methods. Respiratory isolation is not needed for this blood- and body fluid–borne disease.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 567 OBJ: Nursing Process: Planning
MSC: Client Needs: Health Promotion and Maintenance

22. A woman has tested human immunodeficiency virus (HIV)-positive and has now discovered that she is pregnant. Which statement indicates that she understands the risks of this diagnosis?
a. "Even though my test is positive, my baby might not be affected."
b. "I know I will need to have an abortion as soon as possible."
c. "This pregnancy will probably decrease the chance that I will develop AIDS."
d. "My baby is certain to have AIDS and die within the first year of life."

ANS: A
The rate of perinatal transmission of HIV has decreased with the use of antiretroviral medications during pregnancy. There is no need to have an abortion. The mother may or may not go on to develop AIDS.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 568 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Physiologic Integrity

23. A nurse has taught a pregnant woman about toxoplasmosis. What statement by the patients indicates a need for further instruction?

a. “I will be certain to empty the litter boxes regularly.”
b. “I won’t eat raw eggs.”
c. “I had better wash all of my fruits and vegetables.”
d. “I need to be cautious when cooking meat.”

ANS: A
The patient should avoid contact with materials that are possibly contaminated with cat feces while pregnant. This includes cat litter boxes, sand boxes, and garden soil. She should wash her hands thoroughly after working with soil or handling animals. The other statements show good understanding.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 569 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Health Promotion and Maintenance

24. A woman who had no prenatal care has just delivered after a brief labor. The baby has rough, dry skin; is large for gestational age; and has an umbilical hernia. What action by the nurse is most appropriate?
a. Question the mother about substance abuse.
b. Reassess the baby’s gestational age.
c. Inform the mother her thyroid levels will be checked.
d. Perform a bedside blood glucose test on the mother.

ANS: C
These signs in the newborn are indicative of hypothyroidism. The mother will have thyroid levels checked. Asking about substance abuse, reassessing gestational age, and obtaining a blood glucose reading are all unnecessary.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 570 | Table 26.3 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

25. A woman in the perinatal clinic asks the nurse how her asthma will affect her pregnancy and fetus. What response by the nurse is best?
a. Asthma medications cannot be used during pregnancy.
b. The only problem is that you will not be able to breastfeed.
c. Medications for asthma do not appear to harm the fetus.
d. Pregnancy tends to make asthma worse.

ANS: C
Medications for asthma seem to be well tolerated during pregnancy. Breastfeeding is safe for the newborn. The course of asthma is variable in pregnancy.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 570 | Table 26.3 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

26. A woman has been admitted to the labor and delivery unit who is HIV positive. She is in active labor. What action by the nurse is most appropriate?
a. Prepare to administer IV zidovudine.

b. Place the mother on contact precautions.
c. Administer oxygen by face mask.
d. Notify social services.

ANS: A
During labor, an IV infusion of zidovudine is administered. The woman does not need contact precautions; standard precautions suffice. The woman does not need oxygen because of her HIV status. There is no reason to notify social services.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 568 | Box 26.3 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. The student nurse learns that maternal complications of diabetes include which of the following? (*Select all that apply.*)
   a. Atherosclerosis
   b. Retinopathy
   c. IUFD
   d. Nephropathy
   e. Caudal regression syndrome

   ANS: A, B, D
   Maternal complications of diabetes include heart disease, retinopathy, nephropathy, and neuropathy. Stillbirth and caudal regression syndrome are fetal complications.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 550 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

2. Congenital anomalies can occur with the use of antiepileptic drugs, including (*Select all that apply*.)
   a. Craniofacial abnormalities
   b. Congenital heart disease
   c. Neural tube defects
   d. Gastroschisis
   e. Diaphragmatic hernia

   ANS: A, B, C
   Congenital anomalies that can occur with antiepileptic drugs include craniofacial abnormalities, congenital heart disease, and neural tube defects. They are not known to cause gastroschisis or diaphragmatic hernias.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 563 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. The student nurse learns that maternal risks of systemic lupus erythematosus include (*Select all that apply*.)

a. Premature rupture of membranes (PROM)
b. Fetal death resulting in stillbirth
c. Hypertension
d. Preeclampsia
e. Renal complications

ANS: A, C, D, E
PROM, hypertension, preeclampsia, and renal complications are all maternal risks associated with SLE. Stillbirth and prematurity are fetal risks of SLE.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 563 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

4. When caring for a pregnant woman with suspected cardiomyopathy, the nurse must be alert for signs and symptoms of cardiac decompensation, which include (*Select all that apply*.)
a. A regular heart rate
b. Hypertension
c. Shortness of breath
d. Weakness
e. Crackles in the lung bases

ANS: C, D, E
Some symptoms of cardiomyopathy include shortness of breath, weakness, and crackles in the lung bases. A regular heart rate may or may not be present. Hypertension is not a typical finding.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 557 | Safety Alert Box OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. Which actions by the nurse may prevent infections in the labor and delivery area?
   a. Vaginal examinations every hour while the woman is in active labor
   b. Use of clean techniques for all procedures
   c. Cleaning secretions from the vaginal area by using back-to-front motion
   d. Keeping underpads and linens as dry as possible

   ANS: D
   Bacterial growth prefers a moist, warm environment. Vaginal examinations should be limited to decrease transmission of vaginal organisms into the uterine cavity. Use an aseptic technique if membranes are not ruptured; use a sterile technique if membranes are ruptured. Vaginal drainage should be removed with a front-to-back motion to decrease fecal contamination.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 579 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Safe and Effective Care Environment

2. A woman in labor at 34 weeks of gestation is hospitalized and treated with intravenous magnesium sulfate for 18 to 20 hours. When the magnesium sulfate is discontinued, which oral drug will probably be prescribed for continuation of the tocolytic effect?
   a. Ritodrine
   b. Terbutaline
   c. Calcium gluconate
   d. Pitocin

   ANS: B
   The woman receiving decreasing doses of magnesium sulfate is often switched to oral terbutaline to maintain tocolysis for 48 hours. The terbutaline will probably be discontinued prior to discharge. Ritodrine is the only drug approved by the FDA for tocolysis; however, it is rarely used because of significant side effects. Calcium gluconate reverses magnesium sulfate toxicity. The drug should be available for complications of magnesium sulfate therapy. Pitocin is used to augment labor, not stop it.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 588 OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

3. Which technique is least effective for the woman with persistent occiput posterior position?
   a. Lie supine and relax.
   b. Sit or kneel, leaning forward with support.
   c. Rock the pelvis back and forth while on hands and knees.
   d. Squat.

   ANS: A

Lying supine increases the discomfort of “back labor.” A sitting or kneeling position may help the fetal head to rotate to occiput anterior. Rocking the pelvis encourages rotation from occiput posterior to occiput anterior. Squatting aids both rotation and fetal descent.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 575 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

4. Birth for the nulliparous woman with a fetus in a breech presentation is usually by
   a. cesarean delivery.
   b. vaginal delivery.
   c. forceps-assisted delivery.
   d. vacuum extraction.

   ANS: A
   Delivery for the nulliparous woman with a fetus in breech presentation is almost always cesarean section. The greatest fetal risk in the vaginal delivery of breech presentation is that the head (largest part of the fetus) is the last to be delivered. The delivery of the rest of the baby must be quick so that the infant can breathe.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 576 OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

5. Which patient situation presents the greatest risk for the occurrence of hypotonic dysfunction during labor?
   a. A primigravida who is 17 years old
   b. A 22-year-old multiparous woman with ruptured membranes
   c. A multiparous woman at 39 weeks of gestation who is expecting twins
   d. A primigravida woman who has requested no analgesia during her labor

   ANS: C
   Overdistention of the uterus in a multiple pregnancy is associated with hypotonic dysfunction because the stretched uterine muscle contracts poorly. A young primigravida usually will have good muscle tone in the uterus. This prevents hypotonic dysfunction. There is no indication that this woman’s uterus is overdistended, which is the main cause of hypotonic dysfunction. A primigravida usually will have good uterine muscle tone, and there is no indication of an overdistended uterus.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 578 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

6. A primigravida at 40 weeks of gestation is having uterine contractions every 1.5 to 2 minutes and says that they are very painful. Her cervix is dilated 2 cm and has not changed in 3 hours. The woman is crying and wants an epidural. What is the likely status of this woman’s labor?
   a. She is exhibiting hypotonic uterine dysfunction.
   b. She is experiencing a normal latent stage.
   c. She is exhibiting hypertonic uterine dysfunction.

d. She is experiencing pelvic dystocia.

ANS: C
Women who experience hypertonic uterine dysfunction, or primary dysfunctional labor, often are anxious first-time mothers who are having painful and frequent contractions that are ineffective at causing cervical dilation or effacement to progress. With hypotonic uterine dysfunction, the woman initially makes normal progress into the active stage of labor and then the contractions become weak and inefficient or stop altogether. This is not a normal latent stage. Pelvic dystocia can occur whenever contractures of the pelvic diameters reduce the capacity of the bony pelvis, including the inlet, midpelvis, outlet, or any combination of these planes.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 575 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

7. A woman is having her first child. She has been in labor for 15 hours. Two hours ago, her vaginal examination revealed the cervix to be dilated to 5 cm and 100% effaced, and the presenting part was at station 0. Five minutes ago, her vaginal examination indicated that there had been no change. What abnormal labor pattern is associated with this description?
   a. Prolonged latent phase
   b. Protracted active phase
   c. Secondary arrest
   d. Protracted descent

   ANS: C
   With a secondary arrest of the active phase, the progress of labor has stopped. This patient has not had any anticipated cervical change, indicating an arrest of labor. Dilation at 5 cm is past the latent phase. This does not describe a “protracted” labor.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 573 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

8. Which factor is most likely to result in fetal hypoxia during a dysfunctional labor?
   a. Incomplete uterine relaxation
   b. Maternal fatigue and exhaustion
   c. Maternal sedation with narcotics
   d. Administration of tocolytic drugs

   ANS: A
   A high uterine resting tone, with inadequate relaxation between contractions, reduces maternal blood flow to the placenta and decreases fetal oxygen supply. Maternal fatigue or sedation does not decrease uterine blood flow. Tocolytic drugs decrease contractions. This will increase uterine blood flow.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 579 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

9. After a birth complicated by a shoulder dystocia, what action by the nurse is most appropriate?
   a. Give supplemental oxygen with a small face mask.
   b. Encourage the parents to hold the infant.
   c. Palpate the infant's clavicles.
   d. Perform a complete newborn assessment.

   ANS: C
   Because of the shoulder dystocia, the infant's clavicles may have been fractured. Palpation is a simple assessment to identify crepitus or deformity that requires follow-up. There is no indication for oxygen. The infant needs to be assessed for clavicle fractures before excessive movement. A complete newborn assessment is necessary for all newborns, but assessment of the clavicle is top priority for this infant.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 575 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

10. A laboring patient in the latent phase is experiencing uncoordinated, irregular contractions of low intensity. How should the nurse respond to complaints of constant cramping pain?
   a. "You are only 2 cm dilated, so you should rest and save your energy for when the contractions get stronger."
   b. "You must breathe more slowly and deeply so there is greater oxygen supply for your uterus. That will decrease the pain."
   c. "Let me take off the monitor belts and help you get into a more comfortable position."
   d. "I have notified the doctor that you are having a lot of discomfort. Let me rub your back and see if that helps."

   ANS: D
   Intervention is needed to manage the dysfunctional pattern. Offering support and comfort is important to help the patient cope with the situation. Telling the woman to rest is belittling her complaints. Breathing will not reduce the pain. Fetal monitoring should continue as the woman changes positions.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 574 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

11. Why is adequate hydration important when uterine activity occurs before pregnancy is at term?
   a. Fluid and electrolyte imbalance can interfere with the activity of the uterine pacemakers.
   b. Dehydration may contribute to uterine irritability for some women.
   c. Dehydration decreases circulating blood volume, which leads to uterine ischemia.
   d. Fluid needs are increased because of increased metabolic activity occurring during contractions.

   ANS: B

Dehydration can contribute to uterine irritability for some women, especially if the woman has an infection. Fluid and electrolyte imbalances are not associated with preterm labor. The woman has an increased blood volume during pregnancy. Fluid needs do not increase due to contractions.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 586 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

12. In planning for home care of a woman with preterm labor, the nurse needs to address which concern?
    a. Nursing assessments will be different from those done in the hospital setting.
    b. Restricted activity and medications will be necessary to prevent recurrence of preterm labor.
    c. Prolonged bed rest may cause negative physiologic effects.
    d. Home health care providers will be necessary.

    ANS: C
    Prolonged bed rest may cause adverse effects such as weight loss, loss of appetite, muscle wasting, weakness, bone demineralization, decreased cardiac output, risk for thrombophlebitis, alteration in bowel functions, sleep disturbance, and prolonged postpartum recovery. Nursing assessments will differ somewhat from those performed in the acute care setting, but this is not the concern that needs to be addressed. Restricted activity and medication may prevent preterm labor but not in all women. Many, but not all, women will receive home health nurse visits.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 585 OBJ: Nursing Process: Planning
    MSC: Client Needs: Health Promotion and Maintenance

13. A woman in preterm labor at 30 weeks of gestation receives two 12-mg doses of betamethasone intramuscularly. The purpose of this pharmacologic treatment is to
    a. stimulate fetal surfactant production.
    b. reduce maternal and fetal tachycardia associated with ritodrine administration.
    c. suppress uterine contractions.
    d. maintain adequate maternal respiratory effort and ventilation during magnesium sulfate therapy.

    ANS: A
    Antenatal glucocorticoids given as intramuscular injections to the mother accelerate fetal lung maturity. Inderal would be given to reduce the effects of ritodrine administration. Betamethasone has no effect on uterine contractions. Calcium gluconate would be given to reverse the respiratory depressive effects of magnesium sulfate therapy.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 588 | Drug Guide Box OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

14. With regard to the care management of preterm labor, nurses should be aware that
    a. teaching pregnant women the symptoms probably causes more harm through false

alarms.

b. Braxton Hicks contractions often signal the onset of preterm labor.
c. because preterm labor is likely to be the start of an extended labor, a woman with symptoms can wait several hours before contacting the primary caregiver.
d. the diagnosis of preterm labor is based on gestational age, uterine activity, and progressive cervical change.

ANS: D

Gestational age of 20 to 37 weeks, uterine contractions, and a thinning cervix are all indications of preterm labor. It is essential that nurses teach women how to detect the early symptoms of preterm labor. Braxton Hicks contractions resemble preterm labor contractions, but they are not true labor. Waiting too long to see a health care provider could result in essential medications failing to be administered.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 585 OBJ: Nursing Process: Planning
MSC: Client Needs: Safe and Effective Care Environment

15. Which nursing action must be initiated first when evidence of prolapsed cord is found?
a. Notify the provider.
b. Apply a scalp electrode.
c. Prepare the mother for an emergency cesarean delivery.
d. Reposition the mother with her hips higher than her head.

ANS: D

The priority is to relieve pressure on the cord. Changing the maternal position will shift the position of the fetus so that the cord is not compressed. The provider needs to be notified but not until the nurse has taken some corrective action. Trying to relieve pressure on the cord should take priority over increasing fetal monitoring techniques. Emergency cesarean delivery may be necessary if relief of the cord is not accomplished, but attempting to relieve the pressure takes priority. Trying to relieve pressure on the cord should be the first priority.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 593 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

16. A woman who had two previous cesarean births is in active labor, when she suddenly complains of pain between her scapulae. The nurse's priority action is to
a. reposition the woman with her hips slightly elevated.
b. observe for abnormally high uterine resting tone.
c. decrease the rate of nonadditive intravenous fluid.
d. notify the provider promptly and prepare the woman for surgery.

ANS: D

Pain between the scapulae may occur when the uterus ruptures, because blood accumulates under the diaphragm. This is an emergency that requires surgical intervention so the nurse notifies the provider and prepares the woman for surgery. Repositioning the woman with her hips slightly elevated is the treatment for a prolapsed cord. That position in this scenario would cause respiratory difficulties. Since the uterus is no longer able to contract, high resting tones cannot be assessed. However, high resting tones during labor indicate a risk for uterine rupture. The woman is now at high risk for shock. Nonadditive intravenous fluids should be increased.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 595 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

17. Which action should be initiated to limit hypovolemic shock when uterine inversion occurs?
    a. Administer oxygen at 31 L/min by nasal cannula.
    b. Administer an oxytocin by intravenous push.
    c. Monitor fetal heart rate every 5 minutes.
    d. Increase the intravenous infusion rate.

    ANS: D
    Intravenous fluids are necessary to replace the lost blood volume that occurs in uterine inversion. The woman may need blood products as well. Administering oxygen will not prevent hypovolemic shock. Oxytocin should not be given until the uterus is repositioned. A uterine inversion occurs during the third stage of labor.

    PTS: 1 DIF: Cognitive Level: Application REF: p. 595
    OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

18. What factor found in maternal history should alert the nurse to the potential for a prolapsed umbilical cord?
    a. Oligohydramnios
    b. Pregnancy at 38 weeks of gestation
    c. Presenting part at station –3
    d. Meconium-stained amniotic fluid

    ANS: C
    Because the fetal presenting part is positioned high in the pelvis and is not well applied to the cervix, a prolapsed cord could occur if the membranes rupture. Hydramnios puts the woman at high risk for a prolapsed umbilical cord. A very small fetus, normally preterm, puts the woman at risk for a prolapsed umbilical cord. Meconium-stained amniotic fluid shows that the fetus already has been compromised, but it does not increase the chance of a prolapsed cord.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 593 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

19. The fetus in a breech presentation is often born by cesarean delivery because
    a. the buttocks are much larger than the head.
    b. postpartum hemorrhage is more likely if the woman delivers vaginally.

c. internal rotation cannot occur if the fetus is breech.
d. compression of the umbilical cord is more likely.

ANS: D
After the fetal legs and trunk emerge from the woman's vagina, the umbilical cord can be compressed between the maternal pelvis and the fetal head if a delay occurs in the birth of the head. The head is the largest part of a fetus. There is no relationship between breech presentation and postpartum hemorrhage. Internal rotation can occur with a breech.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 593 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

20. An important independent nursing action to promote normal progress in labor is
a. assessing the fetus.
b. encouraging urination about every 1 to 2 hours.
c. allowing the woman to stay in her preferred position.
d. regulating intravenous fluids.

ANS: B
The bladder can reduce room in the woman’s pelvis that is needed for fetal descent and can increase her discomfort. Assessment of the fetus is an important task, but will not promote normal progression of labor. Position changes help labor progress and should be encouraged. Maintaining hydration is an important task, but it will not promote normal progression of labor.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 577 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

21. A woman who is 32 weeks pregnant telephones the nurse at her obstetrician's office and complains of constant backache. She asks what pain reliever is safe for her to take. The best nursing response is
a. “Back pain is common at this time during pregnancy due to poor posture.”
b. “Acetaminophen is acceptable during pregnancy; however, do not take aspirin.”
c. “You should come into the office and let the doctor check you.”
d. “Try a warm bath or using a heating pad.”

ANS: C
A prolonged backache is one of the subtle symptoms of preterm labor. Early intervention may prevent preterm birth. The woman should be assessed before trying any home care measures.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 583 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

22. The nurse should suspect uterine rupture if
a. fetal tachycardia occurs.
b. the woman becomes dyspneic.

c. contractions abruptly stop during labor.
d. labor progresses unusually quickly.

ANS: C
A large rupture of the uterus will disrupt its ability to contract. Fetal tachycardia is a sign of hypoxia. Dyspnea and unusually quick labor are not signs of rupture.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 595 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

23. A student nurse is preparing to administer a dose of betamethasone. What action by the student warrants intervention by the registered nurse?
a. Starts a separate IV line to infuse the medication
b. Tells the woman her blood glucose will be monitored more often
c. Prepares an IM injection choosing a 1 ½″ needle
d. Listens to the woman's lungs prior to administering the medication

ANS: A
Betamethasone is given in two IM injections with the appropriate needle. When the student begins to insert a dedicated line for administering it, the nurse intervenes to stop this incorrect action. Since this drug is a steroid, blood glucose readings can rise, so diabetic patients will have more frequent blood sugars. Pulmonary edema is uncommon, but the astute nurse (or student) will listen to lung sounds prior to administration for a baseline.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 588 | Drug Guide Box OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

24. An hour after her membranes ruptured, a laboring woman has a temperature of 38.2° C (100.7° F). What action does the nurse perform first?
a. Provide cool, wet washcloths for the woman's forehead.
b. Assess and document the fetal heart rate.
c. Administer acetaminophen orally.
d. Encourage the woman to drink clear fluids.

ANS: B
Fetal tachycardia is associated with maternal fever. While all options are reasonable, the nurse needs to assess fetal well-being first.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 580 | Safety Alert Box OBJ: Nursing Process: Assessment
MSC: Client Needs: Safe and Effective Care Environment

25. The nursing student observes a laboring woman doing lunges to the left side and asks for an explanation of this activity. What response by the nurse is best?
a. It decreases the pain associated with back labor.
b. It promotes rotation of the fetal occiput to an anterior position.
c. It relieves the cramping associated with a prolonged labor.
d. It causes the pelvic inlet to open wider in preparation for birth.

ANS: B
This action encourages rotation of the fetal head to the anterior position. It does relieve back labor, but this response does not explain why. It does not relieve cramping or open the pelvic inlet.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 575 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. The causes of preterm labor are not fully understood although many factors have been associated with early labor. These include (*Select all that apply*.)
   a. Singleton pregnancy
   b. History of cone biopsy
   c. Smoking
   d. Short cervical length
   e. Higher level of education

   ANS: B, C, D
   A history of cone biopsies, smoking, and a short cervical length are all associated with early labor. Singleton pregnancy and higher level of education are not.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 583 | Table 27.2 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

2. What are the priority nursing assessments for a woman receiving tocolytic therapy with terbutaline? (*Select all that apply*.)
   a. Fetal heart rate
   b. Maternal heart rate
   c. Intake and output
   d. Maternal blood glucose
   e. Maternal blood pressure
   f. Odor of amniotic fluid

   ANS: A, B, E
   All assessments are important, but those most relevant to the medication include the fetal heart rate and maternal pulse, which tend to increase, and the maternal blood pressure, which tends to exhibit a wide pulse pressure. The other assessments are important but not related to this medication.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 587 | Table 27.3 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. A woman reports a sudden gush of fluid from her vagina and is worried about premature rupture of her membranes. What other causes of this does the nurse assess for? *(Select all that apply.)*

a. Urinary incontinence
b. Leaking of amniotic fluid
c. Loss of mucous plug
d. An increase in vaginal discharge
e. Bloody show

ANS: A, C, D, E
Urinary incontinence, loss of the mucous plug (leading to bloody show), and increased vaginal discharge can all be mistaken for PROM. Leaking amniotic fluid is an indication of PROM.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 581 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

4. The nursing faculty explains to students on the labor and delivery unit that late preterm and term births are very different. What distinguishes the late preterm birth from a term birth? (*Select all that apply*.)
a. Late preterm births are between 34 and 36 completed weeks of pregnancy.
b. There is no real difference in mortality between the two types of births.
c. Late preterm infants may appear to be full term at delivery.
d. A late preterm infant who appears full term is classified full term.
e. Late preterm infants need careful assessments of gestational age.

ANS: A, C, E
Late preterm and term deliveries are very different, with late preterm occurring between 34 and 36 completed weeks of gestation. Mortality for late preterm babies is three times higher than for term babies. Because infant appearance can be deceiving, very careful assessment are needed; the late preterm baby can appear as if he or she is full term.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 582 | Safety Alert Box OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

COMPLETION

1. The provider orders an infusion of magnesium sulfate to run at 4 g/hour. The pharmacy delivers a bag of 4 g magnesium sulfate in 250 mL. At what rate does the nurse set the pump? _____

ANS:
250 mL/hour

4 g/250 mL = 0.16 mg/mL
4/0.016 – 250 mL/hour

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: Table 27.3 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. Which statement by a postpartum woman indicates that teaching about thrombus formation has been effective?
   a. "I'll stay in bed for the first 3 days after my baby is born."
   b. "I'll keep my legs elevated with pillows."
   c. "I'll sit in my rocking chair most of the time."
   d. "I'll put my support stockings on every morning before rising."

   ANS: D
   Venous congestion begins as soon as the woman stands up. The stockings should be applied before she rises from the bed in the morning. As soon as possible, the woman should ambulate frequently. The mother should avoid knee pillows because they increase pressure on the popliteal space. Sitting in a chair with legs in a dependent position causes pooling of blood in the lower extremities.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: p. 607 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Health Promotion and Maintenance

2. The perinatal nurse is caring for a woman in the immediate postbirth period. Assessment reveals that the woman is experiencing profuse bleeding. The most likely etiology for the bleeding is
   a. uterine atony.
   b. uterine inversion.
   c. vaginal hematoma.
   d. vaginal laceration.

   ANS: A
   Uterine atony is marked hypotonia of the uterus. It is the leading cause of postpartum hemorrhage. The other situations can cause bleeding but are not the most common cause.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 599 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. The nurse knows that a measure for preventing late postpartum hemorrhage is to
   a. administer broad-spectrum antibiotics.
   b. inspect the placenta after delivery.
   c. manually remove the placenta.
   d. pull on the umbilical cord to hasten the delivery of the placenta.

   ANS: B

If a portion of the placenta is missing, the clinician can explore the uterus, locate the missing fragments, and remove the potential cause of late postpartum hemorrhage. Broad-spectrum antibiotics will be given if postpartum infection is suspected. Manual removal of the placenta increases the risk of postpartum hemorrhage. The placenta is usually delivered 5 to 30 minutes after birth of the baby without pulling on the cord. That can cause uterine inversion.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 602 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

4. A multiparous woman is admitted to the postpartum unit after a rapid labor and birth of a 4000-g infant. Her fundus is boggy, lochia is heavy, and vital signs are unchanged. The nurse has the woman void and massages her fundus, but her fundus remains difficult to find, and the rubra lochia remains heavy. What action should the nurse take next?
   a. Continue to massage the fundus.
   b. Notify the provider.
   c. Recheck vital signs.
   d. Insert an indwelling urinary catheter.

   ANS: B
   After taking these corrective actions, the nurse should contact the provider and anticipate collaborative care measures. Another nurse can assess vital signs. Since the woman just voided, an indwelling catheter is not needed.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 601 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

5. Early postpartum hemorrhage is defined as signs and symptoms of hypovolemia with which of the following descriptions of blood loss?
   a. Cumulative blood loss >1000 mL in the first 24 hours after the birth process.
   b. 750 mL in the first 24 hours after vaginal delivery
   c. Cumulative blood loss >1000 mL in the first 48 hours after the birth process
   d. 1500 mL in the first 48 hours after cesarean delivery

   ANS: A
   The newest definition of early postpoartum hemorrhage is cumulative blood loss >1000 mL with signs of hypovolemia within the first 24 hours after the birth process. Hemorrhage after 24 hours is considered late postpartum hemorrhage.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 599 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

6. A woman delivered a 9-lb, 10-oz baby 1 hour ago. When you arrive to perform her 15-minute assessment, she tells you that she “feels all wet underneath.” You discover that both pads are completely saturated and that she is lying in a 6-inch-diameter puddle of blood. What is your first action?
   a. Call for help.

b. Assess the fundus for firmness.
c. Take her blood pressure.
d. Check the perineum for lacerations.

ANS: B
Firmness of the uterus is necessary to control bleeding from the placental site. The nurse should first assess for firmness and massage the fundus as indicated. Calling for help is not needed unless corrective action does not improve the situation. Another nurse can take the blood pressure or the original nurse can do so after assessing the fundus and massaging it if needed. Checking the perineum for lacerations would be appropriate if the fundus was firm.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: pp. 599-600 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

7. A steady trickle of bright red blood from the vagina in the presence of a firm fundus suggests
a. uterine atony.
b. lacerations of the genital tract.
c. perineal hematoma.
d. infection of the uterus.

ANS: B
Undetected lacerations will bleed slowly and continuously. Bleeding from lacerations is uncontrolled by uterine contraction. The fundus is not firm with uterine atony. A hematoma would be internal. Swelling and discoloration would be noticed, but bright bleeding would not be. With an infection of the uterus there would be an odor to the lochia and systemic symptoms such as fever and malaise.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 602 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

8. A postpartum patient is at increased risk for postpartum hemorrhage if she delivers a(n)
a. 5-lb, 2-oz infant with outlet forceps.
b. 6.5-lb infant after a 2-hour labor.
c. 7-lb infant after an 8-hour labor.
d. 8-lb infant after a 12-hour labor.

ANS: B
A rapid (precipitous) labor and delivery may cause exhaustion of the uterine muscle and prevent contraction. The use of forceps may cause lacerations that could lead to bleeding, but that is not as common as hemorrhage after a precipitous labor when they are used only in the outlet. Eight-hour and 12-hour labors are normal in length.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 600 | Box 28.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

9. What instructions should be included in the discharge teaching plan to assist the patient in recognizing early signs of complications?
   a. Palpate the fundus daily to ensure that it is soft.
   b. Notify the physician of a return to bright red bleeding.
   c. Report any decrease in the amount of brownish red lochia.
   d. The passage of clots as large as an orange can be expected.

   ANS: B
   An increase in lochia or a return to bright red bleeding after the lochia has become pink indicates a complication. The fundus should stay firm. Large clots after discharge are a sign of complications and should be reported.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 602 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

10. Which woman is at greatest risk for early postpartum hemorrhage?
    a. A primiparous woman being prepared for an emergency cesarean birth for fetal distress
    b. A woman with severe preeclampsia on magnesium sulfate whose labor is being induced
    c. A multiparous woman with an 8-hour labor
    d. A primigravida in spontaneous labor with preterm twins

    ANS: B
    Magnesium sulfate administration during labor poses a risk for PPH. Magnesium acts as a smooth muscle relaxant, thereby contributing to uterine relaxation and atony. The other situations do not post risk factors or causes of early PPH.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 600 | Box 28.1 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

11. When caring for a postpartum woman experiencing hypovolemic shock, the nurse recognizes that the most objective and least invasive assessment of adequate organ perfusion and oxygenation is
    a. absence of cyanosis in the buccal mucosa.
    b. cool, dry skin.
    c. diminished restlessness.
    d. decreased urinary output.

    ANS: D
    Hemorrhage may result in hypovolemic shock. Shock is an emergency situation in which the perfusion of body organs may become severely compromised, and death may occur. The presence of adequate urinary output indicates adequate tissue perfusion. The assessment of the buccal mucosa for cyanosis can be subjective in nature. The presence of cool, pale, clammy skin is an indicative finding associated with hypovolemic shock. Restlessness indicates decreased cerebral perfusion.

    PTS: 1 DIF: Cognitive Level: Analysis/Analyzing

REF: p. 603 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

12. The nurse should expect medical intervention for subinvolution to include
    a. oral methylergonovine maleate (Methergine) for 48 hours.
    b. oxytocin intravenous infusion for 8 hours.
    c. oral fluids to 3000 mL/day.
    d. intravenous fluid and blood replacement.

    ANS: A
    Methergine provides long-sustained contraction of the uterus and is the usual treatment. Oxytocin and oral fluids are not used for this condition. There is no indication that blood loss has occurred in this situation; if it does blood replacement may be necessary.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 605 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

13. If nonsurgical treatment for late postpartum hemorrhage is ineffective, which surgical procedure is appropriate to correct the cause of this condition?
    a. Hysterectomy
    b. Laparoscopy
    c. Laparotomy
    d. D&C

    ANS: D
    D&C allows examination of the uterine contents and removal of any retained placental fragments or blood clots. Hysterectomy, laparoscopy, and laparotomy are not indicated.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: pp. 602-603 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

14. The mother-baby nurse must be able to recognize what sign of thrombophlebitis?
    a. Visible varicose veins
    b. Positive Homans sign
    c. Local tenderness, heat, and swelling
    d. Pedal edema in the affected leg

    ANS: C
    Tenderness, heat, and swelling are classic signs of thrombophlebitis that appear at the site of the inflammation. Varicose veins may predispose the woman to thrombophlebitis but are not a sign. A positive Homans sign may be caused by a strained muscle or contusion. Edema may be caused by other factors, and the edema with thrombophlebitis may be more extensive. Edema may be more involved than pedal.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 606 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

15. Which nursing measure is appropriate to prevent thrombophlebitis in the recovery period after a cesarean birth?
    a. Roll a bath blanket and place it firmly behind the knees.
    b. Limit oral intake of fluids for the first 24 hours.
    c. Assist the patient in performing gentle leg exercises.
    d. Ambulate the patient as soon as her vital signs are stable.

    ANS: C
    Leg exercises and passive range of motion promote venous blood flow and prevent venous stasis while the patient is still on bed rest. The blanket behind the knees will cause pressure and decrease venous blood flow. Limiting oral intake will produce hemoconcentration, which may lead to thrombophlebitis. The patient may not have full return of leg movements, and ambulating is contraindicated until she has full motion and sensation.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 607 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

16. One of the first symptoms of puerperal infection to assess for in the postpartum woman is
    a. fatigue continuing for longer than 1 week.
    b. pain with voiding.
    c. profuse vaginal bleeding with ambulation.
    d. temperature of 38° C (100.4° F) or higher after 24 hours.

    ANS: D
    Postpartum or puerperal infection is any clinical infection after childbirth. The definition used in the United States continues to be the presence of a fever of 38° C (100.4° F) or higher on 2 successive days of the first 10 postpartum days, starting 24 hours after birth. Fatigue is a later finding associated with infection. Pain with voiding may indicate a UTI, but it is not typically one of the earlier symptoms of infection. Profuse lochia may be associated with endometritis, but it is not the first symptom associated with infection.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 609 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

17. The perinatal nurse caring for the postpartum woman understands that late postpartum hemorrhage is most likely caused by
    a. subinvolution of the uterus.
    b. defective vascularity of the decidua.
    c. cervical lacerations.
    d. coagulation disorders.

    ANS: A
    The most common causes of late postpartum hemorrhage are subinvolution and retained placental fragments.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 602 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

18. The patient who is being treated for endometritis is placed in Fowler's position because it
    a. promotes comfort and rest.
    b. facilitates drainage of lochia.
    c. prevents spread of infection to the urinary tract.
    d. decreases tension on the reproductive organs.

    ANS: B
    Lochia and infectious material are eliminated by gravity drainage when the woman is placed in the Fowler's position.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 610 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

19. Nursing measures that help prevent postpartum urinary tract infection include which of the following?
    a. Promoting bed rest for 12 hours after delivery
    b. Discouraging voiding until the sensation of a full bladder is present
    c. Forcing fluids to at least 3000 mL/day
    d. Encouraging the intake of orange, grapefruit, or apple juice

    ANS: C
    Adequate fluid intake of 2500 to 3000 mL/day prevents urinary stasis, dilutes urine, and flushes out waste products. The woman should be encouraged to ambulate early. With pain medications, trauma to the area, and anesthesia, the sensation of a full bladder may be decreased. The woman needs to be encouraged to void frequently. Juices such as cranberry juice can discourage bacterial growth.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 611 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

20. Which measure may prevent mastitis in the breastfeeding mother?
    a. Initiating early and frequent feedings
    b. Nursing the infant for 5 minutes on each breast
    c. Wearing a tight-fitting bra
    d. Applying ice packs before feeding

    ANS: A
    Early and frequent feedings prevent stasis of milk, which contributes to engorgement and mastitis. Five minutes does not adequately empty the breast. This will produce stasis of the milk. A firm-fitting bra will support the breast but not prevent mastitis. The breast should not be bound. Warm packs before feeding will increase the flow of milk.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 611 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

21. A mother with mastitis is concerned about breastfeeding while she has an active infection. The nurse should explain that
    a. the infant is protected from infection by immunoglobulins in the breast milk.
    b. the infant is not susceptible to the organisms that cause mastitis.
    c. the organisms that cause mastitis are not passed to the milk.
    d. the organisms will be inactivated by gastric acid.

    ANS: C
    The organisms are localized in the breast tissue and are not excreted in the breast milk. The mother is just producing the immunoglobulin from this infection, so it is not available for the infant. Because of an immature immune system, infants are susceptible to many infections. However, this infection is in the breast tissue and is not excreted in the breast milk. The organism will not get into the infant's gastrointestinal system.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 611 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

22. If the nurse suspects a uterine infection in the postpartum patient, she should assess the
    a. pulse and blood pressure.
    b. odor of the lochia.
    c. episiotomy site.
    d. abdomen for distention.

    ANS: B
    An abnormal odor of the lochia indicates infection in the uterus. The pulse may be altered with an infection, but the odor of the lochia will be an earlier sign and more specific. The infection may move to the episiotomy site if proper hygiene is not followed, but this does not demonstrate a uterine infection. The abdomen becomes distended usually because of a decrease of peristalsis, such as after cesarean section.

    PTS: 1 DIF: Cognitive Level: Application
    REF: p. 612 | Safety Alert Box OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

23. Which condition is a transient, self-limiting mood disorder that affects new mothers after childbirth?
    a. Postpartum depression
    b. Postpartum psychosis
    c. Postpartum bipolar disorder
    d. Postpartum blues

    ANS: D
    Postpartum blues, or "baby blues," is a transient self-limiting disease that is believed to be related to hormonal fluctuations after childbirth. Postpartum depression is not the normal worries (blues) that many new mothers experience. Many caregivers believe that postpartum depression is underdiagnosed and underreported. Postpartum psychosis is a rare condition that usually surfaces within 3 weeks of delivery. Hospitalization of the woman is usually necessary for treatment of this disorder. Bipolar disorder is one of the two categories of postpartum psychosis, characterized by both manic and depressive episodes.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 613 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

24. When a woman is diagnosed with postpartum psychosis, one of the main concerns is that she may
    a. have outbursts of anger.
    b. neglect her hygiene.
    c. harm her infant.
    d. lose interest in her husband.

    ANS: C
    Thoughts of harm to one's self or the infant are among the most serious symptoms of PPD and require immediate assessment and intervention. The other problems can be attributed to postpartum psychosis, but the major concern is harm to the infant.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 614 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

25. What risk factor for peripartum depression (PPD) is likely to have the greatest effect on the woman's condition?
    a. Personal history of depression
    b. Single-mother status
    c. Low socioeconomic status
    d. Unplanned or unwanted pregnancy

    ANS: A
    A personal history of depression is a known risk factor for peripartum depression. Being single, from a low socioeconomic status, or having an unplanned or unwanted pregnancy may contribute to depression for some women but are not strong predictors.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 614 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

26. The maternity nurse knows that which disorder can be triggered by a birth the woman views as traumatic?
    a. A phobia
    b. Panic disorder
    c. Posttraumatic stress disorder (PTSD)
    d. Obsessive-compulsive disorder (OCD)

    ANS: C
    In PTSD, women perceive childbirth as a traumatic event. They have nightmares and flashbacks about the event, anxiety, and avoidance of reminders of the traumatic event. This will not lead to phobias, panic disorder, or OCD.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering

REF: p. 615 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

27. To provide adequate postpartum care, the nurse should be aware that peripartum depression (PPD)
    a. is the “baby blues,” plus the woman has a visit with a counselor or psychologist.
    b. does not affect the father who can then care for the baby.
    c. is distinguished by pervasive sadness that lasts at least 2 weeks.
    d. will disappear on its own without outside help.

    ANS: C
    PPD is characterized by a persistent depressed state. The woman is unable to feel pleasure or love although she is able to care for her infant. She often experiences generalized fatigue, irritability, little interest in food and sleep disorders. PPD is more serious and persistent than postpartum baby blues. Fathers are often affected. Most women need professional help to get through PPD, including pharmacologic intervention.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 613 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

28. What teaching does the nurse provide to help new mothers prevent postpartum depression?
    a. Stay home and avoid outside activities to ensure adequate rest.
    b. Be the only caregiver for your baby to facilitate infant attachment.
    c. Keep feelings of sadness and adjustment to your new role to yourself.
    d. Realize that this is a common occurrence that affects many women.

    ANS: D
    The new mother should understand that postpartum depression is common. Rest is important, but she does not need to confine herself to the house. Others need to help care for the baby so the mother can rest. Women need to be open and discuss their feelings.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 613 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Psychosocial Integrity

29. A provider left an order for a woman to have Methylergonovine 0.2 mg IM. The nurse assesses the woman and finds her vital signs to be: temperature 37.9° C (100.2° F), pulse 90 beats/minute, respirations 18 breaths/minute, and blood pressure 152/90 mm Hg. What action by the nurse is most appropriate?
    a. Administer acetaminophen first.
    b. Check policy for administration.
    c. Give the medication as prescribed.
    d. Consult with the provider.

    ANS: B
    Methylergonovine is contraindicated in women with hypertension. The nurse should check the agency’s policy to see at what blood pressure reading this medication should be held. After checking the policy, the nurse can consult the provider if it can’t be given. Acetaminophen is not related to this situation.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 601 | Drug Guide OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

MULTIPLE RESPONSE

1. Medications used to manage postpartum hemorrhage include which of the following? (*Select all that apply*.)
   a. Oxytocin
   b. Methergine
   c. Terbutaline
   d. Hemabate
   e. Magnesium sulfate

   ANS: A, B, D
   Pitocin, Methergine, and Hemabate are all used to manage PPH. Terbutaline and magnesium sulfate are tocolytics; relaxation of the uterus causes or worsens PPH.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 600 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

2. What actions can the labor and delivery nurse take to decrease a woman's chance of contracting a puerperal infection? (*Select all that apply*.)
   a. Avoid straight catheterizing the woman unless she cannot void.
   b. Keep vaginal examinations to a minimum.
   c. Change wet peripads and linens frequently.
   d. Maintain the woman on bedrest while laboring.
   e. Use good hand hygiene before and after contact with the woman.

   ANS: A, B, C, E
   Risk for infection increases with catheterization, vaginal examinations, exposure to wet linens and pads, and poor hand hygiene. Remaining on bedrest does not reduce the chance for infection.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 609 | Table 28.2 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

3. The nurse explain to the student that which of the following factors increase a woman's risk for thrombosis? (*Select all that apply*.)
   a. Use of stirrups for a prolonged period of time
   b. Prolonged bedrest during or after labor and delivery
   c. Adherence to a strict vegetarian diet
   d. Excessive sweating during labor
   e. Maternal age greater than 30 years of age

   ANS: A, B, D, E

Use of stirrups for a prolonged period of time, bedrest, excessive sweating (leading to dehydration) all increase the risk of thrombosis. Vegetarian diets are not related. Maternal age >35 increases the risk.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 606 | Box 28.2 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

4. A woman just received an injection of carboprost, 2500 mcg IM. What actions by the nurse take priority? (*Select all that apply*.)
   a. Assess for nausea and vomiting
   b. Assess fetal well-being.
   c. Administer acetaminophen for headache.
   d. Monitor urine output.
   e. Notify the provider immediately.

   ANS: B, E
   The usual dose of carboprost is 250 mcg, so this excessive dose could lead to uterine rupture. The nurse monitors the woman for signs of this and continually monitors the fetus for well-being. The provider would be notified and agency policy followed for variance reporting. Nausea, vomiting, and headache are side effects of the usual dose of the drug. This drug is excreted through urine, so monitoring urine output is important but not as critical as checking fetal well-being and notifying the provider.

   PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
   REF: p. 601 | Drug Guide Box OBJ: Nursing Process: Implementation
   MSC: Client Needs: Safe and Effective Care Environment

5. A home health care nurse is checking on a new mother with signs of obsessive-compulsive disorder. What assessment findings correlate with this condition? (*Select all that apply*.)
   a. Frequently checking on the baby
   b. Fear of being alone with the baby
   c. Woman states she feels worthless
   d. Woman has bought $5,000 worth of toys
   e. Mother states birth was very traumatic

   ANS: A, B
   Postpartum OCD often manifests with women performing obsessive behaviors and voicing fear of being left alone with their baby. Feeling worthless is a sign of depression. A spending spree might be a sign of the manic phase of bipolar disease. Viewing the birth as traumatic may lead to PTSD.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 615 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Psychosocial Integrity

MULTIPLE CHOICE

1. What is most helpful in preventing premature birth?
   a. High socioeconomic status
   b. Adequate prenatal care
   c. Transitional Assistance to Needy Families
   d. Women, Infants, and Children nutritional program

   ANS: B
   Prenatal care is vital in identifying possible problems. Women from higher economic status are more likely to seek adequate prenatal care, but it is the care that is most helpful. Government programs help with specific needs of the pregnant woman, but adequate care is more important.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 620 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

2. Compared to the term infant, the preterm infant has
   a. few blood vessels visible though the skin.
   b. more subcutaneous fat.
   c. well-developed flexor muscles.
   d. greater surface area in proportion to weight.

   ANS: D
   Preterm infants have greater surface area in proportion to their weight. They often have visible blood vessels because their skin is thin and they have less fat. More fat and well-developed flexor muscles are characteristic of a more mature infant.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 623 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. Decreased surfactant production in the preterm lung is a problem because surfactant
   a. causes increased permeability of the alveoli.
   b. provides transportation for oxygen to enter the blood supply.
   c. keeps the alveoli open during expiration.
   d. dilates the bronchioles, decreasing airway resistance.

   ANS: C
   Surfactant prevents the alveoli from collapsing each time the infant exhales, thus reducing the work of breathing. It does not cause increased permeability, provide transportation of oxygen or dilate the bronchioles.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 635 OBJ: Nursing Process: Assessment

MSC: Client Needs: Physiologic Integrity

4. A preterm infant is on a respirator with intravenous lines and much equipment around her when her parents come to visit for the first time. What action by the nurse is most important?
   a. Suggest that the parents visit for only a short time to reduce their anxieties.
   b. Reassure the parents that the baby is progressing well.
   c. Encourage the parents to touch her.
   d. Discuss the care they will give her when she goes home.

   ANS: C
   Physical contact with the infant is important to establish early bonding. The nurse as the support person and teacher is responsible for shaping the environment and making the care giving responsive to the needs of both the parents and the infant. The nurse should encourage the parents to touch their baby and show them how to do so safely. Bonding needs to occur, and this can be fostered by encouraging the parents to spend time with the infant. It is important to keep the parents informed about the infant's progression, but the nurse needs to be honest with the explanations. Discussing home care needs to wait until the parents are ready and discharge is closer with known needs.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 631 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Psychosocial Integrity

5. A nurse is caring for a late preterm infant. What action by the nurse is inconsistent with best practice to prevent cold stress?
   a. Wean the infant directly to an open crib.
   b. Check temperature every 3 to 4 hours.
   c. Encourage kangaroo care.
   d. Place infant on a radiant warmer.

   ANS: A
   Weaning to an open crib takes many steps and is not done directly because of the risk of cold stress. The other actions help prevent cold stress.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: pp. 622-623 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

6. Which preterm infant should receive gavage feedings instead of a bottle?
   a. Sometimes gags when a feeding tube is inserted
   b. Is unable to coordinate sucking and swallowing
   c. Sucks on a pacifier during gavage feedings
   d. Has an axillary temperature of 98.4° F, an apical pulse of 149 beats/min, and respirations of 54 breaths/min

   ANS: B
   An infant who cannot coordinate sucking, swallowing, and breathing should receive gavage feedings. The other infants are ready for bottle feedings.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 627 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

7. Overstimulation may cause increased oxygen use in a preterm infant. Which nursing intervention helps to avoid this problem?
   a. Group all care activities together to provide long periods of rest.
   b. While giving your report to the next nurse, stand in front of the incubator and talk softly about how the infant responds to stimulation.
   c. Teach the parents signs of overstimulation, such as turning the face away or stiffening and extending the extremities and fingers.
   d. Keep charts on top of the incubator so the nurses can write on them there.

   ANS: C
   Parents should be taught these signs of overstimulation so they will learn to adapt their care to the needs of their infant. This may understimulate the infant during those long periods and overtire the infant during the procedures. Talking in front of the incubator could overstimulate the baby. Placing objects on top of the incubator or using it as a writing surface increases the noise inside.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 629 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

8. A premature infant never seems to sleep longer than an hour at a time. Each time a light is turned on, an incubator closes, or people talk near her crib, she wakes up and cries inconsolably until held. The correct nursing diagnosis is ineffective coping related to
   a. severe immaturity.
   b. environmental stress.
   c. physiologic distress.
   d. behavioral responses.

   ANS: B
   This nursing diagnosis is the most appropriate for this infant. Light and sound are known adverse stimuli that add to an already stressed premature infant. The nurse must monitor the environment closely for sources of overstimulation. The other diagnoses do not recognize that fact.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 626 OBJ: Nursing Process: Diagnosis
   MSC: Client Needs: Safe and Effective Care Environment

9. In caring for the preterm infant, what complication is thought to be a result of high arterial blood oxygen level?
   a. Necrotizing enterocolitis (NEC)
   b. Retinopathy of prematurity (ROP)
   c. Bronchopulmonary dysplasia (BPD)
   d. Intraventricular hemorrhage (IVH)

   ANS: B

ROP is thought to occur as a result of high levels of oxygen in the blood. NEC is due to the interference of blood supply to the intestinal mucosa. Necrotic lesions occur at that site. BPD is caused by the use of positive pressure ventilation against the immature lung tissue. IVH is due to rupture of the fragile blood vessels in the ventricles of the brain. It is most often associated with hypoxic injury, increased blood pressure, and fluctuating cerebral blood flow.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 636 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

10. With regard to eventual discharge of the high-risk newborn or transfer to a different facility, nurses and families should be aware that
    a. infants will stay in the NICU until they are ready to go home.
    b. once discharged to home, the high-risk infant should be treated like any healthy term newborn.
    c. parents of high-risk infants need special support and detailed contact information.
    d. if a high-risk infant and mother need transfer to a specialized regional center, it is better to wait until after birth and the infant is stabilized.

    ANS: C
    High-risk infants can cause profound parental stress and emotional turmoil. Parents need support, special teaching, and quick access to various resources available to help them care for their baby. Parents and their high-risk infant should get to spend a night or two in a predischarge room, where care for the infant is provided away from the NICU. Just because high-risk infants are discharged does not mean they are normal, healthy babies. Follow-up by specialized practitioners is essential. Ideally, the mother and baby are transported with the fetus in utero; this reduces neonatal morbidity and mortality.

    PTS: 1 DIF: Cognitive Level: Comprehension REF: p. 634
    OBJ: Nursing Process: Planning MSC: Client Needs: Psychosocial Integrity

11. Which combination of expressing pain could be demonstrated in a neonate?
    a. Low-pitched crying, tachycardia, eyelids open wide
    b. Cry face, flaccid limbs, closed mouth
    c. High-pitched, shrill cry, withdrawal, change in heart rate
    d. Cry face, eye squeeze, increase in blood pressure

    ANS: D
    Cry face, eye squeeze, and an increase in blood pressure indicate pain. The other manifestations are not those of pain in the neonate.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 624 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

12. Which is true about newborns classified as small for gestational age (SGA)?
    a. They weigh less than 2500 g.
    b. They are born before 38 weeks of gestation.
    c. Placental malfunction is the only recognized cause of this condition.

d. They are below the 10th percentile on gestational growth charts.

ANS: D
SGA infants are defined as below the 10th percentile in growth when compared with other infants of the same gestational age. SGA is not defined by weight. Infants born before 38 weeks are defined as preterm. There are many causes of SGA babies.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 637 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

13. A nurse is caring for an SGA newborn. What nursing action is most important?
a. Observe for respiratory distress syndrome.
b. Observe for and prevent dehydration.
c. Promote bonding.
d. Prevent hypoglycemia by early and frequent feedings.

ANS: D
The SGA infant has poor glycogen stores and is subject to hypoglycemia. Respiratory distress syndrome is seen in preterm infants. Dehydration is a concern for all infants and is not specific for SGA infants. Promoting bonding is a concern for all infants and is not specific for SGA infants.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 638 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

14. A nurse is assessing an SGA infant with asymmetric intrauterine growth restriction. What assessment finding correlates with this condition?
a. One side of the body appears slightly smaller than the other.
b. All body parts appear proportionate.
c. The head seems large compared with the rest of the body.
d. The extremities are disproportionate to the trunk.

ANS: C
In asymmetric intrauterine growth restriction, the head is normal in size but appears large because the infant's body is long and thin due to lack of subcutaneous fat. The left and right side growth should be symmetric. With asymmetric intrauterine growth restrictions, the body appears smaller than normal compared to the head. The body parts are out of proportion, with the body looking smaller than expected due to the lack of subcutaneous fat. The body, arms, and legs have lost subcutaneous fat so they will look small compared to the head.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 637 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

15. Which statement is true about large for gestational age (LGA) infants?
a. They weigh more than 3500 g.
b. They are above the 80th percentile on gestational growth charts.

c. They are prone to hypoglycemia, polycythemia, and birth injuries.
d. Postmaturity syndrome and fractured clavicles are the most common complications.

ANS: C
Hypoglycemia, polycythemia, and birth injuries are common in LGA infants. LGA infants are determined by their weight compared to their age. They are above the 90th percentile on the gestational growth charts. Birth injuries are a problem, but postmaturity syndrome is not an expected complication with LGA infants.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 638 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

16. Of all the signs seen in infants with respiratory distress syndrome, which sign is especially indicative of the syndrome?
a. Pulse more than 160 beats/min
b. Circumoral cyanosis
c. Grunting
d. Substernal retractions

ANS: C
Grunting increases the pressure inside the alveoli to keep them open when surfactant is insufficient. This is a characteristic and often early sign of RDS. The other assessments are not specific to RDS.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 621 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

17. While caring for the postterm infant, the nurse recognizes that the fetus may have passed meconium prior to birth as a result of
a. hypoxia in utero.
b. NEC.
c. placental insufficiency.
d. rapid use of glycogen stores.

ANS: A
When labor begins, poor oxygen reserves may cause fetal compromise. The fetus may pass meconium as a result of hypoxia before or during labor, increasing the risk of meconium aspiration. Meconium is not passed as a result of NEC, placental insufficiency, or rapid use of glycogen stores.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 636 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

18. Which data should alert the nurse that the neonate is postmature?
a. Cracked, peeling skin
b. Short, chubby arms and legs

c. Presence of vernix caseosa
d. Presence of lanugo

ANS: A
Loss of vernix caseosa, which protects the fetal skin in utero, may leave the skin macerated and appearing cracked and peeling. Postmature infants usually have long, thin arms and legs. Vernix caseosa decreases in the postmature infant. Absence of lanugo is common in postmature infants.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 637 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

19. Because of the premature infant's decreased immune functioning, what nursing diagnosis should the nurse include in a plan of care for a premature infant?
a. Delayed growth and development
b. Ineffective thermoregulation
c. Ineffective infant feeding pattern
d. Risk for infection

ANS: D
The nurse needs to know that decreased immune functioning increases the risk for infection. The other diagnoses are appropriate for the premature infant but not related directly to immune function.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 624 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

20. To maintain optimal thermoregulation for the premature infant, what action by the nurse is most appropriate?
a. Bathe the infant once a day.
b. Put an undershirt on the infant in the incubator.
c. Assess the infant's hydration status.
d. Lightly clothe the infant under the radiant warmer.

ANS: B
Air currents around an unclothed infant will result in heat loss. Bathing causes evaporative heat loss. Assessing hydration will not maintain thermoregulation. Clothing is not worn when the infant is under a radiant warmer.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 623 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

21. A nurse is caring for a preterm baby who weighs 4.8 pounds. What assessment finding indicates the baby is dehydrated?
a. Urine output of 3.3 mL/hour
b. Urine specific gravity of 1.001
c. Low serum sodium

d. Weight gain of 43 g in one day

ANS: A
This baby weighs 2.18 kg. Dehydration is noted with a urine output of <2 mL/kg/hour. A urine output of 3.3 mL is 1.5 mL/kg/hour and so indicates dehydration. The dilute urine specific gravity indicates overhydration as does the low serum sodium. The weight gain is normal (15 to 20 g/kg/day).

PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
REF: p. 623 | Safety Alert Box OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

22. The nurse is observing a parent holding a preterm infant. The infant is sneezing, yawning, and extending the arms and legs. What action by the nurse is best?
    a. Cover the infant with a warmed blanket.
    b. Encourage the parent to do kangaroo care.
    c. Encourage the parent to place the infant back in the warmer
    d. Have the parent fold the infant's arms across the chest.

    ANS: C
    These are signs that the preterm infant is overstimulated. The parent should place the infant back in her warmer, and the nurse can turn down the lights and limit noise. The other suggestions will not help decrease stimulation.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 626 | Safety Alert Box OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

23. A nurse is caring for a preterm infant who has a weak cry and is irritable. What action by the nurse is best?
    a. Assess the infant for pain.
    b. Take the infant's temperature.
    c. Obtain a bedside glucose reading.
    d. Reduce stimulation in the environment.

    ANS: B
    These are signs of inadequate thermoregulation. The nurse should assess the infant's temperature first. The other actions do not address thermoregulation.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 622 | Safety Alert Box OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. The nurse tells the nursing student that late preterm infants are at increased risk for which of the following problems? (*Select all that apply*.)
    a. Problems with thermoregulation
    b. Cardiac distress
    c. Hyperbilirubinemia

d. Sepsis
e. Hyperglycemia

ANS: A, C, D
Problems with thermoregulation, hyperbilirubinemia, and sepsis are common with late preterm infants. They typically have respiratory distress and hypoglycemia.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 619 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

2. An important nursing factor during the care of the infant in the NICU is assessment for signs of adequate parental attachment. The nurse must observe for signs that bonding is not occurring as expected. These include (*Select all that apply.*)
a. using positive terms to describe the infant.
b. showing interest in other infants equal to that of their own.
c. naming the infant.
d. decreasing the number and length of visits.
e. refusing offers to hold and care for the infant.

ANS: B, D, E
Bonding is not progressing as expected when parents show interest in other babies equal to that of their own, decreasing the number and length of visits, and refusing to hold and help care for the infant. Using positive terms to describe the baby and naming the infant are signs that bonding is occurring.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 631 | Nursing Quality Alert Box OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

MULTIPLE CHOICE

1. The infant of a mother with diabetes is hypoglycemic. What type of feeding should be instituted first?
   a. Glucose water in a bottle
   b. D_5W intravenously
   c. Formula via nasogastric tube
   d. Breast milk

   ANS: D
   Breast milk is metabolized more slowly and provides longer normal glucose levels. Breast milk is best for nearly all babies. High levels of dextrose correct the hypoglycemia but will stimulate the production of more insulin. Oral feedings are tried first; intravenous lines should be a later choice if the hypoglycemia continues. Formula does provide longer normal glucose levels but would be administered via bottle, not by tube feeding unless the baby is unable to take oral feedings.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 652 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

2. The nurse learns that the most common cause of pathologic hyperbilirubinemia is which of the following?
   a. Hepatic disease
   b. Hemolytic disorders in the newborn
   c. Postmaturity
   d. Congenital heart defect

   ANS: B
   Hemolytic disorders in the newborn are the most common cause of pathologic jaundice. Hepatic damage and prematurity may be causes of pathologic hyperbilirubinemia, but they are not the most common cause. Congenital heart defect is not a common cause of pathologic hyperbilirubinemia in neonates.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 645 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

3. An infant with severe meconium aspiration syndrome (MAS) is not responding to conventional treatment. Which treatment may be necessary for this infant?
   a. Extracorporeal membrane oxygenation
   b. Respiratory support with ventilator
   c. Insertion of laryngoscope and suctioning of the trachea
   d. Insertion of an endotracheal tube

   ANS: A

Extracorporeal membrane oxygenation is a highly technical method that oxygenates the blood while bypassing the lungs, allowing the infant's lungs to rest and recover. The infant is most likely intubated and on a ventilator already. Laryngoscope insertion and tracheal suctioning are performed after birth before the infant takes the first breath.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 644 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

4. Four hours after delivery of a healthy neonate of an insulin-dependent diabetic woman, the baby appears jittery, irritable, and has a high-pitched cry. Which nursing action has top priority?
   a. Start an intravenous line with D_5W.
   b. Notify the clinician stat.
   c. Document the event in the nurses' notes.
   d. Test for blood glucose level.

   ANS: D
   These are signs of hypoglycemia in the newborn. The nurse should test the infant's blood glucose level and then feed the infant if it is low. It is not common practice to give intravenous glucose to a newborn prior to feeding. Feeding the infant is preferable because the formula or breast milk will last longer. The provider needs to be notified after corrective action has been taken. Documentation should occur but is not the priority.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 652 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Safe and Effective Care Environment

5. A nurse is participating in a neonatal resuscitation. What action by the nurse takes priority?
   a. Suction the mouth and nose.
   b. Stimulate the infant by rubbing the back.
   c. Perform the Apgar test.
   d. Place the infant in a preheated warmer.

   ANS: D
   In a resuscitation situation, the nurse places the newborn in a preheated warmer immediately to reduce cold stress. Next position the infant in a "sniffing" position. Suctioning is the third step. Drying the infant is fourth, although if more than one health care provider is present, drying can occur simultaneously with the other actions.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 643 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

6. A neonate has white patches in her mouth that bled when the mother tried wiping them away. What action by the nurse is best?
   a. Tell the mother to leave the patches alone.
   b. Assess the mother for a perineal rash.
   c. Give the infant medicated pacifiers.
   d. Test the infant for toxoplasmosis.

ANS: B
These patches are characteristic of maternal infection with *candidiasis* or yeast. The nurse assesses the mother's perineal area for a rash. Telling the mother to leave the rash alone may be appropriate information but does not get to the bottom of the issue. The nurse should not provide medication without knowing what is being treated. The baby does not have toxoplasmosis.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 650 | Table 30.1 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

7. Transient tachypnea of the newborn (TTN) is thought to occur as a result of
   a. a lack of surfactant.
   b. hypoinflation of the lungs.
   c. delayed absorption of fetal lung fluid.
   d. a slow vaginal delivery associated with meconium-stained fluid.

   ANS: C
   Delayed absorption of fetal lung fluid is thought to be the reason for TTN. Lack of surfactant and hypoinflation of the lungs are not related to TTN. A slow vaginal delivery will help prevent TTN.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 642 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

8. A newborn has meconium aspiration at birth. The nurse notes increasing respiratory distress. What action takes priority?
   a. Obtain an oxygen saturation.
   b. Notify the provider at once.
   c. Stimulate the baby to increase respirations.
   d. Prepare to initiate ECMO.

   ANS: A
   This baby has a risk for, and signs of, persistent pulmonary hypertension. The nurse first checks an oxygen saturation then notifies the provider, or alternatively, gets the reading (and other assessments) while another nurse does the notification. This baby most likely has tachypnea so stimulation to increase respirations is not needed. ECMO may or may not be needed depending on whether or not other treatments work.

   PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
   REF: p. 645 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Safe and Effective Care Environment

9. The nurse present at the delivery is reporting to the nurse who will be caring for the neonate after birth. What information might be included for an infant who had thick meconium in the amniotic fluid?
   a. The infant had Apgar scores of 6 and 8.
   b. An IV was started immediately after birth to treat dehydration.

c. No meconium was found below the vocal cords when they were examined.
d. The parents spent an hour bonding with the baby after birth.

ANS: C
A laryngoscope is inserted to examine the vocal cords. If no meconium is below the cords, probably no meconium is present in the lower air passages, and the infant will not develop meconium aspiration syndrome. Apgar scores are important but not directly related to meconium. There is no relationship between dehydration and meconium fluid. Bonding is an expected occurrence.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 643 OBJ: Integrated Process: Communication and Documentation
MSC: Client Needs: Safe and Effective Care Environment

10. The nurse is teaching the parents of a newborn who is going to receive phototherapy. What other measure does the nurse teach to help reduce the bilirubin?
a. Increase the frequency of feedings.
b. Increase oral intake of water between feedings.
c. How to prepare the newborn for an exchange transfusion
d. Wrap the infant in triple blankets to prevent cold stress during phototherapy.

ANS: A
Frequent feedings prevent hypoglycemia, provide protein to maintain albumin levels in the blood and promote gastrointestinal motility and removal of bilirubin in the stools. More frequent breastfeeding should be encouraged. Avoid offering water between feedings, because the infant may decrease his or her milk intake. Breast milk or formula is more effective at removing bilirubin from the intestines. Exchange transfusions are seldom necessary but may be performed when phototherapy cannot reduce high bilirubin levels quickly enough. Wrapping the infant in blankets will prevent the phototherapy from getting to the skin and being effective. The infant should be uncovered and unclothed.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 647 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

11. A mother with diabetes has done some reading about the effects of the condition on her newborn. Which statement shows a misunderstanding that should be clarified by the nurse?
a. “Although my baby is large, some women with diabetes have very small babies because the blood flow through the placenta may not be as good as it should be.”
b. “My baby will be watched closely for signs of low blood sugar, especially during the early days after birth.”
c. “The red appearance of my baby’s skin is due to an excessive number of red blood cells.”
d. “My baby’s pancreas may not produce enough insulin because the cells became smaller than normal during my pregnancy.”

ANS: D
Infants of diabetic mothers may have hypertrophy of the islets of Langerhans, which may cause them to produce more insulin than they need. The other statements are correct and show good understanding.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 652 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Health Promotion and Maintenance

12. Nursing care of the infant with neonatal abstinence syndrome should include
    a. Positioning the infant's crib in a quiet corner of the nursery
    b. Feeding the infant on a 2-hour schedule
    c. Placing stuffed animals and mobiles in the crib to provide visual stimulation
    d. Spending extra time holding and rocking the infant

    ANS: A
    Placing the crib in a quiet corner helps avoid excessive stimulation of the infant. These infants have an increase calorie needs but poor suck and swallow coordination. Feeding should occur to meet these needs. Stimulation should be kept to a minimum.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 655 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

13. The difference between physiologic and nonphysiologic jaundice is that nonphysiologic jaundice
    a. usually results in kernicterus.
    b. appears during the first 24 hours of life.
    c. results from breakdown of excessive erythrocytes not needed after birth.
    d. begins on the head and progresses down the body.

    ANS: B
    Nonphysiologic jaundice appears during the first 24 hours of life, whereas physiologic jaundice appears after the first 24 hours of life. Pathologic jaundice may lead to kernicterus, but it needs to be stopped before that occurs. Both jaundices are the result of the breakdown of erythrocytes. Pathologic jaundice is due to a pathologic condition, such as Rh incompatibility.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 645 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

14. The goal of treatment of the infant with phenylketonuria (PKU) is to
    a. cure cognitive delays.
    b. prevent central nervous system (CNS) damage.
    c. prevent gastrointestinal symptoms.
    d. prevent the renal system damage.

    ANS: B
    CNS damage can occur as a result of toxic levels of phenylalanine. No cure exists for cognitive delays should they occur. Digestive problems are a clinical manifestation of PKU, but it is more important to prevent the CNS damage. PKU does not involve renal dysfunction.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 655 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

15. Parents of a newborn with phenylketonuria are anxious to learn about the appropriate treatment for their infant. What topic does the nurse include in the teaching plan?
    a. Fluid and sodium restrictions
    b. A phenylalanine-free diet
    c. Progressive mobility and splinting
    d. A protein-rich diet

    ANS: B
    Phenylketonuria is treated with a special diet that restricts phenylalanine intake. Fluid and sodium restrictions are not included in this plan. Mobility and splinting are not included in the plan. A protein-rich diet is not in the plan.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 655 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

16. The nurse is caring for a neonate undergoing phototherapy. What action does the nurse include on the infant's care plan?
    a. Keep the infant's eyes covered under the light.
    b. Keep the infant supine at all times.
    c. Restrict parenteral and oral fluids.
    d. Dress the infant in only a T-shirt and diaper.

    ANS: A
    Retinal damage from phototherapy should be prevented by using eye shields on the infant under the light. To ensure total skin exposure, the infant's position is changed frequently. Special attention to increasing fluid intake ensures that the infant is well hydrated. To ensure total skin exposure, the infant is not dressed.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 647 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

17. An infant with hypocalcemia is receiving an intravenous bolus of calcium. The infant's heart rate changes from 144 beats/minute to 62 beats/minute. What action by the nurse is best?
    a. Call for a stat EGG.
    b. Stop the infusion.
    c. Stimulate the infant.
    d. Administer magnesium.

    ANS: B
    IV calcium can lead to bradycardia. When this infant's heart rate drops to 60 beats/minute, the nurse stops the infusion. A stat ECG is not necessary unless policy requires it or the bradycardia does not resolve. Stimulating the infant will not increase the heart rate. Magnesium infusion will also not increase the heart rate.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 653 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

18. A macrosomic infant is born after a difficult, forceps-assisted delivery. After stabilization, the infant is weighed, and the birth weight is 4550 g (9 pounds, 6 ounces). What action by the nurse is most appropriate?
    a. Leave the infant in the room with the mother.
    b. Take the infant immediately to the nursery.
    c. Perform a gestational age assessment.
    d. Monitor blood glucose levels frequently.

    ANS: D
    This infant is macrosomic (over 4000 g) and is at high risk for hypoglycemia. Blood glucose levels should be monitored frequently, and the infant should be observed closely for signs of hypoglycemia. The infant can stay with the mother, but this is not the best answer since it does not include the close monitoring needed. Regardless of gestational age, this infant is macrosomic.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 652 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

19. A pregnant woman at 37 weeks of gestation has had ruptured membranes for 26 hours. A cesarean section is performed for failure to progress. The fetal heart rate before birth is 180 beats/min with limited variability. At birth, the newborn has Apgar scores of 6 and 7 at 1 and 5 minutes and is noted to be pale and tachypneic. Based on the maternal history, the cause of this newborn's distress is most likely
    a. hypoglycemia.
    b. phrenic nerve injury.
    c. respiratory distress syndrome.
    d. sepsis.

    ANS: D
    The prolonged rupture of membranes and the tachypnea (before and after birth) both suggest sepsis. There is no evidence of phrenic nerve damage or respiratory distress syndrome. Early signs of sepsis may be difficult to distinguish from other problems such as hypoglycemia, but the prolonged rupture of membranes puts this baby at high risk of sepsis.

    PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
    REF: p. 650 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

20. What action by the nurse is the most important action in preventing neonatal infection?
    a. Good hand hygiene
    b. Isolation of infected infants
    c. Separate gown technique
    d. Standard Precautions

ANS: A
Virtually all controlled clinical trials have demonstrated that effective handwashing is responsible for the prevention of nosocomial infection in nursery units. The other actions do reduce risk but not nearly to the degree that good hand hygiene does.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 651 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

21. What action does the nurse add to the plan of care for an infant experiencing symptoms of drug withdrawal?
    a. Keeping the newborn sedated
    b. Feeding every 4 to 6 hours to allow extra rest
    c. Swaddling the infant snugly
    d. Playing soft music during feeding

    ANS: C
    The infant should be wrapped snugly to reduce self-stimulation behaviors and protect the skin from abrasions. The baby is not kept sedated. The infant should be fed in small, frequent amounts and burped well to diminish aspiration and maintain hydration. The infant should not be stimulated (such as with music), because this will increase activity and potentially increase CNS irritability.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 655 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

22. The nursing student learns that transmission of HIV from mother to baby occurs in which fashion?
    a. From the maternal circulation only in the third trimester
    b. From the use of unsterile instruments
    c. Only through the ingestion of amniotic fluid
    d. Through the ingestion of breast milk from an infected mother

    ANS: D
    Postnatal transmission of HIV through breastfeeding may occur. Transplacental transmission can occur at any time during pregnancy. Unsterile instruments are possible sources of transmission but highly unlikely. Transmission of HIV may also occur during birth from blood or secretions. Transmission of HIV from the mother to the infant may occur transplacentally at various gestational ages. This is highly unlikely as most health care facilities must meet sterility standards for all instrumentation.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 649 | Table 30.1 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

23. A primigravida has just delivered a healthy infant girl. The nurse is about to administer erythromycin ointment in the infant's eyes when the mother asks, "What is that medicine for?" The nurse responds
    a. "It is an eye ointment to help your baby see you better."

b. “It is to protect your baby from contracting herpes from your vaginal tract.”
c. “Erythromycin is given to prevent a gonorrheal infection.”
d. “This medicine will protect your baby’s eyes from drying out.”

ANS: C
With the prophylactic use of erythromycin, the incidence of gonococcal conjunctivitis has declined to less than 0.5%. Eye prophylaxis is administered at or shortly after birth to prevent ophthalmia neonatorum. Erythromycin has no bearing on enhancing vision and is not used for herpes infections or lubrication.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 649 | Table 30.1 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

24. Near the end of the first week of life, an infant who has not been treated for any infection develops a copper-colored, maculopapular rash on the palms and around the mouth and anus. The newborn is showing signs of
a. gonorrhea.
b. herpes simplex virus infection.
c. congenital syphilis.
d. HIV.

ANS: C
This rash is indicative of congenital syphilis. The lesions may extend over the trunk and extremities. This is not characteristic of gonorrhea, herpes, or HIV.

PTS: 1 DIF: Cognitive Level: Knowledge
REF: p. 650 | Table 30.1 | p. 654 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

25. Providing care for the neonate born to a mother who abuses substances can present a challenge for the health care team. Nursing care for this infant requires a multisystem approach. The first step in the provision of this care is
a. pharmacologic treatment.
b. reduction of environmental stimuli.
c. neonatal abstinence syndrome scoring.
d. adequate nutrition and maintenance of fluid and electrolyte balance.

ANS: C
Various scoring systems exist to determine the number, frequency, and severity of behaviors that indicate neonatal abstinence syndrome. The score is helpful in determining the necessity of drug therapy to alleviate withdrawal. Pharmacologic treatment is based on the severity of withdrawal symptoms. Swaddling, holding, and reducing environmental stimuli are essential in providing care to the infant who is experiencing withdrawal. However, the scoring helps provide definitive care. Fluids and electrolyte balance are appropriate for any infant.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 654 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

26. A woman who has had no prenatal care enters the labor and delivery unit in advanced labor. She has chickenpox. What action by the nurse is best?
    a. Place the woman in isolation.
    b. Give the woman immune globulin before delivery.
    c. Treat the woman with acyclovir.
    d. Administer antibiotics to the infant after birth.

    ANS: A
    Women with varicella infections (chickenpox or shingles) need to be in isolation (airborne and contact per the CDC). There might not be enough time to administer immune globulin to the mother before delivery, but it could be given to the baby. Acyclovir is the drug of choice for treatment, but the staff needs to be protected from this infection through isolation precautions. Antibiotics are not used for this disease.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 649 | Table 30.1 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Safe and Effective Care Environment

27. A woman who has a history of frequent substance abuse is close to delivering. What action by the nurse is best?
    a. Notify social services of the situation prior to the birth.
    b. Draw up and label a syringe of naloxone.
    c. Administer naloxone if the baby shows signs of withdrawal.
    d. Prepare to administer naloxone to the mother.

    ANS: B
    When anticipating the delivery of a baby whose mother is addicted to opioids, the nurse prepares to give the newborn naloxone for respiratory depression. To administer the drug in the fastest way possible, the nurse prepares a syringe with the medication. Then when the baby's weight is known, the nurse discards the excess drug and administers the correct dose to the baby. Social services will need to be involved but not at this point; the medication is the priority. The naloxone may cause signs of withdrawal in the infant. The baby gets the naloxone, not the mother.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 641 | p. 642 | Drug Guide OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. Some infants develop hypoxic-ischemic encephalopathy after asphyxia. *Therapeutic hypothermia* has been used to improve neurologic outcomes for these infants. Criteria for the use of this modality include (*Select all that apply.*)
    a. The infant must be 28 weeks gestation or greater.
    b. Have evidence of an acute hypoxic event.
    c. Be in a facility they can initiate treatment within 6 hours.
    d. The infant must be 36 or more weeks' gestation.
    e. The treatment must be initiated within the first 12 hours of life.

ANS: B, C, D
The infant must be at least 36 weeks of gestation to meet the criteria for therapeutic hypothermia. Treatment should be initiated within the first 6 hours of life, ideally at a tertiary care center. The infant must have evidence of perinatal hypoxic-ischemic episodes.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 642 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

2. Newborns whose mothers are substance abusers frequently have what behaviors? (*Select all that apply*.)
   a. Circumoral cyanosis
   b. Decreased amounts of sleep
   c. Hyperactive Moro (startle) reflex
   d. Difficulty feeding
   e. Weak cry

   ANS: B, C, D
   The infant exposed to drugs in utero often has poor sleeping patterns, hyperactive reflexes, and uncoordinated sucking and swallowing behavior. They do not have circumoral cyanosis and will have a high-pitched cry.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 654 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

COMPLETION

1. The nurse is preparing a dose of naloxone for a newborn who weighs 6.9 pounds. How much naloxone does the nurse administer? _____ mg

   ANS:
   0.31 mg

   The dose is 0.1 mg/kg for this 3.1-kg baby.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 642 | Drug Guide OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. The conscious decision on when to conceive or avoid pregnancy throughout the reproductive years is called
   a. family planning.
   b. birth control.
   c. contraception.
   d. assisted reproductive therapy.

   ANS: A
   Family planning is the process of deciding when and if to have children. Birth control is the device and/or practice used to reduce the risk of conceiving or bearing children. Contraception is the intentional prevention of pregnancy during sexual intercourse. Assisted reproductive therapy is one of several possible treatments for infertility.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 659 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

2. While instructing a couple regarding birth control, the nurse should be aware that the method called *natural family planning*
   a. is the same as coitus interruptus, or "pulling out."
   b. uses the calendar method to align the woman's cycle with sexual activity.
   c. is used by 2% of Roman Catholics.
   d. relies on barrier methods during fertility phases.

   ANS: C
   Natural family planning is used by about 2% of Roman Catholics. It is not the same a coitus interruptus. It uses a variety of methods to determine a woman's fertility. Those practicing natural family planning do not use barrier methods at any time.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 663 OBJ: Nursing Process: Planning
   MSC: Client Needs: Health Promotion and Maintenance

3. A nurse is providing information about contraceptives to a couple. Which contraceptive method provides protection against sexually transmitted diseases?
   a. Oral contraceptives
   b. Tubal ligation
   c. Male or female condoms
   d. Intrauterine device (IUD)

   ANS: C

Only the barrier methods provide some protection from sexually transmitted diseases. Because latex condoms provide the best protection available, they should be used during any potential exposure to a sexually transmitted disease. Oral contraceptives, tubal ligations, or IUDs do not provide protection against STDs.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 671 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Safe and Effective Care Environment

4. A couple is discussing alternatives for pregnancy prevention and has asked about fertility awareness methods (FAMs). The nurse's most appropriate reply is
   a. "They're not very effective, and it's very likely you'll get pregnant."
   b. "They can be effective for many couples, but they require motivation."
   c. "These methods have a few advantages and several health risks."
   d. "You would be much safer going on the pill and not having to worry."

   ANS: B
   FAMs are effective with proper vigilance about ovulatory changes in the body and with adherence to coitus intervals. However, the typical failure rate is 25%. This is not the best response, however. The nurse should provide positive feedback first; otherwise, the couple may become discouraged and think the nurse is negative or biased against a method they are interested in. FAMs have no associated health risks. The use of birth control has associated health risks. In addition, taking a pill daily requires compliance on the patient's part.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 671 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

5. A woman who has a seizure disorder and takes barbiturates and phenytoin sodium daily asks the nurse about the pill as a contraceptive choice. The nurse's most appropriate response is
   a. "This is a highly effective method, but it has some side effects."
   b. "Your current medications will reduce the effectiveness of the pill."
   c. "The pill will reduce the effectiveness of your seizure medication."
   d. "This is a good choice for a woman of your age and personal history."

   ANS: B
   Because the liver metabolizes oral contraceptives, their effectiveness is reduced when they are taken simultaneously with anticonvulsants. Telling the woman the pill has some side effects or that it is a good choice for some women is not tailoring teaching to her specific situation. The anticonvulsant will reduce the effectiveness of the pill, not the other way around.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 668 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

6. Injectable progestins (DMPA, Depo-Provera) are a good contraceptive choice for women who
   a. want menstrual regularity and predictability.
   b. have a history of thrombotic problems or breast cancer.

c. have difficulty remembering to take oral contraceptives daily.
d. are homeless or mobile and rarely receive health care.

ANS: C
Advantages of DMPA include a contraceptive effectiveness comparable to that of combined oral contraceptives with the requirement of only four injections a year. Disadvantages of injectable progestins are menstrual irregularities. Use of injectable progestin carries an increased risk of venous thrombosis and thromboembolism. To be effective, DMPA injections must be administered every 11 to 13 weeks. Access to health care is necessary to prevent pregnancy or potential complications.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 666 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

7. Which woman is the safest candidate for the use of oral contraceptives?
a. 39-year-old with a history of thrombophlebitis
b. 16-year-old with a benign liver tumor
c. 20-year-old who suspects she may be pregnant
d. 43-year-old who does not smoke cigarettes

ANS: D
Cigarette smoking is a contraindication, especially in women older than 35. Oral contraceptives are contraindicated with a history of thrombophlebitis, liver tumors, or pregnancy.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 668 | Safety Alert Box OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

8. The role of the nurse in family planning is to
a. advise couples on which contraceptive to use.
b. educate couples on the various methods of contraception.
c. decide on the best method of contraception for the couple.
d. refer the couple to a reliable physician.

ANS: B
The nurse's role is to provide information to the couple so that they can make an informed decision about family planning. The nurse should not advise the couple or pick the best method for them, nor does he or she need to refer couples for information about contraceptives.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 659 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

9. What does the nurse know about postcoital emergency contraception with Ella or Next Choice?
a. Requires that the first dose be taken within 72 hours of unprotected intercourse
b. Requires that the woman take second and third doses at 24 and 36 hours after the

first dose
c. Must be taken in conjunction with an IUD insertion
d. Most states require the woman to have a valid prescription

ANS: A
Emergency contraception is most effective when used within 72 hours of intercourse but may be used with lessened effectiveness up to 120 hours later. Insertion of the copper IUD within 5 days of intercourse may also be used and is up to 99% effective. Emergency contraception is available without a prescription for women over 17 and for those younger than 17 with prescription.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 669 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

10. Informed consent concerning contraceptive use is important because some of the methods
a. are invasive procedures that require hospitalization.
b. require a surgical procedure to insert.
c. may not be reliable.
d. have potentially dangerous side effects.

ANS: D
It is important for couples to be aware of potential side effects so they can make an informed decision about the use of contraceptives. The only contraceptive method that requires hospitalization is sterilization. The only surgical procedure used would be for permanent sterilization. Some have more effective rates, and this should be included in the teaching.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 663 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

11. Which contraceptive method is contraindicated in a woman with a history of toxic shock syndrome?
a. Condom
b. Spermicide
c. Cervical cap
d. Norplant

ANS: C
The cervical cap may increase the risk of toxic shock syndrome because it may be left in the vagina for a prolonged period. Condoms, spermicides, and Norplant are not contraindicated in women who have had toxic shock syndrome.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 671 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

12. What is important in instructing a patient in the use of spermicidal foams or gels? a. Insert 1 to 2 hours before intercourse.

b. One application is effective for several hours.
c. Avoid douching for at least 6 hours.
d. There are no known side effects.

ANS: C
Douching within 6 hours of intercourse removes the spermicide and increases the risk of pregnancy. Foams or gels should be inserted just before intercourse and are effective for about 1 hour. Each application is effective for about 1 hour. Effectiveness is about 74% when used alone. Vaginal irritation may occur with spermicide use.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 670 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

13. A woman currently uses a diaphragm and spermicide for contraception. She asks the nurse what the major differences are between the cervical cap and diaphragm. The nurse's most appropriate response is
a. "No spermicide is used with the cervical cap, so it's less messy."
b. "The diaphragm can be left in place longer after intercourse."
c. "Repeated intercourse with the diaphragm is more convenient."
d. "You can have intercourse several times without removing the cap to add more spermicide."

ANS: D
The cervical cap can be inserted hours before sexual intercourse without the need for additional spermicide later. No additional spermicide is needed inside the cap for repeated acts of intercourse but more is inserted into the vagina. Spermicide should be used inside the cap as an additional chemical barrier. The cervical cap should remain in place for 6 hours after the last act of intercourse but can stay in place up to 48 hours. Repeated intercourse with the cervical cap is more convenient, because no additional spermicide is needed.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 671 | Table 31.1 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

14. A young woman describes her sex life as "active" and involving "many" partners. She wants a contraceptive method that is reliable and does not interfere with sex. She requests an intrauterine device (IUD). The nurse's most appropriate response is
a. "The IUD does not interfere with sex."
b. "The risk of pelvic inflammatory disease will be higher for you."
c. "The IUD will protect you from sexually transmitted diseases."
d. "Pregnancy rates are high with the IUDs."

ANS: B

Disadvantages of IUDs include an increased risk of pelvic inflammatory disease (PID) in the first 20 days after insertion, as well as the risks of bacterial vaginosis and uterine perforation. The IUD offers no protection against sexually transmitted diseases (STDs) or the human immunodeficiency virus (HIV). Because this woman has multiple sex partners, she is at higher risk of developing an STD. The IUD does not protect against infection, as does a barrier method. Although the IUD does not interfere with sex, this is not the most appropriate response. The typical failure rate of the IUD ranges from 0.8% to 2%.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 665 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

15. A woman will be taking oral contraceptives using a 28-day pack. The nurse should advise this woman to protect against pregnancy by
    a. limiting sexual contact for one cycle after starting the pill.
    b. using condoms and foam instead of the pill for as long as she takes an antibiotic.
    c. taking one pill at the same time every day.
    d. using a backup method if she misses two pills during week 1 of her cycle.

ANS: C
To maintain adequate hormone levels for contraception and to enhance compliance, patients should take oral contraceptives at the same time each day. If contraceptives are to be started at any time other than during normal menses or within 3 weeks after birth or abortion, another method of contraception should be used through the first week to prevent the risk of pregnancy. Taken exactly as directed, oral contraceptives prevent ovulation, and pregnancy cannot occur. No strong pharmacokinetic evidence indicates a link between the use of broad-spectrum antibiotics and altered hormonal levels in oral contraceptive users. If the patient misses two pills during week 1, she should take two pills a day for 2 days and finish the package and use a backup method for the next 7 consecutive days.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 667 | Box 31.1 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

16. With regard to the use of intrauterine devices (IUDs), nurses should be aware that
    a. return to fertility can take several weeks after the device is removed.
    b. IUDs containing copper can provide an emergency contraception option if inserted within a few days of unprotected intercourse.
    c. IUDs offer the same protection against sexually transmitted diseases as the diaphragm.
    d. consent forms are not needed for IUD insertion.

ANS: B
The woman has up to 5 days to insert the IUD after unprotected sex. Return to fertility is immediate after removal of the IUD. IUDs offer no protection for sexually transmitted diseases. A consent form and a negative pregnancy test are required for insertion.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 669 | Table 31.1 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

17. A physician prescribes clomiphene citrate (Clomid, Serophene) for a woman experiencing infertility. She is very concerned about the risk of multiple births. Which response by the nurse is most appropriate?
    a. “This is a legitimate concern. Would you like to discuss this further before your treatment begins?”
    b. “No one has ever had more than triplets with Clomid.”
    c. “Ovulation will be monitored with ultrasound so that this will not happen.”
    d. “That has a very low chance of happening, so you don’t need to worry too much.”

    ANS: A
    The incidence of multiple pregnancies with the use of these medications is increased. The patient’s concern is legitimate and should be discussed so that she can make an informed decision. Women have had more that triplets on this medication. Ultrasound cannot prevent multiple gestation. Telling the woman not to worry is belittling her concerns.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 680 OBJ: Nursing Process: Planning
    MSC: Client Needs: Health Promotion and Maintenance

18. A couple comes in for an infertility workup, having attempted to get pregnant for 2 years. The woman, 37, has always had irregular menstrual cycles but is otherwise healthy. The man has fathered two children from a previous marriage and had a vasectomy reversal 2 years ago. The man has had two normal semen analyses, but the sperm seem to be clumped together. What additional test is needed?
    a. Testicular biopsy
    b. Antisperm antibodies
    c. FSH level
    d. Examination for testicular infection

    ANS: C
    The woman has irregular menstrual cycles. The scenario does not indicate that she has had any testing related to this irregularity. Hormone analysis is performed to assess endocrine function of the hypothalamic-pituitary-ovarian axis when menstrual cycles are absent or irregular. Determination of blood levels of prolactin, FSH, luteinizing hormone (LH), estradiol, progesterone, and thyroid hormones may be necessary to diagnose the cause of irregular menstrual cycles. A testicular biopsy would be indicated only in cases of azoospermia (no sperm cells) or severe oligospermia (low number of sperm cells). Antisperm antibodies are produced by a man against his own sperm. This is unlikely to be the case here, because the husband has already produced children. Examination for testicular infection should be done before semen analysis. Furthermore, infection affects spermatogenesis. However, the woman’s hormone levels would likely be tested first.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 679 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

19. A couple is trying to cope with an infertility problem. They want to know what they can do to preserve their emotional equilibrium. What response by the nurse is most appropriate? a. “Tell your friends and family so that they can help you.”

b. “Talk only to other friends who are infertile, because only they can help.”
c. “Get involved with a support group. I’ll give you some names.”
d. “You might start thinking about adoption to end this roller coaster of emotion.”

ANS: C
Venting negative feelings may unburden the couple. A support group may provide a safe haven for the couple to share their experiences and gain insight from others’ experiences. Although talking about their feelings may unburden them of negative feelings, infertility can be a major stressor that affects the couple’s relationships with family and friends who often don’t understand the couple’s feelings. It is not reasonable to suggest they only talk to other infertile couples. The nurse should not suggest the couple consider adoption while they are still trying to conceive, plus adoption has its own set of stressors.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 684 OBJ: Integrated Process: Caring
MSC: Client Needs: Psychosocial Integrity

20. A couple are asking the nurse about in vitro fertilization. What explanation by the nurse is best?
a. “IVF places the product of conception from your sperm and her egg into the uterus.”
b. “A donor embryo will be transferred into your wife’s uterus.”
c. “Donor sperm will be used to inseminate your wife.”
d. “Don’t worry about the technical stuff; that’s what we are here for.”

ANS: A
A woman’s eggs are collected from her ovaries, fertilized in the laboratory with sperm, and transferred to her uterus after normal embryonic development has occurred. There are no donors involved in this specific type of assisted reproductive technology although if the process does not work due to problems with either the man or the woman, donor products can be used. Telling the couple to not worry about the technical aspects of the treatment does not offer them any information and belittles their questions and concerns.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 681 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

21. With regard to the assessment of female, male, and couple infertility, nurses should be aware of which of the following?
a. The couple’s religious, cultural, and ethnic backgrounds do not affect the diagnosis.
b. The investigation is lengthy and can be very costly.
c. The woman is assessed first; if she is not the problem, the male partner is analyzed.
d. Semen analysis is for men; the postcoital test is for women.

ANS: B

Fertility assessment and diagnosis take time, money, and commitment from the couple. Religious, cultural, and ethnic-bred attitudes about fertility and related issues always have an impact on diagnosis and assessment. Both partners are assessed systematically and simultaneously, as individuals and as a couple. Semen analysis is for men, but the postcoital test is for the couple.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 678 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

22. A woman has been prescribed metformin at the infertility clinic. She says "Why am I on this? I am not a diabetic; my sister takes it for her diabetes!" What response by the nurse is best?
    a. "It is used to promote ovulation in polycystic ovary disease."
    b. "It will prevent your body from forming antibodies to sperm."
    c. "It helps prepare the uterine lining for eventual implantation."
    d. "I don't know but I will find out and let you know right away."

    ANS: A
    Metformin is used as an adjunctive therapy to promote ovulation in the woman with polycystic ovary disease. It does not prevent antibody formation or prepare the uterine lining. The nurse should know this information but if he or she does not know, finding out and telling the woman as soon as possible would be the correct response.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 681 | Table 31.6 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

23. A nurse is teaching a couple about basal body temperature. What information is most accurate?
    a. Measures the man's scrotal temperature related to sperm production.
    b. Basal body temperature is the average resting temperature in the woman.
    c. It detects slight temperature elevation just prior to ovulation in the woman
    d. Ovulation is the only event that affects the change in body temperature.

    ANS: C
    This method assesses for the slight rise in temperature just prior to ovulation. It is done on the woman and not the man. Other factors such as illness and poor sleep can affect the reading.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 673 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. The nurse is reviewing the educational packet provided to a patient about tubal ligation. What important facts should the nurse point out? (*Select all that apply.*)
    a. "It is highly unlikely that you will become pregnant after the procedure."

b. “This is an effective form of 100% permanent sterilization.”
c. “Sterilization offers protection against sexually transmitted diseases.”
d. “Sterilization offers no protection against sexually transmitted diseases.”
e. “Your menstrual cycle will greatly increase after your sterilization.”

ANS: A, D
A woman is unlikely to get pregnant after a tubal ligation, but it is not impossible. Sterilization does not offer protection against STDs. Typically, the menstrual cycle remains the same after a tubal ligation.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 665 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

2. The nurse teaches women to recognize signs of complications when using oral contraceptives using the acronym ACHES. What does this acronym stand for? (*Select all that apply.*)
a. Aching all over
b. Chest pain, dyspnea, hemoptysis, cough
c. Severe headache, weakness or numbness of extremities, and hypertension
d. Eye problems
e. Several swollen areas all over the body

ANS: B, C, D, E
ACHES stands for Abdominal pain (severe,) Chest pain, dyspnea, hemoptysis, cough, severe Headache, severe weakness or numbness of extremities, hypertension, Eye problems, and severe pain or Swelling, heat, or redness of calf or thigh. It does not include aching all over.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 669 | Table 31.3 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. Which piece of the usual equipment setup for a pelvic examination is omitted with a Pap test?
   a. Gloves and eye protectors
   b. Speculum
   c. Fixative agent
   d. Lubricant

   ANS: D
   Lubricants interfere with the accuracy of the cytology report. Gloves and eye protectors, speculum, and a fixative agent are all used during the exam.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 692 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

2. The microscopic examination of scrapings from the cervix, endocervix, or other mucous membranes to detect premalignant or malignant cells is called
   a. bimanual palpation.
   b. rectovaginal palpation.
   c. a Papanicolaou test.
   d. DNA testing.

   ANS: C
   The Pap test is a microscopic examination for cancer that should be performed regularly, depending on the patient's age. Bimanual palpation is a physical examination of the vagina,. rectovaginal palpation is a physical examination performed through the rectum, and DNA testing for the various types of HPV that cause cervical cancer is now available. Samples are collected in the same way as a Pap test.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 692 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

3. The nurse providing care in a women's health care setting must be aware that which sexually transmitted disease (STD) can be cured?
   a. Herpes
   b. Acquired immunodeficiency syndrome (AIDS)
   c. Venereal warts
   d. Chlamydia

   ANS: D

The usual treatment for chlamydia bacterial infection is doxycycline or azithromycin. Concurrent treatment of all sexual partners is needed to prevent recurrence. Because no cure is known for herpes, treatment focuses on pain relief and preventing secondary infections. Because no cure is known for AIDS, prevention and early detection are the main focus. Condylomata acuminata (venereal warts) is caused by the human papillomavirus. No treatment eradicates the virus.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 712 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

4. Which statement by a woman diagnosed with premenstrual syndrome indicates that further health teaching is needed?
   a. "I may have to try some antidepressants."
   b. "I need to limit my intake of caffeine."
   c. "I might try taking some vitamin E."
   d. "Salty foods will not affect this condition."

   ANS: D
   Eating salty foods contributes to edema and fluid retention and should be avoided as much as possible. This statement indicates a lack of understanding. The other statements are all accurate.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: p. 703 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Physiologic Integrity

5. Which statement by the patient indicates that she understands breast self-examination?
   a. "I will examine both breasts in two different positions."
   b. "I will perform breast self-examination 1 week after my menstrual period starts."
   c. "I will examine the outer upper area of the breast only."
   d. "I will use the palm of the hand to perform the examination."

   ANS: B
   The woman should examine her breasts when hormonal influences are at a low level, typically the week after her menses. Women who don't menstruate should pick a date and perform SBE on that date every month. She should use four positions: standing with arms at her sides, standing with arms raised above her head, standing with hands pressed against hips, and lying down. The entire breast needs to be examined, including the outer upper area. She should use the sensitive pads of the middle three fingers.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: p. 691 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Health Promotion and Maintenance

6. A benign breast condition that includes dilation and inflammation of the collecting ducts is called
   a. ductal ectasia.
   b. intraductal papilloma.
   c. chronic cystic disease.

d. fibroadenoma.

ANS: A
Generally occurring in women approaching menopause, ductal ectasia results in a firm irregular mass in the breast, enlarged axillary nodes, and nipple discharge. Intraductal papillomas develop in the epithelium of the ducts of the breasts; as the mass grows, it causes trauma or erosion within the ducts. Chronic cystic disease causes pain and tenderness. The cysts that form are multiple, smooth, and well delineated. Fibroadenoma is fibrous and glandular tissue. They are felt as firm, rubbery, and freely mobile nodules.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 694 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

7. Which patient is most at risk for fibroadenoma of the breast?
   a. A 38-year-old woman
   b. A 50-year-old woman
   c. A 16-year-old woman
   d. A 27-year-old woman

   ANS: C
   Although it may occur at any age, fibroadenoma is most common in the teenage years.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 693 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

8. Adjuvant treatment with tamoxifen may be recommended for patients with breast cancer if the tumor is
   a. smaller than 5 cm.
   b. located in the upper outer quadrant only.
   c. contained only in the breast.
   d. estrogen receptive.

   ANS: D
   Tamoxifen is antiestrogen therapy for tumors stimulated by estrogen. Tamoxifen is used depending on age, stage, and hormone receptor status, not size. Location of the cancer does not determine the usefulness of tamoxifen. Stage of the cancer is a consideration, but more important is its sensitivity to estrogen.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 696 OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

9. Which statement is true about primary dysmenorrhea?
   a. It occurs in young multiparous women.
   b. It is experienced by all women.
   c. It may be due to excessive endometrial prostaglandin.
   d. It is unaffected by oral contraceptives.

   ANS: C

Some women produce excessive endometrial prostaglandin during the luteal phase of the menstrual cycle. Prostaglandin diffuses into endometrial tissue and causes uterine cramping. It usually occurs in young nulliparous women. It is not experienced by all women. Oral contraceptives can be a treatment choice.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 701 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

10. In helping a patient manage PMS, the nurse should
    a. recommend a diet with more red meat and sugar.
    b. suggest herbal therapies and massage.
    c. tell the patient to ask for medications as soon as symptoms occur.
    d. suggest the use of diuretics.

    ANS: B
    Herbal therapies, conscious relaxation and massage have all been reported to have a beneficial effect on PMS. Carbohydrates may decrease cravings. Medications can be tried if lifestyle changes do not help or if there are depressive symptoms. Diuretics are not usually prescribed.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 703 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

11. With regard to endometriosis, nurses should be aware that
    a. it is characterized by the presence and growth of endometrial tissue inside the uterus.
    b. it affects 25% of all women.
    c. it may worsen with repeated cycles or remain asymptomatic and disappear after menopause.
    d. it is unlikely to affect sexual intercourse or fertility.

    ANS: C
    Symptoms vary among women, ranging from nonexistent to incapacitating. Endometriosis affects 10% of all women and is found equally in Caucasian and African-American women. With endometriosis, the endometrial tissue is outside the uterus. Symptoms vary among women, ranging from nonexistent to incapacitating. Women can experience painful intercourse and impaired fertility.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 701 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

12. A 49-year-old patient confides to the nurse that she has started experiencing pain with intercourse and asks, “Is there anything I can do about this?” What is the best response by the nurse?
    a. “You need to be evaluated for a sexually transmitted disease.”
    b. “Water-soluble vaginal lubricants may provide relief.”
    c. “No, it is part of the aging process.”

d. “You may have vaginal scar tissue that is producing the discomfort.”

ANS: B

Loss of lubrication with resulting discomfort in intercourse is a symptom of estrogen deficiency. This is a normal occurrence with the aging process and does not indicate STDs. It is part of the aging process, but the use of lubrication will help relieve the symptoms. It is due to loss of lubrication with the decrease in estrogen and not scar tissue formation.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 705 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

13. A 70-year-old woman should be taught to report what condition to her health care provider?
    a. Vaginal bleeding
    b. Pain with intercourse
    c. Breasts become smaller
    d. Skin becomes thinner

    ANS: A
    Vaginal bleeding after menopause should always be investigated. It is highly suggestive of endometrial cancer. The other conditions are related to aging.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 711 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

14. Which woman is most likely to have osteoporosis?
    a. A 50-year-old woman receiving estrogen therapy
    b. A 60-year-old woman who takes supplemental calcium
    c. A 55-year-old woman with a sedentary lifestyle
    d. A 65-year-old woman who walks 2 miles each day

    ANS: C
    Risk factors for the development of osteoporosis include smoking, alcohol consumption, sedentary lifestyle, family history of the disease, and a high-fat diet. Hormone therapy may prevent bone loss. Supplemental calcium will help prevent bone loss, especially when combined with vitamin D. Weight-bearing exercises have been shown to increase bone density.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 706 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

15. A woman with a history of a cystocele should contact the physician right away if she experiences
    a. involuntary loss of urine when she coughs.
    b. constipation.
    c. backache.
    d. urinary frequency and burning.

    ANS: D

Urinary frequency and burning are symptoms of cystitis, a common problem associated with cystocele. Involuntary loss of urine during coughing is stress incontinence and is not an emergency. Constipation may be a problem with rectoceles. Back pain is a symptom of uterine prolapse.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 707 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

16. To assist the woman in regaining control of the urinary sphincter, the nurse should teach her to
    a. practice Kegel exercises.
    b. void every hour while awake.
    c. allow the bladder to become full before voiding.
    d. restrict fluids to limit incontinent episodes.

    ANS: A
    Kegel exercises, tightening and relaxing the pubococcygeal muscle, will improve control of the urinary sphincter. Voiding every hour is too frequent and not realistic. Overdistention of the bladder will contribute to incontinence. Restricting fluids will cause bladder irritation that increases the problem.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 709 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

17. The physician diagnoses a 3-cm ovarian cyst in a 28-year-old woman. The nurse expects the initial treatment to include
    a. beginning hormone therapy.
    b. examining the woman after her next menstrual period.
    c. scheduling a laparoscopy as soon as possible, to remove the cyst.
    d. aspirating the cyst as soon as possible and sending the fluid to pathology.

    ANS: B
    If the woman is in her childbearing years, when the risk of ovarian cancer is less, the physician may wait until after the next menstrual cycle and examine the woman again. Cysts in women of childbearing age may decrease within one cycle, so treatment is not necessary at this point.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 710 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

18. The drug of choice to treat gonorrhea is
    a. penicillin G.
    b. tetracycline.
    c. ceftriaxone.
    d. acyclovir.

    ANS: C

Penicillin is the drug of choice used to treat syphilis.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 712 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

19. When a nurse is counseling a woman for primary dysmenorrhea, which nonpharmacologic intervention might be recommended?
    a. Increasing the intake of red meat and simple carbohydrates
    b. Reducing the intake of diuretic foods, such as peaches and asparagus
    c. Temporarily substituting physical activity for a sedentary lifestyle
    d. Using a heating pad on the abdomen to relieve cramping

    ANS: D
    Heat minimizes cramping by increasing vasodilation and muscle relaxation and minimizing uterine ischemia. Dietary changes are not needed. Physical activity is beneficial for everyone but is not a treatment for this condition.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 702 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

20. Nafarelin (Synarel) is currently used as a treatment for mild to severe endometriosis. The nurse should tell the woman taking this medication that the drug
    a. stimulates the secretion of gonadotropin-releasing hormone (GnRH).
    b. may produce masculinizing effects.
    c. must be continued for at least a year.
    d. can cause her to experience some hot flashes and vaginal dryness.

    ANS: D
    Nafarelin is a GnRH agonist, and its side effects are similar to those of menopause. The hypoestrogenism effect results in hot flashes and vaginal dryness. Danazole, another mediction to treat endometriosis causes masculinizing effects. Nararelin is used for 3 to 6 months usually.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 702 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

21. The nurse who is teaching a group of women about breast cancer should tell the women that
    a. risk factors identify almost all women who will develop breast cancer.
    b. African-American women have a higher rate of breast cancer.
    c. 1 in 10 women in the United States will develop breast cancer in her lifetime.
    d. the exact cause of breast cancer is unknown.

    ANS: D

The exact cause of breast cancer in unknown. Risk factors help identify women who may get breast cancer and for whom increased surveillance is recommended; however, breast cancer can occur without risk factors. Caucasian women have a higher incidence of breast cancer; however, African-American women have a higher rate of dying of breast cancer after they are diagnosed. One in eight women in the United States will develop breast cancer in her lifetime.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 694 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

22. The nurse providing education regarding breast care should explain to the woman that fibrocystic changes in breasts are
    a. a disease of the milk ducts and glands in the breasts.
    b. a pre-malignant disorder characterized by lumps found in the breast tissue.
    c. lumpiness with pain and tenderness found in the breasts of healthy women.
    d. lumpiness accompanied by tenderness after menses.

    ANS: C
    Fibrocystic changes are palpable thickenings in the breast usually associated with pain and tenderness. The pain and tenderness fluctuate with the menstrual cycle. Fibrocystic changes are palpable thickenings in the breast. Fibrocystic changes are not pre-malignant changes.
    This information is inaccurate. Fibrocystic changes are palpable thickenings in the breast usually associated with pain and tenderness. Most often tenderness occurs prior to menses.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 694 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

23. Which diagnostic test is used to confirm a suspected diagnosis of breast cancer?
    a. Mammogram
    b. Ultrasound
    c. Core needle biopsy
    d. MRI

    ANS: C
    When a suspicious mammogram is noted or a lump is detected, diagnosis is confirmed by either a core needle biopsy or one of the other types of biopsies. A mammogram screens for breast cancer. An ultrasound may be used with or before biopsy. An MRI might be used in select cases.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 694 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

24. A 36-year-old woman has been diagnosed as having uterine fibroids. When planning care for this patient, the nurse should know that
    a. fibroids are malignant tumors of the uterus.
    b. fibroids will increase in size during the perimenopausal period.
    c. abnormal uterine bleeding is a common finding.

d. hysterectomy should be performed.

ANS: C
The major symptoms associated with fibroids are menorrhagia and the physical effects produced by large leimyomas. Excessive menstrual bleeding is one possible symptom of fibroids. They are benign. They atrophy during menopause. A hysterectomy may be performed if the woman does not want more children and other therapies are not successful. Fibroids are benign tumors of the smooth muscle of the uterus, and their etiology is unknown. Fibroids are estrogen-sensitive and shrink as levels of estrogen decline.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 700 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

25. When assessing a woman for menopausal discomforts, the nurse expects the woman to describe the most frequently reported discomfort, which is
a. headaches.
b. hot flashes.
c. mood swings.
d. vaginal dryness with dyspareunia.

ANS: B
Vasomotor instability, in the form of hat flashes or flushing, is a result of fluctuating estrogen levels and is the most common disturbance of the perimenopausal woman. Headaches are not a commonly reported symptom. Mood swings and vaginal dryness with dyspareunia do occur but are not the most commonly reported symptom.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 705 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

26. While evaluating a patient for osteoporosis, the nurse should be aware of what risk factor?
a. African-American race
b. Low protein intake
c. Obesity
d. Cigarette smoking

ANS: D
Smoking is associated with earlier and greater bone loss and decreased estrogen production. Women at risk for osteoporosis are likely to be Caucasian or Asian. Inadequate calcium intake is a risk factor for osteoporosis. Women at risk for osteoporosis are likely to be small boned and thin. Obese women have higher estrogen levels as a result of the conversion of androgens in the adipose tissue. Mechanical stress from extra weight also helps preserve bone mass.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 706 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

27. When discussing estrogen replacement therapy (ERT) with a perimenopausal woman, the nurse should include the risks of
    a. breast cancer.
    b. vaginal and urinary tract atrophy.
    c. osteoporosis.
    d. arteriosclerosis.

    ANS: A
    Women with a high risk of breast cancer should be counseled against using ERT. Estrogen prevents atrophy of vaginal and urinary tract tissue and protects against the development of osteoporosis. Estrogen has a favorable effect on circulating lipids, reducing low-density lipoprotein (LDL) and total cholesterol and increasing high-density lipoprotein (HDL). It also has a direct antiatherosclerotic effect on the arteries.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 695 | Box 32.2 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

28. During her annual gynecologic checkup, a woman states that recently she has been experiencing cramping and pain during her menstrual periods. The nurse should document this complaint as
    a. amenorrhea.
    b. dysmenorrhea.
    c. dyspareunia.
    d. PMS.

    ANS: B
    Dysmenorrhea is pain during or shortly before menstruation. Pain is described as sharp and cramping or sometimes as a dull ache. It may radiate to the lower back or upper thighs. Amenorrhea is the absence of menstrual flow. Dyspareunia is pain during intercourse. PMS is a cluster of physical, psychologic, and behavioral symptoms that begin in the luteal phase of the menstrual cycle and resolve within a couple of days of the onset of menses.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 701 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

29. Management of primary dysmenorrhea often requires a multifaceted approach. The nurse who provides care for a patient with this condition should be aware that the optimal pharmacologic therapy for pain relief is
    a. acetaminophen.
    b. oral contraceptives (OCPs).
    c. nonsteroidal anti-inflammatory drugs (NSAIDs).
    d. aspirin.

    ANS: C

Nonsteroidal anti-inflammatory medications are the first-line drug for primary dysmenorrhea. Preparations containing acetaminophen are less effective for dysmenorrhea because they lack the antiprostaglandin properties of NSAIDs. OCPs are a reasonable choice for women who also want birth control. The benefit of OCPs is the reduction of menstrual flow and irregularities. OCPs may be contraindicated for some women and have a number of potential side effects. Aspirin is usually not as effective as NSAIDs but can be used.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 701 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

30. A woman is 6 weeks pregnant and has elected to terminate her pregnancy. The nurse knows that the most common technique used for medical termination of a pregnancy in the first trimester is
    a. administration of prostaglandins.
    b. dilation and evacuation.
    c. intravenous administration of Pitocin.
    d. vacuum aspiration.

    ANS: A
    The most common technique for medical termination of a pregnancy within the first 7 weeks of pregnancy is administration of prostaglandins. D&C is the most common method of surgical abortion used if medical abortion fails. Pitocin would not be used. Vacuum aspiration is used in the first trimester.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 704 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

31. The nurse should be aware that a pessary is most effective in the treatment of what disorder?
    a. Cystocele
    b. Uterine prolapse
    c. Rectocele
    d. Stress urinary incontinence

    ANS: B
    A fitted pessary may be inserted into the vagina to support the uterus and hold it in the correct position. It is not used for cystocele, rectocele, or incontinence.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 708 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

32. A postmenopausal woman who is 54 years old has been diagnosed with two leiomyomas. What assessment finding is most commonly associated with the presence of leiomyomas?
    a. Abnormal uterine bleeding
    b. Diarrhea
    c. Weight loss
    d. Acute abdominal pain

ANS: A
Most women are asymptomatic. Abnormal uterine bleeding is the most common symptom of leiomyomas, or fibroids. Diarrhea, weight loss, and acute abdominal pain are not characteristic of fibroids.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: pp. 709-710 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

33. A woman calls the triage nurse at the family medicine clinic and reports a raised area on her vulva. What response by the nurse is best?
    a. Ask her when her next annual physical is due.
    b. Make an appointment for the next day or two.
    c. Send her directly to the emergency department.
    d. Ask about protection she uses during sexual activity.

    ANS: B
    A raised or discolored lesion of the vulva needs to be examined as soon as possible. The nurse should schedule the woman for the soonest available appointment. This could be a cancerous lesion and so should not wait until the next annual physical, so there is no reason to ask that question. While urgent, this is not something the woman should go to the ED for. The lesion is not related to STDs so asking about protection during sex is not needed.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 710 | Safety Alert Box OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. Women are often reluctant to have annual mammograms for many reasons. These reasons include which of the following? (*Select all that apply.*)
    a. Reluctance to hear bad news
    b. Fear of x-ray exposure
    c. Belief that lack of family history makes this test unnecessary
    d. Expense of the procedure
    e. Having heard that the test is painful

    ANS: A, B, D, E
    Common reasons women give for postponing or avoiding mammography include reluctance to hear bad news, fears of x-ray exposure, and fear of pain. Some women may believe their family history makes it unnecessary, but this is not a common statement. Expense may be an issue for some women, but hopefully with the Affordable Care Act, the number of women worried about expense is declining.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 692 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

2. Which medications can be taken by postmenopausal women to treat and/or prevent osteoporosis? (*Select all that apply.*)
   a. Calcium
   b. Evista
   c. Fosamax
   d. Actonel
   e. Vitamin C

   ANS: A, B, C, D
   Calcium, Evista, Fosamax, and Actonel are all used to prevent or treat osteoporosis. Vitamin C is not.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: pp. 706-707 OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

3. The exact cause of breast cancer remains undetermined. Researchers have found that there are a number of common risk factors that increase a woman's chance of developing a malignancy. It is essential for the nurse who provides care to women of any age to be aware of which risk factors? (*Select all that apply.*)
   a. Family history
   b. Late menarche
   c. Early menopause
   d. Race
   e. Nulliparity or first pregnancy after age 30

   ANS: A, D, E
   Family history, race, and nulliparity or first pregnancy after age 30 are all risk factors for breast cancer. Early menarche (not late) and late (not early) menopause are also risk factors.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 695 | Box 32.2 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

4. A nurse is teaching a community group of women about ways to decrease their risk of cardiovascular disease. What actions does the nurse recommend? (*Select all that apply.*)
   a. Stop smoking
   b. Drink 8 to 10 glasses of water daily
   c. Exercise on most days of the week
   d. Get your blood pressure checked
   e. Decrease the fat in your diet

   ANS: A, C, D, E
   Risk factors for coronary artery disease include smoking, sedentary lifestyle, hypertension, and a high-fat diet. Drinking water is healthy but not specifically related to cardiovascular disease.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: pp. 698-699 | Box 32.3 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE CHOICE

1. The nurse percussing over an empty stomach expects to hear which sound?
   a. Tympany
   b. Resonance
   c. Flatness
   d. Dullness

   ANS: A
   Tympany is a high-pitched, loud-intensity sound heard over air-filled body parts such as the stomach and bowel. Resonance is a low-pitched, low-intensity sound elicited over hollow organs such as the lungs. Flatness is a high-pitched, soft-intensity sound elicited by percussing over solid masses such as bone or muscle. Dullness is a medium-pitched, medium-intensity sound elicited when percussing over high-density structures such as the liver.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 720 | Box 33.1 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

2. The nurse is admitting a toddler to the pediatric infectious disease unit. What is the single most important component of the child's physical examination?
   a. Assessment of heart and lungs
   b. Measurement of height and weight
   c. Documentation of parental concerns
   d. Obtaining an accurate history

   ANS: D
   An accurate history is most helpful in identifying problems and potential problems. Heart and lung assessment is not as important as an accurate history. A single measurement of height and weight is not as significant as determining growth over time. The child's growth pattern can be elicited from the history. Documentation of parental concerns is not as relevant to the physical examination as an accurate history in this case.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 720 | Box 33.1 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. In which section of the health history should the nurse record that the parent brought the infant to the clinic today because of frequent diarrhea?
   a. Review of systems
   b. Chief complaint
   c. Lifestyle and life patterns
   d. Health history

   ANS: B

The chief complaint is documented using the child's or parent's words for the reason the child was brought to the health care center. The review of systems includes health functions of body systems. Lifestyle and life patterns include the child's interaction with the social, psychological, physical, and cultural environment. Health history includes birth history, growth and development, common childhood illnesses, immunizations, hospitalizations, injuries, and allergies.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 721 | Box 33.4 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

4. The nurse assesses a child's oculomotor, trochlear, and abducent nerves by using which technique?
   a. Assessing the six cardinal gazes
   b. Identification of common odors
   c. Having child bite on a tongue blade
   d. Ask child to shrug against resistance

   ANS: A
   Using the six cardinal gazes the nurse assesses the oculomotor, trochlear, and abducent nerves. Odors are detected by the olfactory nerve. Biting on tongue blade assesses the trigeminal nerve. Shrugging against resistance assesses the accessory nerve.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 745 | Table 33.4 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

5. The nurse is performing a comprehensive physical examination on a young child in the hospital. At what age can the nurse expect a child's head and chest circumferences to be almost equal?
   a. Birth
   b. 6 months
   c. 1 year
   d. 3 years

   ANS: C
   Head and chest measurements are almost equal at 1 year of age.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 724 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

6. An 8-year-old girl asks the nurse how the blood pressure apparatus works. The most appropriate nursing action is to
   a. ask her why she wants to know.
   b. determine why she is so anxious.
   c. explain in simple terms how it works.
   d. tell her she will see how it works as it is used.

   ANS: C

School-age children require explanations and reasons for everything. They are interested in the functional aspect of all procedures, objects, and activities. It is appropriate for the nurse to explain how equipment works and what will happen to the child. “Why” questions are not therapeutic, plus this question makes it sound like the nurse thinks the child does not need this information. The child is not exhibiting anxiety, just requesting clarification of what will be occurring. The nurse must explain how the blood pressure cuff works so that the child can then observe during the procedure.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 719 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

7. Which chart should the nurse use to assess the visual acuity of an 8-year-old child?
   a. Lea chart
   b. Snellen chart
   c. HOTV chart
   d. Tumbling E chart

   ANS: B
   The Snellen chart is used to assess the vision of children older than 6 years of age. The Lea chart tests vision using four different symbols designed for use with preschool children. The HOTV chart tests vision by using graduated letters and is designed for use with children ages 3 to 6 years. The tumbling E chart uses the letter E in various directions and is designed for use with children ages 3 to 6 years.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 731 | Box 33.8 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

8. Which action is appropriate when the nurse is assessing breath sounds of an 18-month-old crying child?
   a. Ask the parent to quiet the child so the nurse can listen.
   b. Auscultate breath sounds and chart that the child was crying.
   c. Let the child play with the stethoscope for distraction.
   d. Document that data are not available because of crying.

   ANS: C
   Distracting the child with an interesting activity can assist the child to calm down so an accurate assessment can be made. Asking a parent to quiet the child may or may not work. Auscultating while the child is crying typically results in less than optimal data. The assessment needs to be completed so documenting that data are not available is not appropriate.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 735 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

9. The nurse is obtaining vital signs on a 1-year-old child. What is the most appropriate site for assessing the pulse rate?
   a. Apical

b. Radial
c. Carotid
d. Femoral

ANS: A
Apical pulse rates are taken in children younger than 2 years. Radial pulse rates may be taken in children older than 2 years. It is difficult to palpate the carotid pulse in an infant. The femoral pulse is palpated when comparing peripheral pulses, but it is not used to measure an infant's pulse rate.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 722 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

10. A nurse is reviewing pediatric physical assessment techniques. Which statement about performing a pediatric physical assessment is correct?
a. Physical examinations proceed systematically from head to toe unless developmental considerations dictate otherwise.
b. The physical examination should be done with parents in the examining room for children of any age.
c. Measurement of head circumference is done until the child is 5 years old.
d. The physical examination is done only when the child is cooperative.

ANS: A
Physical assessment usually proceeds from head to toe; however, developmental considerations with infants and toddlers dictate that the least threatening assessments be done first to obtain accurate data. Having parents in the examining room with adolescents is not appropriate. Head circumference is routinely measured until 36 months of age. Children will not always be cooperative during the physical examination. The examiner will need to incorporate communication and play techniques to facilitate cooperation.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 718 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

11. What term should be used in the nurse's documentation to describe auscultation of breath sounds that are short, popping, and discontinuous on inspiration?
a. Pleural friction rub
b. Sonorous rhonchi
c. Crackles
d. Wheeze

ANS: C
Crackles are short, popping, discontinuous sounds heard on inspiration. Sonorous rhonchi are low-pitched, moaning, musical sounds. A pleural friction rub has a grating, coarse, low-pitched sound. Wheezes are musical, high-pitched, predominant sounds heard on expiration.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 737 | Table 33.2 OBJ: Nursing Process: Assessment

MSC: Client Needs: Health Promotion and Maintenance

12. Which strategy is the best approach when initiating the physical examination of a 9-month-old male infant?
    a. Undress the infant and do a head-to-toe examination.
    b. Have the parent hold the child on his or her lap.
    c. Put the infant on the examination table and begin assessments at the head.
    d. Ask the parent to leave because the infant will be upset.

    ANS: B
    Toddlers may be resistant and uncooperative. The nurse allows the child to remain on the parent's lap to ease anxiety. The head-to-toe approach needs to be modified for the infant. Uncomfortable procedures, such as the otoscopic examination, should be left until last. There is no reason to ask a parent to leave when an infant is being examined. Having the parent with the infant will make the experience less upsetting for the infant.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: pp. 718-719 | Figure 33.1 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

13. Which strategy is not always appropriate for pediatric physical examination?
    a. Take the history in a quiet, private place.
    b. Examine the child from head to toe.
    c. Exhibit sensitivity to cultural needs and differences.
    d. Perform frightening procedures last.

    ANS: B
    The classic approach to physical examination is to begin at the head and proceed through the entire body to the toes. When examining a child, however, the examiner must tailor the physical assessment to the child's age and developmental level. The nurse should collect the child's health history in a quiet, private area. The nurse should always be sensitive to cultural needs and differences among children. When examining children, painful or frightening procedures should be left to the end of the examination.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 719 | Nursing Quality Alert Box OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

14. Which assessment should the nurse perform last when examining a 5-year-old child?
    a. Heart
    b. Lungs
    c. Abdomen
    d. Throat

    ANS: D
    Examination of the mouth and throat is considered to be more invasive than other parts of a physical examination. For preschool children, invasive procedures should be left to the end of the examination. Examination of the heart, lungs, and abdomen are seen as less threatening.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 719 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

15. When is the most appropriate time to inspect the genital area during a well-child examination of a 14-year-old girl?
    a. It is not necessary to inspect the genital area.
    b. Examine the genital area first.
    c. After the abdominal assessment
    d. Do the genital inspection last.

    ANS: C
    It is best to incorporate the genital assessment into the middle of the examination. This allows ample time for questions and discussion. If possible, proceed from the abdominal area to the genital area. A visual inspection of all areas of the body is included in a physical examination. Examination of the genital area can be embarrassing. It is not appropriate to begin the examination with this area. Assessing the genital area earlier in the examination allows more time for the adolescent to ask questions and engage in discussion.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 719 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

16. Which measurement is not indicated for a 4-year-old well-child examination?
    a. Blood pressure
    b. Weight
    c. Height
    d. Head circumference

    ANS: D
    Head circumference is measured on all children from birth to 3 years. Children older than 3 years of age with questionable head size or a history of megalocephaly, hydrocephalus, or microcephaly should have their head circumference assessed at every visit. A 4- year-old without a history of these problems does not need his or her head circumference measured. Blood pressure, weight, and height measurements are taken on all children at every ambulatory visit.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 724 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

17. The nurse inspecting the skin of a dark-skinned child notices an area that is a dusky red or violet color. This skin coloration is associated with what?
    a. Cyanosis
    b. Erythema
    c. Vitiligo
    d. Nevi

    ANS: B

In dark-skinned children, erythema appears as dusky red or violet skin coloration. Cyanosis in a dark-skinned child appears as a black coloration of the skin. Vitiligo refers to areas of depigmentation. Nevi are areas of increased pigmentation.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 725 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

18. The nurse palpated the anterior fontanel of a 14-month-old infant and found that it was closed. What does this finding indicate?
    a. This is a normal finding.
    b. This finding indicates premature closure of cranial sutures.
    c. This is abnormal, and the child should have a developmental evaluation.
    d. This is an abnormal finding, and the child should have a neurologic evaluation.

    ANS: A
    The anterior fontanel should be completely closed by 12 to 18 months of age. It does not mean premature closure or indicate a need for developmental or neurologic evaluations.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 727 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

19. The nurse is assessing a 4-year-old child's visual acuity. The results indicate a visual acuity of 20/40 in both eyes. The child's father asks the nurse about his son's results. Which response, if made by the nurse, is correct?
    a. "Your child will need a referral to the ophthalmologist before he can attend preschool next week."
    b. "Your child's visual acuity is normal for his age."
    c. "The results of this test indicate your child may be color blind."
    d. "Your child did not pass; he will need to see an eye doctor."

    ANS: B
    Normal visual acuity for a 4-year-old is 20/40 to 20/50. This finding is normal. No other action is needed.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 732 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

20. When interviewing the mother of a 3-year-old child, the nurse asks about developmental milestones. This should be considered
    a. unnecessary information, because the child is 3 years old.
    b. an important part of the family history.
    c. an important part of the child's past growth and development.
    d. an important part of the child's review of systems.

    ANS: C

Information about the attainment of developmental milestones is necessary and important to obtain. It provides data about the child's growth and development that should be included in the history. Developmental milestones provide important information about the child's physical, social, and neurologic health. The developmental milestones are specific to this child. If pertinent, attainment of milestones by siblings should be included in the family history. The review of systems does not include the developmental milestones.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 721 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

21. Which cranial nerve is assessed when the child is asked to imitate the examiner's wrinkled frown, wrinkled forehead, smile, and raised eyebrow?
    a. Accessory
    b. Hypoglossal
    c. Trigeminal
    d. Facial

    ANS: D
    The facial nerve is assessed as described in the question. To assess the accessory nerve, the examiner palpates and notes the strength of the trapezius and sternocleidomastoid muscles against resistance. To assess the hypoglossal nerve, the examiner asks the child to stick out the tongue. To assess the trigeminal nerve, the child is asked to identify a wisp of cotton on the face. The corneal reflex and temporal and masseter muscle strength are evaluated.

    PTS: 1 DIF: Cognitive Level: Comprehension REF: p. 727
    OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

22. Which assessment finding is considered a neurologic soft sign in a 7-year-old child?
    a. Plantar reflex
    b. Poor muscle coordination
    c. Stereognostic function
    d. Graphesthesia

    ANS: B
    Poor muscle coordination is a neurologic soft sign. The plantar reflex is a normal response. Stereognostic function refers to the ability to identify familiar objects placed in each hand. Graphesthesia is the ability to identify letters or numbers traced on the palm or back of the hand with a blunt point.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 746 | Box 33.13 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

23. Which parameter correlates best with measurements of the body's total muscle mass–to-fat ratio?
    a. Height
    b. Weight
    c. Skinfold thickness

d. Mid-arm circumference

ANS: D
The mid-arm circumference reflects muscle and fat. Height, weight, and skinfold thickness do not reflect muscle and fat.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 724 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

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

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

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 724 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

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

ANS: D
Small nontender nodes are normal. Tender, enlarged, and warm lymph nodes may indicate infection or inflammation close to their location. They are not indicative of cancer or scalp infection.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 726 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

26. What heart sound is produced by vibrations within the heart chambers or in the major arteries from the back-and-forth flow of blood?
a. S_1, S_2
b. Snaps and clicks
c. Murmur
d. Physiologic splitting

ANS: C

Murmurs are the sounds that are produced in the heart chambers or major arteries from the turbulence of blood flow. Murmurs create a blowing and swooshing sound. S_1 and S_2 are the normal heart sounds. Snaps and clicks are short, high-pitched sounds heard with valve disorders and do not vary with respirations. The physiologic splitting of S_2 , an audible pause between the closing of the aortic and pulmonic valves, frequently heard in children of all ages, is considered normal.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 737 | Table 33.2 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

27. Examination of the abdomen is performed correctly by the nurse in which order?
    a. Inspection, palpation, and auscultation
    b. Palpation, inspection, and auscultation
    c. Palpation, auscultation, and inspection
    d. Inspection, auscultation, and palpation

    ANS: D
    The correct order of abdominal examination is inspection, auscultation, and palpation. If the nurse percusses the abdomen, that is done prior to palpation. Palpation is always last because it may distort the normal abdominal sounds.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 739 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

28. The nurse has a 2-year-old boy sit in a “tailor” position during palpation for the testes. What is the rationale for this position?
    a. It prevents cremasteric reflex.
    b. Undescended testes can be palpated.
    c. This tests the child for an inguinal hernia.
    d. The child does not yet have a need for privacy.

    ANS: A
    The tailor position stretches the muscle responsible for the cremasteric reflex. This prevents its contraction, which pulls the testes into the pelvic cavity.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 741 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

29. During examination of a toddler’s extremities, the nurse notes that the child is bowlegged. The nurse should recognize that this finding is
    a. abnormal, requiring further investigation.
    b. abnormal unless it occurs in conjunction with knock-knee.
    c. normal if the condition is unilateral or asymmetric.
    d. normal, because the lower back and leg muscles are not yet well developed.

    ANS: D

Genu varum (bowlegged) is common in toddlers when they begin to walk. It usually persists until all of their lower back and leg muscles are well developed, usually by age 3.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 743 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

30. Kimberly is having a checkup before starting kindergarten. The nurse asks her to do the "finger-to-nose" test. The nurse is testing for
    a. deep tendon reflexes.
    b. cerebellar function.
    c. sensory discrimination.
    d. ability to follow directions.

    ANS: B
    The finger-to-nose-test is an indication of cerebellar function. This test checks balance and coordination. It does not assess DTRs, sensory discrimination, or the ability to follow directions.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 746 | Box 33.11 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

31. A nurse is assessing a 12-month-old baby. What question about growth and development is most appropriate?
    a. Can the baby roll over?
    b. Does your baby pull himself up?
    c. Is your baby cruising around yet?
    d. Will your baby sit alone?

    ANS: C
    Cruising should occur by 12 months. Rolling over occurs by 3 to 6 months. A baby will pull herself up by around 11 months. Sitting alone occurs by 7 months.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 745 | Table 33.3 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

32. A student nurse hears two registered nurses discussing a child who has neurologic soft signs. The student asks what this means. What response by the nurse is best?
    a. The baby's fontanels have not yet closed.
    b. Tests of neurologic function are indeterminate.
    c. The child can't perform activities he should be able to.
    d. The child has a significant neurologic disorder.

    ANS: C
    A neurologic soft sign indicates the child's inability to perform certain activities related to the child's age. They may provide subtle clues to an underlying central nervous system deficit or neurologic maturation delay. They require more evaluation. They are not related to fontanels or indeterminate findings.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 746 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. Which statements about performing a pediatric physical assessment are correct for a school-age child? (*Select all that apply.*)
   a. Physical examinations proceed systematically from head to toe.
   b. The physical examination should be done with parents in the waiting room.
   c. Measurement of head circumference is obtained.
   d. The physical examination is done only when the child is cooperative.
   e. Remove clothing and have the child put on an examination gown.

   ANS: A, D, E
   Physical assessment usually proceeds from head to toe; however, if developmental delays exist, considerations dictate that the least threatening assessments be done first to obtain accurate data. School-age children are at a developmental stage when they should be cooperative for the physical examination. Children of this age are usually modest, and an examination gown should be provided. Having parents in the examining room with adolescents is not appropriate, but it is appropriate for children of other age-groups. Parents usually are not kept in the waiting room. Measurement of head circumference is obtained on children 36 months of age or less.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 719 OBJ: Nursing Process: Planning
   MSC: Client Needs: Health Promotion and Maintenance

2. What should the nurse recognize as a possible indicator of child abuse in a 4-year-old child being treated for ear pain at the emergency department on a cold winter day? (*Select all that apply.*)
   a. The child extends his arms to be hugged by the nurse.
   b. The child is wearing clean, baggy shorts, sandals, and an oversized T-shirt.
   c. The child answers all questions in complete sentences and smiles afterward.
   d. The child has dirty, broken teeth.
   e. The child states “I’m so fat” when the nurse tells his mother he weighs 25 lb.

   ANS: B, D, E
   These clothes are inappropriate for the weather and possibly too big. Dirty, broken teeth possibly show neglect of basic needs. Body image distortion is another possible clue to child abuse. Although it may be unusual for this child to want to be hugged by the nurse, it is not an indicator of child abuse. Answering questions using complete sentences and smiling is appropriate for a 4-year-old.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 720 | Box 33.2 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

3. A nurse is performing an assessment on a newborn. Which vital signs indicate a normal finding for this age-group? (*Select all that apply.*)
   a. Pulse of 80 to 125 a minute
   b. B/P of systolic 65 to 95 and diastolic 30 to 60
   c. Temperature of 36.5° to 37.3° C (axillary)
   d. Temperature of 36.4° to 37° C (axillary)
   e. Respirations of 30 to 60 a minute

   ANS: B, C, E
   The blood pressure, temperature, and respiratory rate are all normal for this child. The pulse of 80 to 125 and the temperature of 36.4° to 37° C (axillary) are both too low for a well newborn.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 722 | Table 33.1 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

4. A school nurse is screening children for scoliosis. Which assessment findings should the nurse expect to observe for scoliosis? (*Select all that apply.*)
   a. Pain with deep palpation of the spinal column
   b. Unequal shoulder heights
   c. The trouser pant leg length appears shorter on one side
   d. Inability to bend at the waist
   e. Unequal waist angles

   ANS: B, C, E
   The assessment findings associated with scoliosis include unequal shoulder heights, trouser pant leg length appearing shorter on one side meaning unequal leg length, and unequal waist angles. Scoliosis is a non-painful curvature of the spine so pain is not expected and the child is able to bend at the waist adequately.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 744 | Box 33.9 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

5. A nurse working with infants recognizes which findings as possible signs of brain dysfunction? (*Select all that apply.*)
   a. Irritability
   b. Nausea
   c. Anorexia
   d. Vomiting
   e. Fever

   ANS: A, C, D, E
   Irritability, loss of appetite, vomiting, and fever may indicate brain dysfunction in infants. Infants cannot complain of nausea.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 743 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE CHOICE

1. Which nursing action facilitates care being provided to a child in an emergency situation?
   a. Encourage the family to remain in the waiting room.
   b. Include parents as partners in providing care for the child.
   c. Always reassure the child and family.
   d. Give explanations using professional terminology.

   ANS: B
   Include parents as partners in the child's treatments. Parents may need direct guidance in concrete terms to help distract the child. Allowing the parents to remain with the child may help calm the child. Telling the truth is the most important thing. False reassurance does not facilitate a trusting relationship. Professional terminology may not be understood. Speak to the child and family in language that they will understand.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 752 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Psychosocial Integrity

2. The father of a child in the emergency department is yelling at the physician and nurses. Which action is *contraindicated* in this situation?
   a. Provide a nondefensive response.
   b. Encourage the father to talk about his feelings.
   c. Speak in simple, short sentences.
   d. Tell the father he must wait in the waiting room.

   ANS: D
   Because a parent who is upset may be aggravated by observers, he should be directed to a quiet area. When dealing with parents who are upset, it is important not to be defensive or attempt to justify anyone's actions. Encouraging the father to talk about his feelings may assist him to acknowledge his emotions and may defuse his angry reaction. People who are upset need to be spoken to with simple words (no longer than five letters) and short sentences (no more than five words).

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 753 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Psychosocial Integrity

3. What is an appropriate nursing intervention for a 6-month-old infant in the emergency department?
   a. Distract the infant with noise or bright lights.
   b. Avoid warming the infant.
   c. Remove any pacifiers from the baby.
   d. Encourage the parent to hold the infant.

   ANS: D

Parents should be encouraged to hold the infant as much as possible while in the emergency department. Having the parent hold the infant may help to calm the child. Distraction with noise or bright lights is most appropriate for a preschool-age child. In an emergency health care facility, it is important to keep infants warm. Infants use pacifiers to comfort themselves; therefore the pacifier should not be taken away.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 756 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

4. Which action should the nurse working in the emergency department implement in order to decrease fear in a 2-year-old child?
   a. Keep the child physically restrained during nursing care.
   b. Allow the child to hold a favorite toy or blanket.
   c. Direct the parents to remain outside the treatment room.
   d. Let the child decide whether to sit up or lie down for procedures.

   ANS: B
   Allowing a child this age to hold a favorite toy or blanket is comforting. It may be necessary to restrain the toddler for some nursing care or procedures. Because toddlers need autonomy and do not respond well to restrictions, the nurse should remove any restriction or restraint as soon as safety permits. Parents should remain with the child as much as possible to calm and reassure her. The toddler should not be given the overwhelming choice of deciding which position she prefers. In addition, the procedure itself may dictate the child's position.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 755 | Box 34.1 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Psychosocial Integrity

5. Which nursing action is most appropriate to assist a preschool-age child in coping with the emergency department experience?
   a. Explain procedures and give the child at least 1 hour to prepare.
   b. Remind the child that she is a big girl.
   c. Avoid the use of bandages.
   d. Use positive terms, and avoid terms such as "shot" and "cut."

   ANS: D
   Using positive terms and avoiding words that have frightening connotations assist the child in coping. Preschool- age children should be told about procedures immediately before they are done. Allowing 1 hour of time to prepare only allows time for fantasies and increased anxiety. Children should not be shamed into cooperation. Bandages are important to preschool-age children. Children in this age-group believe that their insides can leak out and that bandages stop this from happening. Plus a fancy bandage can be used as a reward.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 755 | Box 34.1 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Psychosocial Integrity

6. Which action should the nurse incorporate into a care plan for a 14-year-old child in the emergency department?

a. Limit the number of choices to be made by the adolescent.
b. Insist that parents remain with the adolescent.
c. Provide clear explanations, and encourage questions.
d. Give rewards for cooperation with procedures.

ANS: C
Adolescents are capable of abstract thinking and can understand explanations. They should be offered the opportunity to ask questions. Because adolescents are capable of abstract thinking, they should be allowed to make decisions about their care. Adolescents should have the choice of whether parents remain with them. They are very modest, and this modesty should be respected. Giving rewards such as stickers for cooperation with treatments or procedures is more appropriate for the younger child.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 755 | Box 34.1 OBJ: Nursing Process: Planning
MSC: Client Needs: Psychosocial Integrity

7. The emergency department nurse notices that the mother of a young child is making a lot of phone calls and getting advice from her friends about what she should do. This behavior is an indication of
a. stress.
b. healthy coping skills.
c. attention-getting behaviors.
d. low self-esteem.

ANS: A
Hyperactive behavior such as making a lot of phone calls and enlisting everyone's opinions is a sign of stress. The behavior described is not a healthy coping skill. This may be an attention-getting behavior but is more likely an indicator of stress. This mother may have low self-esteem, but the immediate provocation is stress.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 756 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

8. A preschool child in the emergency department has a respiratory rate of 10 breaths per minute. How should the nurse interpret this finding?
a. The child is relaxed.
b. Respiratory failure is likely.
c. This child is in respiratory distress.
d. The child's condition is improving.

ANS: B
Very slow breathing in an ill child is an ominous sign, indicating respiratory failure. Although the respiratory rate slows when an individual is relaxed, a rate of 10 breaths per minute in an ill preschool child is not a normal finding and is cause for concern. A rapid respiratory rate indicates respiratory distress. Other signs of respiratory distress may include retractions, grunting, and nasal flaring. A respiratory rate of 10 breaths per minute is not a normal finding for a preschool child nor does it demonstrate improvement.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 757 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

9. The nurse observes abdominal breathing in a 2-year-old child. What does this finding indicate?
   a. Imminent respiratory failure
   b. Hypoxia
   c. Normal respiration
   d. Airway obstruction

   ANS: C
   Young children normally exhibit abdominal breathing. When measuring respiratory rate, the nurse should observe the rise and fall of the abdomen. A very slow respiration rate is an indicator of respiratory failure. Nasal flaring with inspiration and grunting on expiration occurs when hypoxia is present. The child with an airway obstruction will use accessory muscles to breathe.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 757 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

10. What should be the emergency department nurse's next action when a 6-year-old child has a systolic blood pressure of 58 mm Hg?
    a. Alert the physician about the systolic blood pressure.
    b. Comfort the child and assess respiratory rate.
    c. Assess the child's responsiveness to the environment.
    d. Alert the physician that the child may need intravenous fluids.

    ANS: A
    Hypotension is a late sign of shock in children. The lower limit for systolic blood pressure for a child more than 1 year old is 70 mm Hg plus two times the child's age in years. A systolic blood pressure of 58 mm Hg calls for immediate action. The nurse should be direct in relaying the child's condition to the physician. Comforting the child and assessing respiratory rate are not priorities. Assessing the child's responsiveness is included in a neurologic assessment. It does not address the systolic blood pressure of 58 mm Hg. Although this child most likely requires intravenous fluids, the physician must be apprised of the systolic blood pressure so that appropriate intervention can be initiated.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 764 | Safety Alert Box OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

11. A nurse is caring for a child diagnosed with septic shock. He develops a dysrhythmia and hemodynamic instability. Endotracheal intubation is necessary. The physician feels that cardiac arrest may soon develop. What drug do you anticipate the physician will order?
    a. Atropine sulfate
    b. Epinephrine
    c. Sodium bicarbonate
    d. Inotropic agents

ANS: B
Epinephrine is the drug of choice for the management of cardiac arrest, dysrhythmias, and hemodynamic instability. Atropine sulfate is used to treat symptomatic bradycardia. Sodium bicarbonate is given to treat severe acidosis associated with cardiac arrest. Inotropic agents are indicated for hypotension or poor peripheral circulation in a child.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 762 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

12. A nurse is working triage in the emergency department. A school-age child is brought in for treatment, carried by her mother. What assessment takes priority?
    a. Assess airway patency.
    b. Obtain a health history.
    c. Obtain a full set of vital signs.
    d. Evaluate for pain.

    ANS: A
    The primary assessment consists of assessing the child's airway, breathing, circulation, level of consciousness, and exposure (ABCDEs). Airway always comes first. History, vital signs, and pain assessment are all part of the secondary survey.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 768 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

13. What is the goal of the initial intervention for a child in cardiopulmonary arrest?
    a. Establishing a patent airway
    b. Determining a pulse rate
    c. Removing clothing
    d. Reassuring the parents

    ANS: A
    The first intervention for a child in cardiopulmonary arrest, as for an adult, is to establish a patent airway. Assessment of pulse follows establishment of a patent airway. Clothing may be removed from the upper body for chest compressions after a patent airway is established. Reassuring the parents is important, but the primary survey and associated interventions come first.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 758 | Table 34.1 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

14. What is the nurse's immediate action when a child comes to the emergency department with sweating, chills, and fang bite marks on the thigh?
    a. Secure antivenin therapy.
    b. Apply a tourniquet to the leg.
    c. Ambulate the child.
    d. Reassure the child and parent.

ANS: A

Antivenin therapy is essential to the child's survival because the child is showing signs of envenomation. The use of a tourniquet is no longer recommended. When a bite or envenomation is located on an extremity, the extremity should be immobilized in a dependent position. Envenomation is a potentially life-threatening condition. False reassurance is not helpful for building a trusting relationship.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 774 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

15. How should the nurse instruct the mother who calls the emergency department because her 9-year-old child has just fallen on his face and one of his front teeth fell out?
    a. Put the tooth back in the child's mouth and call the dentist right away.
    b. Place the tooth in milk or water and go directly to the emergency department.
    c. Gently place the tooth in a plastic zippered bag until she makes a dental appointment.
    d. Clean the tooth and call the dentist for an immediate appointment.

    ANS: B

    The parent should be told to keep the tooth moist by placing it in a saline solution, water, milk, or a commercial tooth-preserving solution and get the child evaluated as soon as possible. The parent may replace the tooth incorrectly, so it is best not to advise the parent to do this. The tooth should be kept moist, not dry. The child should be evaluated as soon as possible. Cleaning or scrubbing the tooth could damage it. It is essential for the child to have an immediate dental evaluation.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 779 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

16. A 3-year-old is brought to the emergency department by ambulance after her body was found submerged in the family pool. The child has altered mental status and shallow respirations. She did not require resuscitative interventions. Which condition should the nurse monitor for as the priority in this child?
    a. Neurologic status
    b. Hypothermia
    c. Hypoglycemia
    d. Hypoxia

    ANS: D

    Hypoxia is responsible for the injury to organ systems during submersion injuries. Hypoxia can progress to cardiopulmonary arrest. Monitoring for hypoxia takes priority for this child over neurologic status, temperature, or glucose status.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 776 | Pathophysiology Box OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

17. Assessment of a child with a submersion injury focuses on which system?

a. Cardiovascular
b. Respiratory
c. Neurologic
d. Gastrointestinal

ANS: B
Assessment of the child with a submersion injury focuses on the respiratory system. The airway and breathing are the priorities. The other systems are of less priority than the respiratory system.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 776 | Pathophysiology Box OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

18. Which is the most critical element of pediatric emergency care?
a. Airway management
b. Prevention of neurologic impairment
c. Maintaining adequate circulation
d. Supporting the child's family

ANS: A
Airway management is the most critical element in pediatric emergency care. The other elements are important, but airway is always the priority.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 757 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

19. Which observations made by an emergency department nurse raises the suspicion that a 3-year-old child has been maltreated?
a. The parents are extremely calm in the emergency department.
b. The injury is unusual for a child of that age.
c. The child does not remember how he got hurt.
d. The child was doing something unsafe when the injury occurred.

ANS: B
An injury that is rarely found in children or is inconsistent with the age and condition of the child should raise suspicion of child maltreatment. The nurse should observe the parents' reaction to the child but must keep in mind that people behave very differently depending on culture, ethnicity, experience, and psychological makeup. The child may not remember what happened as a result of the injury itself, for example, sustaining a concussion. Also, a 3-year-old child may not be a reliable historian. The fact that the child was not supervised might be an area for health teaching. The nurse needs to gather more information to determine whether the parents have been negligent in the care of their child.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 770 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

20. A child is brought to the emergency department after ingesting an acidic substance. What action by the nurse is best?
    a. Induce vomiting in the child.
    b. Give syrup of ipecac.
    c. Ensure a patent airway.
    d. Attach the child to a cardiac monitor.

    ANS: C
    Ensuring a patent airway is always the priority. Since the child ingested an acid that causes corrosive damage, inducing vomiting (which is what syrup of ipecac does) is not advised. The child may need a cardiac monitor, but airway is the priority.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 771 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Safe and Effective Care Environment

21. Which initial assessment made by the triage nurse suggests that a child requires immediate intervention?
    a. The child has thick yellow rhinorrhea.
    b. The child has a frequent nonproductive cough.
    c. The child's oxygen saturation is 95% by pulse oximeter.
    d. The child is grunting.

    ANS: D
    One of the initial observations for triage is respiratory rate and effort. Grunting is a sign of hypoxemia and represents the body's attempt to improve oxygenation by generating positive end-expiratory pressure. Rhinorrhea, coughing, and a normal SaO_2 do not need immediate intervention.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 758 | Table 34.1 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

22. A child is brought to the emergency department. When he is called to triage, which vital sign should be measured first?
    a. Temperature
    b. Heart rate
    c. Respiratory rate
    d. Blood pressure

    ANS: C
    When taking children's vital signs, the nurse observes the respiratory rate first. Temperature and blood pressure should be measured after respiratory and heart rate because it can be upsetting for children. Heart rate is measured after respiratory rate.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 757 | Nursing Quality Alert Box OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

23. A 2-year-old child is in the playroom. The nurse observes him picking up a small toy and putting it in his mouth. The child begins to choke. He is unable to speak. Which intervention is appropriate?
    a. Heimlich maneuver
    b. Abdominal thrusts
    c. Five back blows
    d. Five chest thrusts

    ANS: A
    To clear a foreign body from the airway, the American Heart Association recommends the Heimlich maneuver for a conscious child older than 1 year of age. Abdominal thrusts are indicated when the child is unconscious. Back blows are indicated for an infant with an obstructed airway. Chest thrusts follow back blows for the infant with an obstructed airway.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 761 | Table 34.3 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

24. What condition does the nurse recognize as an early sign of distributive shock?
    a. Hypotension
    b. Skin warm and flushed
    c. Oliguria
    d. Cold, clammy skin

    ANS: B
    An early sign of distributive shock is extremities that are warm to the touch. The child with distributive shock may have hypothermia or hyperthermia. Hypotension is a late sign of all types of shock. Oliguria is a manifestation of hypovolemic shock. Cold, clammy skin is a late sign of septic shock, which is a type of distributive shock.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 765 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

25. What is the leading cause of unintentional death in children younger than 19 years of age in the United States?
    a. Drowning
    b. Airway obstruction
    c. Pedestrian injury
    d. Motor vehicle injuries

    ANS: D
    The Centers for Disease Control and Prevention (CDC) has consistently found that motor vehicle injuries are the leading cause of unintentional death in children younger than 19 years of age in the United States. Drowning, airway obstruction, and pedestrian injury do cause death but not at the rate of motor vehicle crashes.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 766 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

26. A school-aged child develops heat exhaustion at a soccer game. What action by the nurse in attendance is best?
    a. Call 911 immediately.
    b. Move the child to a cooler environment.
    c. Provide oxygen by face mask.
    d. Prepare to begin CPR.

    ANS: B
    For simple heat exhaustion, treatment consists of moving the child to a cooler environment, apply cool, moist cloths to the skin; remove clothing or change to dry clothing; elevate legs; offer oral rehydration fluids if no altered mental status or vomiting. There is no need to call 911, provide oxygen, or prepare to begin CPR at this point.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 779 | Table 34.6 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

27. A child has been brought to the emergency department with carbon monoxide poisoning. After the child is stabilized, what action by the nurse is best?
    a. Have all family members tested for carbon monoxide poisoning.
    b. Help family determine source of the carbon monoxide.
    c. Prepare to administer syrup of ipecac.
    d. Notify social services about the child's condition.

    ANS: B
    After the child has been stabilized, the nurse should help the family brainstorm about the source of the carbon monoxide poisoning, which must be eliminated before the child goes home. The nurse may need to offer assistance to find companies that can help in this search or notify the local fire department for assistance. There is no indication that other family members need to be tested, but those who show signs of carbon monoxide poisoning should be. Syrup of ipecac is no longer used after an oral ingestion. Social services may or may not need to be notified.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 773 | Table 34.5 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Safe and Effective Care Environment

28. A 5-year-old child is in cardiopulmonary arrest, and the nursing staff is performing CPR. One of the nurses is doing compressions at the rate of 90 per minute. What action by the charge nurse is best?
    a. Take over compressions.
    b. Tell the nurse to speed up.
    c. Tell the nurse to slow down.
    d. Have the nurse compress more deeply.

    ANS: B
    The rate of compressions for a child is at least 100/minute. The charge nurse tells the compressing nurse to speed up. If the compressor is fatigued, someone should take over, but that is not indicated in the question. The depth of compressions is not the issue.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 762 | Table 34.3 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. An emergency department nurse is making a general appearance assessment on a preschool child just admitted to the emergency department. Which general assessment findings indicate the child "looks bad"? (*Select all that apply.*)
   a. Color pale
   b. Capillary refill less than 2 seconds
   c. Unwilling to separate from parents
   d. Cold extremities
   e. Lethargic

   ANS: A, D, E
   Signs of a child "looking bad" on a general appearance assessment include pale skin, cold extremities, and lethargy. A capillary refill of less than 2 seconds is a "good sign" as well as a child who is unwilling to separate from parents (separation anxiety, expected).

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 764 | Table 34.4 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

2. What may cause hypovolemic shock in children? (*Select all that apply.*)
   a. Hyperthermia
   b. Burns
   c. Vomiting or diarrhea
   d. Hemorrhage
   e. Skin abscesses

   ANS: A, B, C, D
   Hypovolemic shock is due to decreased circulating volume and can be caused by fluid loss due to hyperthermia, burns, vomiting or diarrhea, and hemorrhage. An abscess will not cause hypovolemia.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 765 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. Which situation poses the greatest challenge to the nurse working with a child and family?
   a. Twenty-four-hour observation
   b. Emergency hospitalization
   c. Outpatient admission
   d. Rehabilitation admission

   ANS: B
   Emergency hospitalization involves (1) limited time for preparation both for the child and family, (2) situations that cause fear for the family that the child may die or be permanently disabled, and (3) a high level of activity, which can foster further anxiety. Although preparation time may be limited with a 24-hour observation, this situation does not usually involve the acuteness of the situation and the high levels of anxiety associated with emergency admission. Outpatient admission generally involves preparation time for the family and child. Because of the lower level of acuteness in these settings, anxiety levels are not as high. Rehabilitation admission follows a serious illness or disease. This type of unit may resemble a home environment, which decreases the child's and family's anxiety.

   PTS: 1 DIF: Cognitive Level: Comprehension/Remembering
   REF: p. 783 OBJ: Nursing Process: Planning
   MSC: Client Needs: Psychosocial Integrity

2. What is the primary disadvantage associated with outpatient and day facility care?
   a. Increased cost
   b. Increased risk of infection
   c. Lack of physical connection to the hospital
   d. Longer separation of the child from family

   ANS: C
   Outpatient and day facility care do not provide extended care; therefore a child requiring extended care should be transferred to the hospital, causing increased stress to the child and parents. This type of care decreases cost and infection and minimizes separation between the child and family.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 783 OBJ: Nursing Process: Planning
   MSC: Client Needs: Safe and Effective Care Environment

3. Based on concepts related to the normal growth and development of children, which child would have the most difficulty with separation from family during hospitalization?
   a. A 5-month-old infant
   b. A 15-month-old toddler
   c. A 4-year-old child
   d. A 7-year-old child

   ANS: B

Separation is the major stressor for children hospitalized between ages 6 and 30 months. Infants younger than 6 months of age will generally adapt to hospitalization if their basic needs for food, warmth, and comfort are met. Although separation anxiety occurs in hospitalized preschoolers, it is usually less obvious and less serious than that experienced by the toddler. The school-age child is accustomed to separation from parents. Although hospitalization is a stressor, the 7-year-old child will have less separation anxiety than a 15-month-old toddler.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 786 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

4. What is the best explanation for a 2-year-old child who is quiet and withdrawn on the fourth day of a hospital admission?
   a. The child is protesting her separation from her caregivers.
   b. The child has adjusted to the hospitalization.
   c. The child is experiencing the despair stage of separation.
   d. The child has reached the stage of detachment.

   ANS: C
   In the despair stage of separation, the child exhibits signs of hopelessness and becomes quiet, withdrawn, and apathetic. In the protest stage, the child would be agitated, crying, resistant to caregivers, and inconsolable. Toddlers do not readily "adjust" to hospitalization and separation from caregivers. The detachment stage occurs after prolonged separation. During this phase, the child becomes interested in the environment and begins to play.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 786 | Box 35.1 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Psychosocial Integrity

5. A 3-year-old child cries, kicks, and clings to the father when the parents try to leave the hospital room. What is the nurse's best response to the parents about this behavior?
   a. "Your child is showing a normal response to the stress of hospitalization."
   b. "Your child is not coping effectively with hospitalization."
   c. "Parents should stay with children during hospitalization."
   d. "You can avoid this if you leave after your child falls asleep."

   ANS: A
   The child is exhibiting a healthy attachment to the father. The child's behavior represents the protest stage of separation and does not represent maladaptive behavior. This response places undue stress and guilt on the parents. Leaving when the child is asleep will foster mistrust.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 786 | Box 35.1 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Psychosocial Integrity

6. Which is the most developmentally appropriate intervention when working with the hospitalized adolescent?
   a. Encourage peers to call and visit when the adolescent's condition allows.
   b. Encourage the adolescent's friends to continue with their daily activities; the adolescent has concrete thinking and will understand.

c. Discourage questions and concerns about the effects of the illness on the adolescent's appearance.
d. Ask the parents how the adolescent usually copes in new situations.

ANS: A
The peer group is important to the adolescent's sense of belonging and identity; therefore separation from friends is a major source of anxiety for the hospitalized adolescent. Adolescents should have advanced beyond concrete thinking. In addition, hospitalized adolescents may be upset if their friends continue with daily activities without them. Communication, interacting, and meeting with friends will be important. Questions and concerns should be encouraged regarding the adolescent's appearance and the effects of illness on appearance. How the adolescent copes should be asked directly of the adolescent.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 791 | Box 35.2 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

7. The nurse is discussing toddler development with the mother of a 2 1/2-year-old child. Which statement by the mother indicates she has an understanding of how to help her daughter succeed in a developmental task while hospitalized?
a. "I always help my daughter complete tasks to help her achieve a sense of accomplishment."
b. "I provide many opportunities for my daughter to play with other children her age."
c. "I consistently stress the difference between right and wrong to my daughter."
d. "I encourage my daughter to do things for herself when she can."

ANS: D
The toddler's developmental task is to achieve autonomy. Encouraging toddlers to do things for themselves assists with this developmental task (i.e., feeding self, putting on own socks). Toddlers should be encouraged to do what they can for themselves. Toddlers participate in parallel play. They play next to rather than with age mates. Excessive stress on the differences between right and wrong can stifle autonomy in the toddler and foster shame and doubt.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 787 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Health Promotion and Maintenance

8. Which intervention helps a hospitalized toddler feel a sense of control?
a. Assign the same nurses to care for the child.
b. Put a cover over the child's crib.
c. Require parents to stay with the child.
d. Follow the child's usual routines for feeding and bedtime.

ANS: D
Familiar rituals and routines are important to toddlers and give the child a sense of control. Following the child's usual routines during hospitalization minimizes feelings of loss of control. Providing consistent caregivers is most applicable for the very young child, such as the neonate and infant. Placing a cover over the child's crib may increase feelings of loss of control. Parents are encouraged, rather than expected, to stay with the child during hospitalization.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 787 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

9. Why is observation for 24 hours in an acute-care setting often appropriate for children?
   a. Longer hospital stays are more costly.
   b. Children become ill quickly and recover quickly.
   c. Children feel less separation anxiety when hospitalized for 24 hours.
   d. Families experience less disruption during short hospital stays.

   ANS: B
   Children become ill quickly and recover quickly; therefore they can require acute care for a shorter period of time. A child's state of wellness, rather than cost, determines the length of stay. Separation anxiety is primarily a factor of the stage of development, not the length of hospital stay. Family disruption is a secondary outcome of a child's hospitalization; it does not determine length of stay.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 782 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

10. In which age-group does the child's active imagination during unfamiliar experiences increase the stress of hospitalization?
    a. Toddlers
    b. Preschoolers
    c. School-age children
    d. Adolescents

    ANS: B
    Active imagination is a primary characteristic of preschoolers. A toddler's primary response to hospitalization is separation anxiety. School-age children experience stress with loss of control. Adolescents experience stress from separation from their peers.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 787 OBJ: Nursing Process: Planning
    MSC: Client Needs: Health Promotion and Maintenance

11. Having explanations for all procedures and selecting their own meals from hospital menus is an important coping mechanism for which age-group?
    a. Toddlers
    b. Preschoolers
    c. School-age children
    d. Adolescents

    ANS: C
    School-age children are developmentally ready to accept detailed explanations. School-age children can select their own menus and become actively involved in other areas of their care. Toddlers need routine and parental involvement for coping. Preschoolers need simple explanations of procedures. Detailed explanations and support of peers help adolescents cope.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering

REF: p. 788 OBJ: Nursing Process: Planning
MSC: Client Needs: Psychosocial Integrity

12. What is the best action for the nurse to take when a 5-year-old child who requires another 2 days of IV antibiotics cries, screams, and resists having the IV restarted?
    a. Exit the room and leave the child alone until he or she stops crying.
    b. Tell the child big boys and girls "don't cry."
    c. Let the child decide which color arm board to use with the IV.
    d. Administer an opioid analgesic for pain to quiet the child.

    ANS: C
    Giving the preschooler some choice and control, while maintaining boundaries of treatment, supports the child's coping skills. Leaving the child alone robs the child of support when a coping difficulty exists. Crying is a normal response to stress. The child needs time to adjust and support to cope with unfamiliar and painful procedures during hospitalization. Although administration of a topical analgesic is indicated before restarting the child's IV, an opioid analgesic is not indicated.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: pp. 787-788 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Psychosocial Integrity

13. What is the best nursing response to the mother of a 4-year-old child who asks what she can do to help the child cope with a sibling's repeated hospitalizations?
    a. Recommend that the child be sent to visit the grandmother until the sibling returns home.
    b. Inform the parent that the child is too young to visit the hospital.
    c. Assume the child understands that the sibling will soon be discharged because the child asks no questions.
    d. Help the mother give the child a simple explanation of the treatment, and encourage the mother to have the child visit the hospitalized sibling.

    ANS: D
    Needs of a sibling will be better met with factual information and contact with the ill child. Separation from family and home may intensify fear and anxiety. Parents are experts on their children and need to determine when their child can visit a hospital. Children may have difficulty expressing questions and fears and need the support of parents and other caregivers.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 798 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Psychosocial Integrity

14. How should the nurse advise parents whose preschooler used to sleep through the night and now awakens at intervals after a short hospitalization?
    a. Regressive behavior after a hospitalization is normal and usually short term.
    b. The child is probably expressing anger.
    c. Egocentric behavior often manifests itself when the child is left alone to sleep.
    d. The child is probably feeling pain and needs further evaluation.

    ANS: A

Regression is manifested in a variety of ways, is normal, and usually is short term. Nighttime waking is not associated with anger. Egocentric behavior is not an explanation for nighttime waking. More information is needed before assessment of pain can be made.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 786 | Nursing Quality Alert Box OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

15. Which is an appropriate nursing intervention for the hospitalized neonate?
    a. Assign the neonate to a room with other neonates.
    b. Provide play activities in the hospital room.
    c. Offer the neonate a pacifier between feedings.
    d. Request that parents bring a security object from home.

    ANS: C
    The neonate needs opportunities for nonnutritive sucking and oral stimulation with a pacifier. The neonate is not aware of other children. The choice of roommate will not affect the neonate socially. It is important for older children to room with similar-age children. Formal play activities are not relevant for the neonate. Having parents bring a security object from home is applicable to older children.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 791 | Box 35.2 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

16. Which therapeutic approach will best help a 7-year-old child cope with a lengthy course of intravenous antibiotic therapy?
    a. Arrange for the child to go to the playroom daily.
    b. Ask the child to draw you a picture of himself or herself.
    c. Allow the child to participate in injection play.
    d. Give the child stickers for cooperative behavior.

    ANS: C
    Injection play is an appropriate intervention for the child who has to undergo frequent blood work, injections, intravenous therapy, or any other therapy involving syringes and needles. The hospitalized child should have opportunities to go to the playroom each day if the child's condition warrants. This free play does not have any specific therapeutic purpose. Children can express their thoughts and beliefs through drawing. Asking the child to draw a picture of himself or herself may not elicit the child's feelings about the treatment. Rewards such as stickers may enhance cooperative behavior. They will not address coping with painful treatments.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 793 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Psychosocial Integrity

17. A preschool-aged child tells the nurse "I was bad, that's why I got sick." What is the best rationale for this child's statement?
    a. The child has a fear that mutilation will lead to death.
    b. The child's imagination is very active, and he may believe the illness is a result of something he did.

c. The child has a general understanding of body integrity at this age.
d. The child will not have fear related to an IV catheter initiation but will have fear of an impending surgery.

ANS: B
The child may believe that an illness occurred as a result of some personal deed or thought or perhaps because he touched something or someone. The child has imaginative thoughts at this stage of growth and development. Preschoolers do not have the cognitive ability to connect mutilation to death and do not have a sound understanding of body integrity. The preschooler fears all types of intrusive procedures, whether undergoing a simple procedure such as an IV start or something more invasive such as surgery.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 787 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Health Promotion and Maintenance

18. A 3 1/2-year-old child who is toilet trained has had several “accidents” since hospital admission. What is the nurse’s best action in this situation?
a. Find out how long the child has been toilet trained at home.
b. Encourage the parents to scold the child.
c. Explain how to use a bedpan and place it close to the child.
d. Follow home routines of elimination.

ANS: D
Cooperation will increase and anxiety will decrease if the child’s normal routine and rituals are maintained. Some regression to previous behaviors is normal during hospitalization, even when the child has been practicing the skill for some time. Hospitalization is a stressful experience. If the incontinence is caused by anxiety, scolding is not indicated and may increase the anxiety. Developmentally, the 3 1/2-year-old child cannot use a bedpan independently.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 791 | Box 35.2 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

19. Which question most likely elicits information about how a family is coping with a child’s hospitalization?
a. “Was this admission an emergency?”
b. “How has your child’s hospitalization affected your family?”
c. “Who is taking care of your other children while you are here?”
d. “Is this the child’s first hospitalization?”

ANS: B
Open-ended questions encourage communication. Ensuring a positive outcome from the hospital experience can be optimized by the nurse addressing the health needs of family members, as well as the needs of the child. Asking closed-ended questions inhibits communication.

PTS: 1 DIF: Cognitive Level: Application REF: p. 797
OBJ: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

20. What should the nurse advise the mother of a 4-year-old child to bring with her child to the outpatient surgery center on the day of surgery?
    a. Snacks
    b. Fruit juice boxes
    c. All of the child's medications
    d. One of the child's favorite toys

    ANS: D
    A familiar toy can be effective in decreasing a child's stress in an unfamiliar environment. The child will be NPO before surgery; therefore including snacks for the child is contraindicated. The child will be NPO before surgery. Unnecessary stress will result when the child is denied the juice. It is not necessary to bring all medications on the day of surgery. The medication the child has been receiving should have been noted during the preoperative workup. The parent should be knowledgeable of which medications the child has been taking if further information is necessary.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 787 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

21. Which play activity should the nurse implement to enhance deep breathing exercises for a toddler?
    a. Blowing bubbles
    b. Throwing a Nerf ball
    c. Using a spirometer
    d. Keeping a chart of deep breathing

    ANS: A
    Age- appropriate play for a toddler to enhance deep breathing is blowing bubbles. Throwing a Nerf ball does not enhance deep breathing. Using a spirometer and keeping a chart of deep breathing are more appropriate for a school-age child.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 793 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

22. Home care is being considered for a young child who is ventilator dependent. Which factor is most important in deciding whether home care is appropriate?
    a. Level of parents' education
    b. Presence of two parents in the home
    c. Preparation and training of family
    d. Family's ability to assume all health care costs

    ANS: C
    One of the essential elements is the training and preparation of the family. The family must be able to demonstrate all aspects of care for the child. In many areas, it cannot be guaranteed that nursing care will be available on a continual basis, and the family will have to care for the child. The amount of formal education reached by the parents is not the important issue. The determinant is the family's ability to care adequately for the child in the home. At least two family members should learn and demonstrate all aspects of the child's care in the hospital, but it does not have to be two parents.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 785 OBJ: Nursing Process: Planning
MSC: Client Needs: Safe and Effective Care Environment

23. The home health nurse outlines short- and long-term goals for a 10-year-old child with many complex health problems. Who should agree on these goals?
    a. Family and nurse
    b. Child, family, and nurse
    c. All professionals involved
    d. Child, family, and all professionals involved

    ANS: D
    In the home, the family is a partner in each step of the nursing process. The family priorities should guide the planning process. Both short-term and long-term goals should be outlined and agreed on by the child, family, and professionals involved. Involvement of the individuals who are essential to the child's care is necessary during this very important stage. The elimination of any one of these groups can potentially create a plan of care that does not meet the needs of the child and family.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 787 OBJ: Nursing Process: Planning
    MSC: Client Needs: Safe and Effective Care Environment

24. A nurse is working with a child who has a sudden, serious illness. To best support the parents, what action by the nurse is best?
    a. Assess the parents' usual coping methods.
    b. Give them information about the unit protocols.
    c. Tell them to stay with the child as much as desired.
    d. Reassure them about how common this illness is.

    ANS: A
    The way these parents will cope with this sudden illness is the same as how they cope with other stressors. The nurse helps the parents identify coping methods and support systems. Giving information about the unit and telling them they can stay are positive interventions but too narrow in scope to be the best answer. Reassuring them that their child's illness is common belittles their concerns.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 792 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

25. A child with a serious, chronic illness is hospitalized frequently. The parents are worried about the child's growth and development. What action by the nurse is best?
    a. Tell parents developmental delays are likely in this case.
    b. Make a referral to the play therapist for therapeutic play.
    c. Encourage the child to perform age-appropriate activities.
    d. Ask the parents if they want a child psychology referral.

    ANS: B

Since developmental delay is a high risk in this situation, the nurse consults with the play therapist for therapeutic play interventions. Encouraging age-appropriate activities is always important but does not address this concern. The child may need a psychology referral, but that is not the first step. Telling parents that delays are likely in this case is discouraging and does not offer any positive solutions.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 792 OBJ: Nursing Process: Intervention
MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. What are age-appropriate nursing interventions to facilitate psychological adjustment for an adolescent expected to have a prolonged hospitalization? (*Select all that apply.*)
   a. Encourage parents to bring in homework and schedule study times.
   b. Allow the adolescent to wear street clothes.
   c. Involve the parents in care.
   d. Follow home routines.
   e. Encourage parents to bring in favorite foods.

   ANS: A, B, E
   Completing homework during study time, allowing the teen to wear street clothes, and encouraging parents to bring favorite foods are all age appropriate. Involving parents in care and following home routines are important interventions for the preschool child who is in the hospital. Adolescents do not need parents to assist in their care. They are used to performing independent self-care. Adolescents may want their parents to be nearby, or they may enjoy the freedom and independence from parental control and routines.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 791 | Box 35.2 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

2. The traditional areas of school health nursing that are still prevalent in many school systems include which of the following? (*Select all that apply.*)
   a. Health screening
   b. Emergency care
   c. Intensive care
   d. Communicable disease management
   e. Health care advice

   ANS: A, B, D, E
   Health screening such as vision, hearing, and growth checks can provide information about problems that may affect the child's ability to learn. School nurses are often the first to provide care for children experiencing an unintentional injury, either on the playground or in the school building. The nurse must assess children for illnesses that may be transmitted to other children and provide care and isolation until a parent can pick up the child from school. The school nurse can be a source of referral for families in need of health care services. Intensive care is provided in the hospital.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 784 OBJ: Nursing Process: Implementation

MSC: Client Needs: Health Promotion and Maintenance

3. The nurse is working with a child in the intensive care unit. The family is from out of town. There are two siblings, both of whom are acting out at home. What suggestions does the nurse provide the family? (*Select all that apply.*)
   a. Let the siblings call the ill child at scheduled times.
   b. Take photographs of the sick child to show the siblings.
   c. Suggest the parents take the siblings to counseling.
   d. Reassure the siblings that they will not get ill themselves.
   e. Stay at home with the siblings until their behavior improves.

   ANS: A, B, D
   Having siblings call or visit the sick child helps them cope with the situation and can ease anxiety. If the sibling fears a similar illness, parents can reassure them this will not happen if reasonable. Going to counseling may be needed if the siblings cannot be reassured but is not the first step as this is normal behavior. The parents may become overly stressed if told to stay at home.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 799 | Box 35.3 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Psychosocial Integrity

MULTIPLE CHOICE

1. The parents of a school-age child are told that their child is diagnosed with leukemia. As the nurse caring for this child, what is the expected first response of the parents to the diagnosis of chronic illness in their child?
   a. Anger and resentment
   b. Sorrow and depression
   c. Shock and disbelief
   d. Acceptance and adjustment

   ANS: C
   According to Kübler-Ross, denial is the initial stage of the grieving process when an individual reacts with shock and disbelief to the diagnosis of chronic illness. The other responses are also part of the grieving process although not usually the initial response.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 803 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Psychosocial Integrity

2. A nurse is caring for a dying child. What action by the nurse best meets the the primary concern of the parents?
   a. Giving the child pain medication on a schedule
   b. Placing the child on fall and safety precautions
   c. Providing the child with favorite foods when requested
   d. Ensuring the child gets the minimum fluid requirement

   ANS: A
   The primary concern of all parents of dying children is the possibility of their child feeling pain. The nurse works vigilantly to assess and treat the child's pain. The other options are also important considerations but usually not the priority concern.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 815 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

3. In order to minimize the negative effects of illness and hospitalization on an infant, the nurse focuses care on which of the following?
   a. Bodily injury and pain
   b. Separation from caregivers and fear of strangers
   c. Loss of control and altered body image
   d. The unknown and being left alone

   ANS: B

The major fear of infants during illness and hospitalization are separation from caregivers and fear of strangers. Bodily injury and pain are fears of preschool and school-age children. Loss of control is a fear of children from the preschool period through adolescence. Altered body image applies to adolescents. Fear of the unknown and being left alone are applicable to preschoolers.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 805 | Box 36.2 OBJ: Nursing Process: Planning
MSC: Client Needs: Psychosocial Integrity

4. What corresponds to a 5-year-old child's understanding of death?
   a. Loss of a caretaker
   b. Reversible and temporary
   c. Permanent
   d. Inevitable

   ANS: B
   Children in early childhood (2 to 7 years old) view death as reversible and temporary. Loss of a caretaker corresponds to the infant/toddler understanding of death. The school-age child and adolescent understand that death is permanent. The adolescent understands death not only as permanent but also inevitable.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 811 | Table 36.1 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Psychosocial Integrity

5. The nurse is counseling the family of a 12-month-old child who has lost his mother in a car accident. How should you explain to the father what the child's understanding of death is, related to theories of growth and development?
   a. Temporary
   b. Permanent
   c. Loss of caretaker
   d. Punishment

   ANS: C
   Infants and toddlers view death as loss of a caretaker. The preschool-age child views death as temporary. The school-age child and adolescent understand the permanence of death. The preschool-age child facing impending death may view his or her condition as punishment for behaviors or thoughts.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 811 | Table 36.1 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Psychosocial Integrity

6. How can chronic illness and frequent hospitalizations affect the psychosocial development of a toddler?
   a. They can create a distortion or differentiation of self from parent.
   b. They can interfere with the development of autonomy.
   c. They can interfere with the acquisition of language, fine motor, and self-care skills.
   d. They can create feelings of inadequacy.

ANS: B
Chronic illness may interfere in the development of autonomy, which is the major psychosocial task of the toddler. The infant with a chronic illness may have distortion of differentiation of self from parents. Chronic illness with frequent hospitalizations can inhibit the acquisition of language, motor, and self-care skills in the preschool-age child. Feelings of inadequacy and inferiority can occur if independence is compromised by chronic illness in the school-age child.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 805 | Box 36.2 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

7. How can chronic illness and frequent hospitalizations affect the psychosocial development of an adolescent?
   a. They can lead to feelings of inadequacy.
   b. They can interfere with parental attachment.
   c. They can block the development of identity.
   d. They can prevent the development of imagination.

   ANS: C
   Development of identity is the task of the adolescent. Inadequacy and inferiority refer to the school-age period. Parental attachment is a task of the infant. Development of imagination occurs in the preschool period.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 805 | Box 36.2 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Psychosocial Integrity

8. What is an important focus of nursing care for the dying child and his or her family?
   a. Nursing care should be organized to minimize contact with the child.
   b. Adequate oral intake is crucial to the dying child.
   c. Families should be taught that hearing is the last sense to stop functioning before death.
   d. It is best for the family if nursing care takes place during periods when the child is alert.

   ANS: C
   Families should be encouraged to talk to the child because verbal communication and physical touch are important both for the family and child. Nursing care should minimize disruptions but not contact. When a child is dying, fluids should be based on the child's requests, with a focus on comfort and preventing a dry mouth. The times when the child is alert should be devoted to family contacts.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 816 OBJ: Nursing Process: Planning
   MSC: Client Needs: Psychosocial Integrity

9. What is the most appropriate response to a school-age child who asks if she can talk to her dying sister?

a. “You need to talk loudly so she can hear you.”
b. “Holding her hand would be better because at this point she can’t hear you.”
c. “Although she can’t hear you, she can feel your presence so sit close to her.”
d. “Even though she will probably not answer you, she can still hear what you say to her.”

ANS: D
Hearing is the last sense to cease before death. Talking to the dying child is important both for the child and the family. The sense of hearing is intact before death and there is no need to speak loudly. The sibling should be encouraged to speak to the child, as well as hold the child’s hand. The sibling should be encouraged to sit close and speak to the dying child.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 816 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

10. What is the priority goal for the child with a chronic illness?
a. To maintain the intactness of the family
b. To eliminate all stressors
c. To achieve complete wellness
d. To obtain the highest level of wellness

ANS: D
To obtain the highest level of health and function possible is the priority goal of nursing children with a chronic illness. Maintaining intactness of the family is a great goal, but it is for the family, not the child. Eliminating all stressors and achieving complete wellness are not realistic.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 804 | Nursing Quality Alert Box OBJ: Nursing Process: Planning
MSC: Client Needs: Health Promotion and Maintenance

11. What is the predominant trait of the resilient family associated with chronic illness?
a. Social separation
b. Family flexibility
c. Family cohesiveness
d. Clear family boundaries

ANS: C
Family cohesiveness is the predominant trait of the resilient family. Social integration, not separation is another trait. Family flexibility and clear family boundaries are other traits of the resilient family but not the predominant one.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 802 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

12. Many parents who have children diagnosed with a chronic illness experience recurrent feelings of grief, loss, and fear related to the child’s condition and loss of the ideal healthy child. The nurse recognizes this process as

a. anticipatory grieving.
b. chronic sorrow.
c. bereavement.
d. illness trajectory.

ANS: B
The stated recurrent feelings define chronic sorrow, which is considered a normal process involving grief that may never be resolved. Anticipatory grieving is the process of mourning, coping, interacting, planning, and psychosocial reorganization that is begun as a response to the impending loss of a loved one. Bereavement is defined as the objective condition or state of loss. Illness trajectory is defined as the impact of the disease or condition on all family members, physiologic unfolding of the disease, and work organization done by the family to cope.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 803 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

13. What is a priority nursing diagnosis for the preschool child with chronic illness?
a. Risk for delayed growth and development related to chronic illness or disability
b. Chronic pain related to frequent injections and invasive procedures
c. Anticipatory grieving related to impending death
d. Anxiety related to frequent hospitalizations

ANS: A
This is the priority nursing diagnosis that is appropriate for the majority of chronic illnesses. The child may or may not have frequent injections and invasive procedures. A chronic illness is one that does not have a cure. It does not mean the child will die prematurely. Frequent hospitalizations are not required for all chronic illnesses.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 804 OBJ: Nursing Process: Diagnosis
MSC: Client Needs: Health Promotion and Maintenance

14. The parents of a chronic illness say, “Living with this disease is really hard; it’s not fair.” What response by the nurse is best?
a. “Tell me about what is hard for you.”
b. “I know exactly how you must feel.”
c. “I know a local support group for families.”
d. “I am going to ask the grief counselor to meet with you.”

ANS: A
The first step in supporting families and helping them deal with chronic sorrow is to listen to and recognize their pain. Each individual’s perception of a situation is different. A nurse can never know exactly how parents feel about having a child with a chronic illness. The family may welcome involvement in a support group or meeting with a counselor, but that should not be the first action.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 803 OBJ: Integrated Process: Communication and Documentation

MSC: Client Needs: Psychosocial Integrity

15. Identify the most appropriate nursing response to a parent who tells the nurse, “I don’t want my child to know she is dying.”
    a. “I shall respect your decision. I won’t say anything to your child.”
    b. “Don’t you think she has a right to know about her condition?”
    c. “Would you like me to arrange for the provider to speak with your child?”
    d. “I’ll answer any questions she asks me as honestly as I can.”

    ANS: D
    Nurses can inform parents that they will not initiate any discussion with the child but that they intend to respond openly and honestly if and when the child initiates such a discussion. As the caregiver and advocate, the nurse should first meet the child’s needs. Asking the parent if the child has the right to know is judgmental and could affect the nurse’s relationship with the child’s parents. Having the provider speak with the child does not address the parent’s concerns or the nurse’s responsibility.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 806 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Psychosocial Integrity

16. Which activity should the nurse implement for the toddler hospitalized with a chronic illness to promote autonomy?
    a. Provide opportunities for play
    b. Making play dates with other toddlers in the unit
    c. Give the toddler art supplies
    d. Turn the television on to cartoons

    ANS: A
    Providing play gives the toddler some time to work on growth and development skills and normalizes hospitalization at least for that time. Toddlers typically don’t play together in groups. Art supplies may or may not be too advanced for the toddler, but in any case, this would be a form of play. Watching cartoons on television is passive and will not promote autonomy.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 805 | Box 36.2 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Psychosocial Integrity

17. The nurse case manager is planning a care conference about a young child who has complex health care needs and will soon be discharged home. Who should the nurse invite to the conference?
    a. Family and nursing staff
    b. Social worker, nursing staff, and primary care physician
    c. Family and key health professionals involved in the child’s care
    d. Primary care physician and key health professionals involved in the child’s care

    ANS: C

A multidisciplinary conference is necessary for coordination of care for children with complex health needs. The family is involved as well as key health professionals who are involved in the child's care. The nursing staff can address the nursing care needs of the child with the family, but other involved disciplines must be included. The family must be included in the discharge conferences, which allow them to determine what education they will require and the resources needed at home. A member of the nursing staff must be included to review the nursing needs of the child.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 810 OBJ: Nursing Process: Planning
MSC: Client Needs: Safe and Effective Care Environment

18. Families progress through various stages of reactions when a child is diagnosed with a chronic illness or disability. After the shock phase, a period of adjustment usually follows. This is often characterized by which response?
    a. Denial
    b. Anger
    c. Social reintegration
    d. Acceptance of child's limitations

    ANS: B
    After the initial shock has worn off, families often respond to a chronic illness diagnosis with anger. Social reintegration and acceptance may or may not ever occur but if they do it is the culmination of the grief process.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 803 OBJ: Nursing Process: Planning
    MSC: Client Needs: Psychosocial Integrity

19. The nurse comes into the room of a child who was just diagnosed with a chronic disability. The child's parents begin to yell at the nurse about a variety of concerns. The nurse's best response is
    a. "What is really wrong?"
    b. "Being angry is only natural."
    c. "Yelling at me will not change things."
    d. "I will come back when you settle down."

    ANS: B
    Parental anger after the diagnosis of a child with a chronic disability is a common response. One of the most common targets for parental anger is members of the staff. The nurse should recognize the common response of anger to the diagnosis and allow the family to ventilate. The other responses do not validate the parents' feelings and concerns and may hamper a therapeutic nurse-family relationship.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 803 OBJ: Integrated Process: Communication and Documentation
    MSC: Client Needs: Psychosocial Integrity

20. The feeling of guilt that the child "caused" the disability or illness is especially critical in which child?

a. Toddler
b. Preschooler
c. School-age child
d. Adolescent

ANS: B
Preschoolers are most likely to be affected by feelings of guilt that they caused the illness/disability or are being punished for wrongdoings.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 805 | Box 36.2 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

21. The nurse is providing support to a family who is experiencing anticipatory grief related to their child's imminent death. An appropriate nursing intervention is to
a. be available to family.
b. attempt to "lighten the mood."
c. not allow visitors at this time.
d. discourage crying because the child can hear it.

ANS: A
The most valuable nursing intervention at this time is to be available to the family. Attempting to lighten the mood or to cheer people up is inappropriate. The family's wishes determine who can visit. The nurse should never discourage the expression of emotions.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 807 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

22. At the time of a child's death, the nurse tells his mother, "We will miss him so much." The best interpretation of this is that the nurse is
a. pretending to be experiencing grief.
b. expressing personal feelings of loss.
c. denying the mother's sense of loss.
d. talking when listening would be better.

ANS: B
The death of a patient is one of the most stressful experiences for a nurse. Nurses experience reactions similar to those of family members because of their involvement with the child and family during the illness. Nurses often have feelings of personal loss when a patient dies. The nurse is not pretending, denying the mother's sense of loss, or talking when listening would be better.

PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
REF: p. 819 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

23. The nurse is caring for a child who has just died. The parents ask to be left alone so that they can rock their child one more time. What response by the nurse is best?
a. Grant their request.

b. Assess why they feel this is necessary.
c. Discourage this because it will only prolong their grief.
d. Kindly explain that they need to say good-bye to their child now and leave.

ANS: A
The parents should be allowed to remain with their child after the death for as long as they need to. No other response is needed.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 817 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

24. A school-age child is diagnosed with a life-threatening illness. The parents want to protect their child from knowing the seriousness of the illness. What should the nurse explain to the parents?
a. This will help the child cope effectively by denial.
b. This attitude is helpful to give parents time to cope.
c. Terminally ill children know when they are seriously ill.
d. Terminally ill children usually choose not to discuss their illness.

ANS: C
The child needs honest and accurate information about the illnesses, treatments, and prognosis. Children, even at a young age, realize that something is seriously wrong and that it involves them. The nurse should help parents understand the importance of honesty. The child will know that something is wrong because of the increased attention of health professionals. The focus should be on the child's needs, not the parents'. Children will usually tell others how much information they want about their condition.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 806 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

25. What intervention will best help the siblings of a child with special needs?
a. Explaining to the siblings that embarrassment is unhealthy
b. Encouraging the parents not to expect siblings to help them care for the child with special needs
c. Providing information to the siblings about the child's condition only as they request it
d. Suggesting to the parents ways of maintaining the siblings' usual routine and participation in activities

ANS: D
Parents should strive for integrating all family members' needs into daily activities. The nurse can help the parents problem solve and come up with ways to maintain as normal a daily routine for the siblings as possible while still meeting the needs of the child with special needs. Siblings may or may not be embarrassed by the special needs of the family member, but this statement belittles their feelings. Parents can ask the siblings if they want to help provide care and offer information but should not force the child into anything.

PTS: 1 DIF: Cognitive Level: Application/Applying

REF: p. 808 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

26. The parents of a child born with disabilities ask the nurse for advice about discipline. The nurse's response should be based on knowledge that discipline is
    a. essential for the child.
    b. too difficult to implement with special-needs child.
    c. not needed unless the child becomes problematic.
    d. best achieved with punishment for misbehavior.

    ANS: A
    Discipline is essential for the child. It provides boundaries on which to test out their behavior and teaches them socially acceptable behaviors. All children in the family should be held to the same standards of behavior to prevent resentment. The nurse should teach the parents ways to manage the child's behavior before it becomes problematic. Punishment is not effective in managing behavior.

    PTS: 1 DIF: Cognitive Level: Application REF: p. 804
    OBJ: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

27. At what age do most children have an adult concept of death as being inevitable, universal, and irreversible?
    a. 4 to 5 years
    b. 6 to 8 years
    c. 9 to 11 years
    d. 12 to 16 years

    ANS: C
    By age 9 or 10 years, children have an adult concept of death. They realize that it is inevitable, universal, and irreversible. Preschoolers and young school-age children are too little to have an adult concept of death. Adolescents have a mature understanding of death.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 811 | Table 36.1 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

28. At what developmental period do children have the most difficulty coping with death, particularly if it is their own?
    a. Toddlerhood
    b. Preschool
    c. School-age
    d. Adolescence

    ANS: D
    Adolescents, because of their mature understanding of death, remnants of guilt and shame, and issues with deviations from normal, have the most difficulty coping with death. Toddlers and preschoolers will fear separation from parents. School -age children will fear the unknown, such as the consequences of the illness and the threat to their sense of security.
    PTS: OBJ:

1 Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity
DIF: Cognitive Level: Comprehension
REF: p. 812

29. Kelly, age 8 years, will soon be able to return to school after an injury that resulted in several severe, chronic disabilities. What action by the school nurse is most appropriate?
    a. Recommend that Kelly's parents attend school at first to prevent teasing.
    b. Prepare Kelly's classmates and teachers for changes they can expect.
    c. Refer Kelly to a school where the children have chronic disabilities similar to hers.
    d. Discuss the fact that her classmates will not accept her as they did before.

    ANS: B
    Attendance at school is an important part of normalization for Kelly. The school nurse should prepare teachers and classmates about her condition, abilities, and special needs. A visit by the parents can be helpful, but unless the classmates are prepared for the changes, it alone will not prevent teasing. Kelly's school experience should be normalized as much as possible. Children need the opportunity to interact with healthy peers, as well as to engage in activities with groups or clubs composed of similarly affected persons. Children with special needs are encouraged to maintain and reestablish relationships with peers and to participate according to their capabilities.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: pp. 807-808 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Psychosocial Integrity

30. A parent of a child with a chronic illness is complaining about "all these care planning meetings." What response by the home health care nurse is best?
    a. "Our plan will change with your child's growth and development."
    b. "We have legal regulations and company policies to follow."
    c. "Do you want to change the frequency of our meetings?"
    d. "If you don't want to come to the meetings you don't have to."

    ANS: A
    As the child goes through the different phases of growth and development, goals and interventions will change to meet the changing needs of the child. This may require frequent care planning meetings and plan updates. The nurse may be also following regulations, but that response does not give the parent useful information. The plan should be based on the child's needs. Asking if the parent wants to change the frequency of meetings is a yes/no question and does not explain the rationale. Of course the parent can opt out of meetings, but the plan will be substandard, and again this does not give the parent useful information.

    PTS: 1 DIF: Cognitive Level: Application REF: p. 804
    OBJ: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

31. The home health care nurse is working with a family with three children, one of whom has a chronic condition. What statement by a parent indicates that goals for a primary nursing diagnosis have been met?
    a. “We take turns going to soccer practice with our other two kids.”
    b. “Each sibling has one night when he or she is in charge so we can go out.”
    c. “We are looking into local support groups for parents.”
    d. “We can’t afford home health care, so one of us will quit our job.”

ANS: A
The family that is demonstrating good ability to balance the needs of all family members is meeting an important goal for the diagnosis Interrupted Family Processes. The other siblings may not want to be "in charge" for an entire evening, but that does not show good balance. Looking into support groups and having to quit a job also do not demonstrate that a goal for this diagnosis is being met.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 802 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. Which should a nurse identify as common chronic illnesses of childhood? (*Select all that apply.*)
   a. Reactive airway disease (asthma)
   b. Respiratory syncytial virus (RSV)
   c. Cerebral palsy
   d. Diabetes mellitus
   e. Human immunodeficiency virus infection (HIV)

   ANS: A, C, D, E
   A chronic illness is defined as a condition that is long term, does not spontaneously resolve, is usually without a complete cure, and affects activities of daily living. Reactive airway disease (asthma), cerebral palsy, diabetes mellitus, and HIV are all chronic illnesses that may occur during childhood. RSV is a virus that is highly contagious and causes bronchiolitis and pneumonia in children. It does not cause chronic illness.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 802 | Box 36.1 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

2. What should the nurse identify as major fears in the preschool child who is hospitalized with a chronic illness? (*Select all that apply.*)
   a. Altered body image
   b. Separation from peer group
   c. Bodily injury
   d. Mutilation
   e. Being left alone

   ANS: C, D, E
   Body injury, mutilation, and being left alone are major fears of the preschooler. Altered body image and separation from peer group are fears of the adolescent.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 805 | Box 36.2 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

3. Which indicators of imminent death in a child should the nurse expect to assess? (*Select all that apply.*)
   a. Heart rate increases.
   b. Blood pressure increases.
   c. Respirations become rapid and shallow.
   d. The extremities become warm.
   e. Peripheral pulses become stronger.

   ANS: A, C
   Indicators of imminent death include heart rate increasing, with a concomitant decrease in the strength and quality of peripheral pulses; respiratory effort decline, as evidenced by rapid, shallow respirations; and cool and cyanotic extremities. Increased BP, warm extremities, and strong peripheral pulses are not indicators of imminent death.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 817 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

4. The student nurse learns the stages of grief according to Kübler-Ross. What stages does this include? (*Select all that apply.*)
   a. Shock
   b. Denial
   c. Anger
   d. Bargaining
   e. Acceptance

   ANS: B, C, D, E
   The stages of grief outlined by Kübler-Ross include denial, anger, bargaining, sadness or depression, and acceptance. Shock occurs during the denial stage.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 803 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Psychosocial Integrity

MULTIPLE CHOICE

1. What is the most appropriate statement for the nurse to make to a 5-year-old child who is undergoing a venipuncture?
   a. "You must hold still or I'll have someone hold you down. This is not going to hurt."
   b. "This will hurt like a pinch. I'll get someone to help hold your arm still so it will be over fast and hurt less."
   c. "Be a big boy and hold still. This will be over in just a second."
   d. "I'm sending your mother out so she won't be scared. You are big, so hold still and this will be over soon."

   ANS: B
   The nurse can help minimize the pain and stress of the venipuncture by having someone help the child maintain control during the procedure. Threatening the child with having someone hold him or her down is likely to produce less cooperation and frighten the child. Telling a child to be a "big boy" does not acknowledge the child's developmental stage. Parents should be allowed to stay during procedures when possible.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 822 | Box 37.1 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Psychosocial Integrity

2. Which nursing diagnosis is appropriate for the 5-year-old child in isolation because of immunosuppression?
   a. Spiritual distress
   b. Social isolation
   c. Deficient diversional activity
   d. Sleep deprivation

   ANS: C
   Children in isolation need extra attention to avoid boredom. A 5-year-old child is not developmentally advanced enough to feel spiritual distress. The main social system for a 5-year-old child is the family, who should be allowed liberal visitation. Sleep deprivation may occur during hospitalization but is not specific to isolation.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 825 OBJ: Nursing Process: Diagnosis
   MSC: Client Needs: Psychosocial Integrity

3. What should the nurse consider when having consent forms signed for surgery and procedures on children?
   a. Only a parent or legal guardian can give consent.
   b. The person giving consent must be at least 18 years old.
   c. The risks and benefits of a procedure are part of the consent process.
   d. A mental age of 7 years or older is required for a consent to be considered

"informed."

ANS: C
The informed consent must include the nature of the procedure, benefits and risks, and alternatives to the procedure. In special circumstances, such as emancipated minors, the consent can be given by someone younger than 18 years without the parent or legal guardian. A mental age of 7 years is too young for consent to be informed.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 823 OBJ: Integrated Process: Communication and Documentation
MSC: Client Needs: Safe and Effective Care Environment

4. The nurse is planning how to prepare a 4-year-old child for some diagnostic procedures. Guidelines for preparing this preschooler should include
   a. planning for a short teaching session of about 30 minutes.
   b. telling the child that procedures are never a form of punishment.
   c. keeping equipment out of the child's view.
   d. using correct scientific and medical terminology in explanations.

   ANS: B
   Illness and hospitalization may be viewed as punishment in preschoolers. Always state directly that procedures are never a form of punishment. Teaching sessions for this age -group should be much shorter in length. Demonstrate the use of equipment, and allow the child to play with miniature or actual equipment. Explain the procedure in simple terms and how it affects the child.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 821 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Psychosocial Integrity

5. Which nursing action is most appropriate when treating a child who has a fever of 102.5° F (39.1° C)?
   a. Restrict fluid intake.
   b. Administer an aspirin.
   c. Administer acetaminophen.
   d. Bathe the child in tepid water.

   ANS: C
   Treatment of a fever can include administration of an antipyretic such as acetaminophen. Dehydration can occur from insensible water loss. Offer the child fluids frequently and evaluate the need for IV therapy. Aspirin is avoided because of the potential association with Reye syndrome. A sponge or tub bath with tepid water to reduce fever can cause shivering and ultimately increase the child's temperature.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 831 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

6. A parent asked, "When should I start dental care for my child?" What response by the nurse is best?

a. “The recommendation is for children to have a dental examination no later than 2.5 years.”
b. “Children should see a dentist at least one time before kindergarten.”
c. “The recommendation is for children to have a dental examination before first grade.”
d. “A dental examination by 1 year of age is the current recommendation.”

ANS: A
Children should see a dentist by 1 year of age.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 827 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

7. Which action is appropriate to promote a toddler’s nutrition during hospitalization?
a. Allow the child to walk around during meals.
b. Require the child to empty his or her plate.
c. Ask the child’s parents to bring a cup and utensils from home.
d. Select new foods for the child from the menu.

ANS: C
Using familiar items during mealtimes increases the toddler’s sense of security and control and may encourage eating. For safety reasons, “roaming” while eating should not be permitted. The child should be seated during meals. Toddlers often use food as a source of control. Forcing a toddler to eat only increases the child’s sense of powerlessness. Toddlers also experience food jags, a normal phenomenon when they will only eat certain foods. Hospitalization is a stressful experience for the toddler. It is not the time to introduce the child to new foods.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 827 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

8. The nurse knows that measuring temperature is an integral part of assessment. Which concept is important for the nurse to know when taking a child’s temperature?
a. The method used should be consistent.
b. Rectal temperatures should always be taken on infants.
c. Oral temperatures can be taken on all children older than 5 years of age.
d. Axillary temperatures should be taken at night.

ANS: A
The method that is determined most appropriate for the child should be used consistently—the same site and device to maintain consistency and allow reliable comparison and tracking of temperatures over time. Because of the risk of rectal perforation and the intrusive nature of the procedure, rectal temperatures are measured only when no other route can be used or when it is necessary to obtain a core body temperature. Oral temperatures can be used on most children older than 6 years of age but may be inaccurate because of oral intake, oral surgery, oxygen therapy, nebulizer treatments, or crying. There is no time specification for when specific types of temperatures are taken.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 828 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

9. A parent calls the pediatrician's office because her 1-year-old child has a 100° F temperature. What is the most appropriate initial nursing response to make to the parent?
   a. "Did you feel your child's forehead?"
   b. "Does your child appear to be uncomfortable?"
   c. "Has anyone in your home been sick lately?"
   d. "Don't worry if the temperature is less than 101° F."

   ANS: B
   The child's comfort is the primary concern in treating a fever in a normally healthy child. The nurse asks about the child's comfort level before giving further information. Feeling a child's forehead can give clues related to whether the child's temperature should be measured; if it has already been measured, this is unnecessary because it does not give accurate information about the child's body temperature. Asking about other ill family members is important, but not as the initial response, which should be to get more data about the child. Although the height of the temperature is not an indication of the seriousness of the child's illness, it is incorrect to tell a parent to be unconcerned about temperatures less than 101° F.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 831 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

10. What nursing action is appropriate for specimen collection?
    a. Follow sterile technique for specimen collection.
    b. Sterile gloves are worn if the nurse plans to touch the specimen.
    c. Use Standard Precautions when handling body fluids.
    d. Avoid wearing gloves in front of the child and family.

    ANS: C
    Standard Precautions should always be used when handling body fluids. Sterile gloves may be needed for some specimens, but Standard Precautions are important for all. The child and family should be educated in the purpose of glove use, including the fact that gloves are used with every patient, so that they will not be offended or frightened.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 832 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Safe and Effective Care Environment

11. A nurse is teaching parents how to care for a child's gastrostomy tube at home. What information should the nurse include?
    a. Bring the child to the clinic for cleaning
    b. Clean around the insertion site daily with soap and water.
    c. Expect some leakage around the button.
    d. Remove the tube for cleaning once a week.

    ANS: B

The skin around the tube insertion site should be cleaned with soap and water once or twice daily. Parents must be able to clean the site; the child is not taken to the clinic for this. Leakage around the tube should be reported to the physician. A gastrostomy tube is placed surgically. It is not removed for cleaning.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 840 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

12. Which nursing action is the most appropriate when applying a face mask to a child for oxygen therapy?
    a. The oxygen flow rate should be less than 6 L/min.
    b. Make sure the mask fits properly.
    c. Keep the child warm.
    d. Remove the mask for 5 minutes every hour.

    ANS: B
    A properly fitting face mask is essential for adequate oxygen delivery. The oxygen flow rate should be greater than 6 L/min to prevent rebreathing of exhaled carbon dioxide. Oxygen delivery through a face mask does not affect body temperature. A face mask used for oxygen therapy is not routinely removed.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 842 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Safe and Effective Care Environment

13. What is appropriate to include in the teaching plan for a family of a child with a tracheostomy?
    a. Suction the tracheostomy as needed.
    b. Apply powder around the stoma to decrease irritation.
    c. Limit suctioning time to 30 seconds.
    d. Provide showers and discourage baths.

    ANS: A
    To maintain a patent airway in a child with a tracheostomy, assessing respiratory status and suctioning as needed using Standard Precautions is an important intervention to teach families. Talc powder should be avoided because of the risk of inhalation injury from breathing the powder particles. Catheter insertion for suctioning should be less than 5 seconds to prevent hypoxia. The family should be taught to avoid getting water in the tracheostomy during bath time. Showers should be discouraged.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 844 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

14. Which action by the nurse indicates that the correct procedure has been used to measure vital signs in a toddler?
    a. Measuring oral temperature for 5 minutes
    b. Counting apical heart rate for 60 seconds
    c. Observing chest movement for respiratory rate

d. Recording blood pressure as P/80

ANS: B
Apical pulse measurement when the child is quiet for 1 full minute is the preferred method for measuring vital signs in infants and children ages 2 years and younger. A child younger than 6 years may not be able to hold a thermometer under the tongue. The respiratory rate should be auscultated on the quiet infant or young child for 1 full minute. The nurse should be able to auscultate the blood pressure of a toddler, so this would not be the correct way to document it.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 829 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

15. Which action by the nurse is appropriate when preparing a child for a procedure?
    a. Discourage the child from crying during the procedure.
    b. Use professional terms so the child will understand what is happening.
    c. Give the child choices whenever possible.
    d. Discourage the parents from staying in the room during the procedure.

    ANS: C
    Allowing children to make choices gives them a sense of control. Children (and adults) should be given permission to cry. Age-appropriate language should always be used. Parents should be encouraged to stay in the room and give support to the child.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 822 | Box 37.1 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Psychosocial Integrity

16. The nurse is preparing a 12-year-old girl for a bone marrow aspiration. She tells the nurse she wants her mother with her “like before.” Which response by the nurse is most appropriate?
    a. Grant her request.
    b. Explain why this is not possible.
    c. Identify an appropriate substitute for her mother.
    d. Offer to provide support to her during the procedure.

    ANS: A
    The parents’ preferences for assisting, observing, or waiting outside the room should be assessed as well as the child’s preference for parental presence. The child’s choice should be respected. If the mother and child are agreeable, then the mother is welcome to stay. An appropriate substitute for the mother is necessary only if the mother does not wish to stay. Support is offered to the child regardless of parental presence.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 823 | Nursing Quality Alert Box OBJ: Nursing Process: Implementation
    MSC: Client Needs: Psychosocial Integrity

17. The nurse wore gloves during a dressing change. When the gloves are removed, the nurse should

a. wash hands thoroughly.
b. check the gloves for leaks.
c. use an alcohol-based hand rub.
d. apply new gloves before touching the next patient.

ANS: C
Evidence-based research has demonstrated that alcohol-based rubs are more effective for eliminating organisms. If the nurse's hands are clean, alcohol-based hand rubs are most appropriate. If hands are soiled, then soap and water are used. Gloves should be disposed of after use. Hands should be thoroughly cleaned before new gloves are applied.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 825 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

18. An important nursing consideration when performing a bladder catheterization on a young child is to
a. use clean technique, not Standard Precautions.
b. insert 2% lidocaine lubricant into the urethra.
c. lubricate catheter with water-soluble lubricant such as K-Y Jelly.
d. delay catheterization for 20 minutes while anesthetic lubricant is absorbed.

ANS: B
The anxiety, fear, and discomfort experienced during catheterization can be significantly decreased by preparation of the child and parents, by selection of the correct catheter, and by appropriate technique of insertion. Generous lubrication of the urethra before catheterization and use of lubricant containing 2% lidocaine may reduce or eliminate the burning and discomfort associated with this procedure. Catheterization is a sterile procedure. Water-soluble lubricants do not provide appropriate local anesthesia. Catheterization should be delayed only 2 to 3 minutes. This provides sufficient local anesthesia for the procedure.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 834 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

19. What is critical for the nurse to know when using restraints on a child?
a. Use the least restrictive type of restraint.
b. Tie knots securely so they cannot be untied easily.
c. Secure the ties to the mattress or side rails.
d. Remove restraints every 4 hours to assess skin integrity.

ANS: A
When restraints are necessary, the nurse should institute the least restrictive type of restraint possible to meet goals. Knots must be tied so that they can be easily undone for quick access to the child. The ties are never tied to the mattress or side rails. They should be secured to a stable device, such as the bed frame. Restraints are removed every 2 hours to allow for range of motion, position changes, and assessment of skin integrity.

PTS: 1 DIF: Cognitive Level: Application
REF: p. 824 | Safety Alert Box OBJ: Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

20. A nurse must do a venipuncture on a 6-year-old child. An important consideration in providing atraumatic care is to
    a. use an 18-gauge needle if possible.
    b. wait 10 minutes after applying EMLA cream.
    c. restrain child only as needed to perform venipuncture safely.
    d. have the parents choose the child's favorite bandage afterward.

    ANS: C
    Restrain child only as needed to perform the procedure safely. Smaller needles are used. After applying EMLA cream, the nurse must wait a minimum of 60 minutes. Allow the child to choose a favorite bandage.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 824 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Psychosocial Integrity

21. In preparing to give enemas to a 4-year-old child, what action by the nurse is best?
    a. Use tap water.
    b. Only use normal saline.
    c. Insert the tip of the tube at least 3 inches.
    d. Instill 120 to 240 mL of solution.

    ANS: B
    Isotonic solutions should be used in children. Saline is the solution of choice. Plain water is not used. This is a hypotonic solution and can cause fluid and electrolyte disturbances. The tip of the tubing should be inserted 3 inches (7.5 cm) maximum. 240 to 360 mL is appropriate for this age group.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 824 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

22. A parent wants to know why acetaminophen should only be given for 2 days for a fever without checking with the provider. What response by the nurse is best?
    a. Acetaminophen is a dangerous drug with bad side effects.
    b. Long-term acetaminophen use can cause liver damage.
    c. There may be better fever relievers you could use.
    d. What if there were something seriously wrong with your child?

    ANS: B
    Long-term use of acetaminophen can lead to liver damage. It is not a particularly dangerous drug and, like all drugs, has side effects. The provider needs to see the child to determine if something is more seriously wrong, but this statement sounds like a threat. There may be other medications the parent could try, but the main concern is liver damage.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 831 | Drug Guide Box OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

23. A student nurse in the emergency department is preparing to obtain a throat culture on a child with suspected epiglottis secondary to a strep infection. What action by the registered nurse is best?
    a. Remind the student to wear personal protective equipment.
    b. Tell the student to get the child to say “ahhh.”
    c. Consult with the provider prior to obtaining the culture.
    d. Inform the parents and child that a throat culture is needed.

    ANS: C
    The nurse never obtains a throat culture on a child in whom epiglottitis is suspected because it may precipitate sudden airway obstruction. The nurse consults with the provider about this issue. Wearing personal protective equipment, having the child say “ahhh,” and informing the child and parents of the needed culture would all be appropriate when obtaining it.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 837 | Safety Alert Box
    OBJ: Integrated Process: Communication and Documentation
    MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. The nurse is preparing for the admission of an infant who will have several procedures performed. In which situations is informed consent required? (*Select all that apply.*)
    a. Catheterized urine collection
    b. IV line insertion
    c. Oxygen administration
    d. Lumbar puncture
    e. Bone marrow aspiration

    ANS: D, E
    Informed consent is required for invasive procedures that involve a risk to a child such as lumbar puncture and bone marrow aspiration. Informed consent is not required for procedures that are covered under the general consent to treat that is signed at admission by a parent or a guardian. These include catheterized urine collection, IV insertion, and oxygen administration.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 822 | Box 37.1
    OBJ: Integrated Process: Communication and Documentation
    MSC: Client Needs: Safe and Effective Care Environment

COMPLETION

1. A toddler’s temperature is 101.5° F (38.6° C) axillary. The physician has ordered acetaminophen 10 mg/kg every 4 to 6 hours. The child weighs 22 lb. The bottle of acetaminophen available is a suspension (160 mg/5 mL)._____
    How much should the nurse administer? Round to the nearest milliliter.

ANS:
3 mL

The first thing the nurse should do is convert the 22 lb into kilograms (10 kg). Next multiply the number of kilograms the child weighs by the dose ordered by the physician (10 mg × 10 kg = 100). Next, use the medication that is available (160 mg/5 mL) and calculate the amount for 100 mg. The answer is 3.125. The last step is to round to the nearest milliliter = 3 mL.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 831 | Drug Guide Box OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE CHOICE

1. What should the nurse use to prepare liquid medication in volumes less than 5 mL?
   a. Calibrated syringe
   b. Paper measuring cup
   c. Plastic measuring cup
   d. Household teaspoon

   ANS: A
   For volumes of 5 mL or less, an oral syringe designed for oral medication administration only should be used. Measuring cups would be too large. A household teaspoon may or may not be accurate and the AAP recommends metric-only measuring devices.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 853 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

2. Which food is appropriate to mix with medication?
   a. Formula or milk
   b. Applesauce
   c. Baby food
   d. Orange juice

   ANS: B
   To prevent the child from developing a negative association with an essential food, a nonessential food such as applesauce is best for mixing with medications. Formula, milk, baby food, and orange juice are essential foods in a child's diet. Medications may alter their flavor and cause the child to avoid them in the future.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 855 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

3. Which physiologic difference affects the absorption of oral medications administered to a 3-month-old infant?
   a. More rapid peristaltic activity
   b. More acidic gastric secretions
   c. Usually more rapid gastric emptying
   d. Variable pancreatic enzyme activity

   ANS: D

Pancreatic enzyme activity is variable in infants for the first 3 months of life as the gastrointestinal system matures. Medications that require specific enzymes for dissolution and absorption might not be digested to a form suitable for intestinal action. Infants up to 8 months of age tend to have prolonged motility. The longer the intestinal transit time, the more medication is absorbed. The gastric secretions of infants are less acidic than in older children or adults. Gastric emptying is usually slower in infants.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 852 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

4. Which factor should the nurse remember when administering topical medication to an infant as compared with an adolescent?
   a. Infants require a larger dosage because of a greater body surface area.
   b. Infants have a thinner stratum corneum that absorbs more medication.
   c. Infants have a smaller percentage of muscle mass.
   d. The skin of infants is less sensitive to allergic reactions.

   ANS: B
   Infants and young children have a thinner outer skin layer (stratum corneum), which increases the absorption of topical medication. A similar dose of a topical medication administered to an infant compared with an adult is approximately three times greater in the infant because of the greater body surface area. The smaller muscle mass in infants affects site selection for injected medications but should not affect administration of topical medications. The young child's skin is more prone to irritation, making contact dermatitis and other allergic reactions more common.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 852 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

5. What is the appropriate nursing response to a parent who asks, "What should I do if my child cannot take a tablet?"
   a. "You can crush the tablet and put it in some food."
   b. "Find out if the medication is available in a liquid form."
   c. "If the child can't swallow the tablet, tell the child to chew it."
   d. "Let me show you how to get your child to swallow tablets."

   ANS: B
   A tablet should not be crushed without knowing whether it will alter the absorption, effectiveness, release time, or taste. Therefore telling the parent to find out whether the medication is available in liquid form is the most appropriate response. A chewed tablet may have an offensive taste, and chewing it may alter its absorption, effectiveness, or release time. Forcing a child, or anyone, to swallow a tablet is not acceptable and may be dangerous.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 855 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

6. What is the maximum safe volume that a neonate can receive in an intramuscular injection?
   a. 0.5 mL
   b. 1.0 mL
   c. 1.5 mL
   d. 2 mL

   ANS: B
   The maximum volume of medication for an intramuscular injection to a neonate is 1.0 mL.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 857 | Safety Alert Box OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

7. Which muscle should the nurse select to give a 6-month-old infant an intramuscular injection?
   a. Deltoid
   b. Ventrogluteal
   c. Dorsogluteal
   d. Vastus lateralis

   ANS: D
   The vastus lateralis is not located near any vital nerves or blood vessels. It is the best choice for intramuscular injections for children younger than 3 years of age. The deltoid muscle is not used for intramuscular injections in young children. The ventrogluteal muscle is safe for intramuscular injections for children older than 13 months. The dorsogluteal muscle does not develop until a child has been walking for at least 1 year.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 858 | Table 38.1 OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

8. The nurse administering an IV piggyback medication to a preschool child should
   a. use a “Smart” pump if available.
   b. flush the IV tubing before and after the infusion with normal saline solution.
   c. inject the medication into the IV catheter using the port closest to the child.
   d. inject the medication into the IV tubing in the direction away from the child.

   ANS: A
   Programmable infusion pumps are frequently used to facilitate safe intermittent infusion of IV medications for children via the piggyback method. Some pumps have preprogrammed drug libraries to assist in the prevention of medication errors. Administering medications via this route does not require flushing unless the medication is incompatible with the maintenance fluid. The nurse is using the IV push method when injecting medication into the IV tubing using the port closest to the child. The medication is not injected away from the child.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 865 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

9. What parameter should guide the nurse when administering a subcutaneous injection to a school-age child with cellulitis?
   a. Do not to give injections in edematous areas.
   b. Attach a clean 1-inch needle to the syringe.
   c. The maximum volume injected into one site is 2 mL.
   d. Do not pinch up tissue before inserting the needle.

   ANS: A
   Subcutaneous injections should never be given in areas of edema or infection because absorption is unreliable. A short (no more than 1/2- to 5/8-inch) needle should be used to deposit medication into subcutaneous tissue. Volumes for subcutaneous injections are small, usually averaging 0.5 mL. The skin is pinched up for a subcutaneous injection to raise the fatty tissue away from the muscle.

   PTS: 1 DIF: Cognitive Level: Application
   REF: p. 857 | Safety Alert Box OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

10. What action is correct when administering ear drops to a 2-year-old child?
    a. Administer the ear drops straight from the refrigerator.
    b. Pull the pinna of the ear back and down.
    c. Massage the pinna after administering the medication.
    d. Pull the pinna of the ear back and up.

    ANS: B
    For children younger than 3 years, the pinna, or lower lobe, of the ear should be pulled back and down to straighten the ear canal. Medication should be at room temperature because cold solutions in the ear will cause pain. The tragus, not the pinna, of the ear should be massaged to ensure that the drops reach the tympanic membrane. For children younger than 3 years, the pinna of the ear should be pulled back and down to straighten the ear canal.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 861 | Procedure Box OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

11. What is the main purpose for using a volume-control device or an infusion pump to administer intravenous fluids to children?
    a. To avoid fluid overload
    b. To aid in measuring intake
    c. To administer antibiotics
    d. To ensure adequate intravenous fluid intake

    ANS: A
    A volume- control device or an infusion pump allows the nurse to set a specific volume of fluid to be given in a specific period of time and decreases the risk of inadvertently administering a large amount of fluid. A pump can display IV intake, making calculation of I&O easier, but that is not its main function. Medications can be given via IV pump, but that is not its main function. The nurse is responsible for knowing a child's fluid requirements.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering

REF: p. 864 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

12. A child is being discharged from the hospital on insulin. The mother is apprehensive about giving the medication. What action by the nurse is most important?
    a. Review the side effects of insulin with the mother.
    b. Have the mother verbalize that she knows the importance of follow-up care.
    c. Observe the mother while she administers an insulin injection.
    d. Help the mother devise a rotation schedule for injections.

    ANS: C
    It is important that the nurse evaluate the mother's ability to give the insulin injection before discharge. Watching her give the injection to the child will give the nurse an opportunity to offer assistance and correct any errors. The other items are important too, but the priority would be ensuring the mother can administer the medication safely.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 867 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

13. When liquid medication is given to a crying 10-month-old infant, which approach minimizes the possibility of aspiration?
    a. Administer the medication with a syringe (without needle) placed along the side of the infant's tongue.
    b. Administer the medication as rapidly as possible with the infant securely restrained.
    c. Mix the medication with the infant's regular formula or juice and administer by bottle.
    d. Keep the child upright with the nasal passages blocked for a minute after administration.

    ANS: A
    Administer the medication with a syringe without a needle placed alongside of the infant's tongue. The contents are administered slowly in small amounts, allowing the child to swallow between deposits. Medications should be given slowly to avoid aspiration. The medication should be mixed with only a small amount of food or liquid. If the child does not finish drinking/eating, it is difficult to determine how much medication was consumed. Essential foods also should not be used. Holding the child's nasal passages will increase the risk of aspiration.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 855 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

14. Guidelines for intramuscular administration of medication in school-age children include
    a. inject medication as rapidly as possible.
    b. insert needle quickly, using a dart-like motion.
    c. penetrate skin immediately after cleansing site.
    d. have child stand, if possible and if child is cooperative.

ANS: B
The needle should be inserted quickly in a dart-like motion at a 90- degree angle unless contraindicated. Inject medications slowly. Allow skin preparation to dry completely before skin is penetrated. Place child in lying or sitting position.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 857 | Safety Alert Box OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

15. What action indicates that a school-age child is using a metered-dose inhaler correctly?
    a. The child uses his inhaled steroid before the bronchodilator.
    b. The child exhales forcefully as he squeezes the inhaler.
    c. The child holds his breath for 10 seconds after the first puff.
    d. The child waits 10 minutes before taking a second puff.

    ANS: C
    After a puff, the child should hold his breath for about 10 seconds or until he counts slowly to 5. If one of the child's medications is an inhaled steroid, it should be administered last. The child should inhale slowly as the inhaler is squeezed or depressed. The child does not need to wait this long to take a second puff of medication. He can take a second puff after 1 to 2 minutes.

    PTS: 1 DIF: Cognitive Level: Analysis
    REF: p. 862 | Procedure Box OBJ: Nursing Process: Evaluation
    MSC: Client Needs: Physiologic Integrity

16. What action is appropriate when using an EMLA cream before intravenous catheter insertion?
    a. Rub a liberal amount of cream into the skin thoroughly.
    b. Cover the skin with a gauze dressing after applying the cream.
    c. Leave the cream on the skin for 1 to 2 hours before the procedure.
    d. Use the smallest amount of cream necessary to numb the skin surface.

    ANS: C
    The cream should be left in place for a minimum of 1 hour and no more than 2 hours. The EMLA cream should not be rubbed into the skin. After the cream is applied to the skin surface, it is covered with a transparent occlusive dressing. The nurse should use a liberal amount of EMLA cream.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 863 | Nursing Quality Alert Box OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

17. A child is receiving intravenous fluids. How frequently should the nurse assess and document the condition of the child's intravenous site?
    a. Every hour
    b. Every 2 hours
    c. Every 4 hours
    d. Every shift

ANS: A
The nurse assesses and documents an IV site at least every hour for signs and symptoms of infiltration and phlebitis.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 863 | Nursing Quality Alert Box OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

18. What is the hourly maintenance fluid rate for an intravenous infusion in a child weighing 19.5 kg?
    a. 19 mL
    b. 61 mL
    c. 195 mL
    d. 1475 mL

ANS: B
The formula for calculating daily fluid requirements is 0 to 10 kg: 100 mL/kg/day; 10 to 20 kg: 1000 mL for the first 10 kg of body weight plus 50 mL/kg/day for each kilogram between 10 and 20. To determine an hourly rate, divide the total milliliters per day by 24. Calculations: Child weighs 19.5 kg. Therefore the child requires 1000 mL; plus 50 mL × 9.5 kg = 475 mL. Next add calculated amounts: 1000 + 475 = 1475 mL, and divide by 24 hours to equal 61.45 mL per hour. This rounds down to 61 mL/hr.

PTS: 1 DIF: Cognitive Level: Application/Application
REF: p. 865 | Box 38.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

19. What nursing action is indicated when a child receiving a unit of packed red blood cells complains of chills, headache, and nausea?
    a. Continue the infusion, and take the child's vital signs.
    b. Stop the infusion immediately, and notify the provider.
    c. Slow the infusion, and assess for cessation of symptoms.
    d. Start a dextrose solution, and stay with the child.

ANS: B
If a reaction is suspected, as in this case, the transfusion is stopped immediately, and the provider is notified. The transfusion cannot continue. Dextrose solutions are never infused with blood products because the dextrose causes hemolysis, but more important, the infusion must be stopped.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 866 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

20. What is the best action for the nurse to take when giving medications to a 3-year-old child?
    a. Tell the child to take the medication "right now."
    b. Tell the child to take the medication or she will have to get a shot.
    c. Allow the child to choose fruit punch or apple juice when giving the medication.
    d. Tell the child that another child her age just took his medication like a "good girl."

ANS: C
Realistic choices such as type of juice to drink with medications allow the child to feel some control. Direct confrontation typically results in a "no" response. Threatening a child with a shot is inappropriate. Comparisons are not helpful in getting a child this age to cooperate.

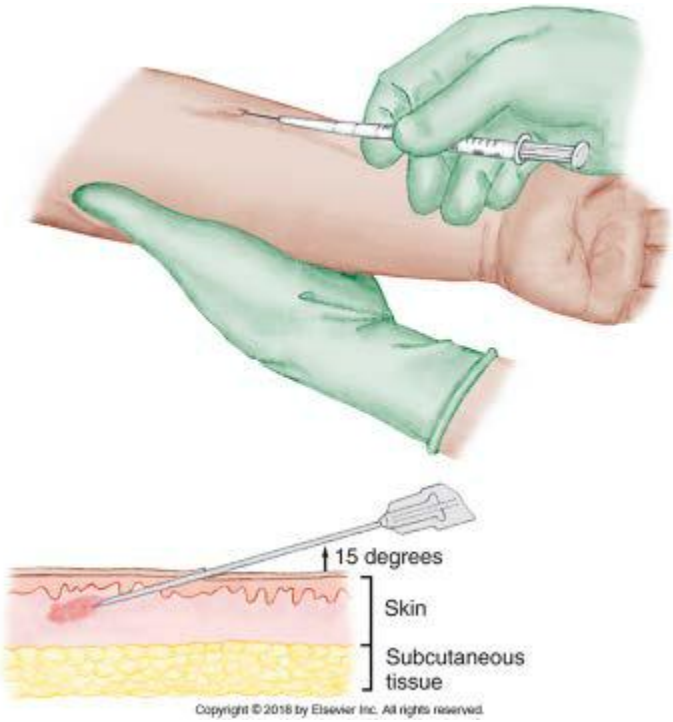
PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 854 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

21. When teaching a mother how to administer eye drops, where should the nurse tell her to place them?
    a. In the conjunctival sac that is formed when the lower lid is pulled down
    b. Carefully under the eyelid while it is gently pulled upward
    c. On the sclera while the child looks to the side
    d. Anywhere as long as drops contact the eye's surface

    ANS: A
    The lower lid is pulled down, forming a small conjunctival sac. The drops are applied to this area. The medication should not be administered directly onto the eyeball.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 860 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

22. A registered nurse is watching a student nurse give an IM injection to a 1-year-old. The student identifies the following site for the injection. What action by the registered nurse is best?



    a. Remind the student to don gloves.
    b. Hand the student an alcohol wipe.

c. Ask the student to find another site.
d. Assess for the correct needle length.

ANS: C
The deltoid muscle (pictured) should not be used on children under 2 years of age. The other actions would be appropriate if the student did not have to find another injection site.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 858 | Table 38.1 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. What nursing actions are correct when administering subcutaneously? (*Select all that apply.*)
   a. Insert the needle with the bevel up at a 15-degree angle.
   b. Insert the needle at a 45- to 90-degree angle.
   c. Insert the needle into the tissue on the upper back.
   d. Insert the needle into the abdominal tissue.
   e. Massage the injection site when the injection is complete.

   ANS: B, D
   For this subcutaneous injection, the nurse inserts the needle at a 45- to 90-degree angle and injects into the subcutaneous abdominal tissue. A 15-degree angle and injecting into the tissue on the upper back are appropriate for intradermal injections. The nurse should not massage the site.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 857 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

2. A nurse should routinely ask a colleague to double-check a medication calculation and the actual medication before administering which medications? (*Select all that apply.*)
   a. Antibiotics
   b. Insulin
   c. Anticonvulsants
   d. Anticoagulants
   e. Narcotics/Opioids

   ANS: B, D, E
   The nurse should ask another nurse to check the dosage calculation and the medication before administering the following: insulin, narcotics, chemotherapy, digoxin or other inotropic drugs, anticoagulants, and K^{+} and Ca^{++} salts. Institutions may require two nurses to check other medications also to prevent medication error. The nurse does not need a second check for antibiotics.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 854 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

COMPLETION

1. What is the 24-hour maintenance fluid requirement for a child weighing 18.7 pounds?

   ANS:
   850 mL

   Calculate weight in kilograms: 18.7 pounds = 8.5 kg.

   The formula for calculating daily fluid requirements is 0 to 10 kg: 100 mL/kg/day; 10 to 20 kg: 1000 mL for the first 10 kg of body weight plus 50 mL/kg/day for each kilogram between 10 and 20. To determine an hourly rate, divide the total milliliters per day by 24: 8.5 kg × 100 mL = 850 mL/24 hr.

   PTS: 1 DIF: Cognitive Level: Analysis REF: p. 865 | Box 38.1
   OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

2. A provider orders odansetron 0.15 mg/kg IV push for a child who weighs 15 pounds. How much medication does the nurse draw up?

   ANS:
   1 mL

   Calculate the weight in kilograms: 15/2.2 =
   6.818181 Multiply by 0.15=1.0227272
   Round as your final answer = 1 mL

   PTS: 1 DIF: Cognitive Level: Analysis REF: NA
   OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. When assessing a child for pain, the nurse is aware that
   a. neonates do not feel pain.
   b. pain is an individualized experience.
   c. children do not remember pain.
   d. a child must cry to express pain.

   ANS: B
   The manner and intensity of how a child expresses pain is dependent on the individual child's experiences. Neonates do express a total-body response to pain with a cry that is intense, high pitched, and harsh sounding. Children of all ages have been reported to have sleeping and eating disruptions after painful experiences. Not all children will cry to express pain.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 869 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

2. When pain is assessed in an infant, it is inappropriate to assess for
   a. facial expressions of pain.
   b. localization of pain.
   c. crying.
   d. thrashing of extremities.

   ANS: B
   Infants cannot localize pain to any great extent. Frowning, grimacing, and facial flinching in an infant may indicate pain. Infants often exhibit high-pitched, tense, harsh crying to express pain. Infants may exhibit thrashing extremities in response to a painful stimulus.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 872 | Box 39.2 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. The nurse knows that physiologic changes associated with pain in the neonate include
   a. increased blood pressure and decreased arterial saturation.
   b. decreased blood pressure and increased arterial saturation.
   c. increased urine output and increased heart rate.
   d. decreased urine output and increased blood pressure.

   ANS: A
   An increase in blood pressure and a decrease in arterial saturation can be noted when the neonate is feeling pain. Urinary output changes have not been associated with pain.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 872 | Box 39.2 OBJ: Nursing Process: Assessment

MSC: Client Needs: Physiologic Integrity

4. What myth may interfere with the treatment of pain in infants and children?
   a. Infants may have sleep difficulties after a painful event.
   b. Children and infants are more susceptible to respiratory depression from narcotics.
   c. Pain in children is multidimensional and subjective.
   d. A child's cognitive level does not influence the pain experience.

   ANS: B
   No data are available to support the belief that infants and children are at higher risk of respiratory depression when given narcotic analgesics. This is a myth. It is true that infants may have sleep difficulties after a painful event. This is not a myth. Pain in children is multidimensional and subjective. The child's cognitive level, along with emotional factors and past experiences, does influence the perception of pain in children. This is not a myth.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 871 | Table 39.1 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

5. The nurse caring for the child in pain knows that distraction
   a. can give total pain relief to the child.
   b. is effective when the child is in severe pain.
   c. is the best method for pain relief.
   d. must be developmentally appropriate to refocus attention.

   ANS: D
   Distraction can be very effective in helping to control pain, but it must be appropriate to the child's developmental level. Distraction can help control pain, but it is rarely able to provide total pain relief. Children in severe pain are not distractible. Children may use distraction to help control pain, but it is not the best method for pain relief.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 876 OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

6. What medication is the most effective choice for treating pain associated with sickle cell crisis in a newly admitted 5-year-old child?
   a. Morphine
   b. Acetaminophen
   c. Ibuprofen
   d. Midazolam

   ANS: A

Opioids, such as morphine, are the preferred drugs for the management of acute, severe pain, including postoperative pain, posttraumatic pain, pain from vaso-occlusive crisis, and chronic cancer pain. Acetaminophen provides only mild analgesic relief and is not appropriate for a newly admitted child with sickle cell crisis. Ibuprofen is a type of nonsteroidal anti-inflammatory drug (NSAID) that is used primarily for pain associated with inflammation. It is appropriate for mild to moderate pain but is not adequate for this patient. Midazolam (Versed) is a short-acting drug used for conscious sedation and preoperative sedation and as an induction agent for general anesthesia.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 881 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

7. When using the poker chip tool, it is important for the nurse to know that
   a. any number of chips can be used.
   b. only a specified number of chips can be used.
   c. the assessment tool is used with adolescents.
   d. the assessment tool is most effectively used with 2-year-old children.

   ANS: B
   In the poker chip tool, four chips are used to represent a hurt. One chip represents a little hurt, and four chips represent the most hurt the child could have. Pain tools are valid only if used as directed. The poker chip tool uses four chips. Adolescents are able to think abstractly. They can describe, quantify, and identify intensity and feelings about pain. This scale is recommended for children ages 4 to 12. Self-report tools are effective in children older than 3 years of age, not 2 years of age.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 875 | Table 39.2 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

8. In which developmental stage is the child first able to localize pain and describe both the amount and the intensity of the pain felt?
   a. Toddler stage
   b. Preschool stage
   c. School-age stage
   d. Adolescent stage

   ANS: B
   The preschool stage is the period when the child is first able to describe the location and intensity of pain, stating, for example, “Ear hurts bad,” when feeling pain. The toddler expresses pain by guarding or touching the painful area, verbalizes words that indicate discomfort such as “ouch” and “hurt,” and demonstrates generalized restlessness when feeling pain. The school-age child describes both the location of the pain and its intensity. The adolescent also describes location and intensity of pain.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 872 | Box 39.2 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

9. Which statement indicates the nurse's lack of understanding about the use of patient-controlled analgesia (PCA) therapy?
   a. Children as young as 3 years old can effectively and successfully use a PCA pump.
   b. Two registered nurses (RNs) are required to double-check the dosage and programmed administration of opioids.
   c. The child should be carefully monitored for signs and symptoms of overmedication with opioids.
   d. Naloxone (Narcan) should be readily available.

   ANS: A
   Children as young as 5 years old have effectively used PCA therapy. Further data are needed to evaluate the use of PCA therapy in children younger than 5 years of age. Two RNs are needed to check the amount of opioid being administered. Once the opioid infusion is hung and programmed, a second RN must double -check the process. Children receiving PCA therapy should be monitored closely to ensure effective pain control and for signs or symptoms of overmedication. Initially, vital signs should be monitored every 15 to 30 minutes and then every 2 to 4 hours. Respiratory rate should be assessed every hour. Narcan should be readily available to reverse opioid overmedication exhibited by respiratory distress.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: p. 880 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

10. Which assessment indicates to a nurse that a 2-year-old child is in need of pain medication?
   a. The child is lying rigidly in bed and not moving.
   b. The child's current vital signs are consistent with previous vital signs.
   c. The child becomes quiet when held and cuddled.
   d. The child has just returned from the recovery room.

   ANS: A
   Behaviors such as crying; distressed facial expressions; certain motor responses, such as lying rigidly in bed and not moving; and interrupted sleep patterns are indicative of pain in children. Current vital signs that are consistent with earlier vital signs do not suggest that the child is feeling pain. Response to comforting behaviors does not suggest the child is feeling pain. A child who is returning from the recovery room may or may not be in pain. Most times the child's pain is under adequate control at this time. The child may be fearful or having anxiety because of the strange surroundings and having just completed surgery.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 871 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

11. When assessing pain in any child, the nurse should consider that
   a. any pain assessment tool can be used to assess pain in children.
   b. children as young as 1 year old use words to express pain.
   c. the child's behavioral, physiologic, and verbal responses are valuable when assessing pain.
   d. pain assessment tools are minimally effective for communicating about pain.

ANS: C
Children's behavioral, physiologic, and verbal responses are indicative when assessing pain. The use of pain measurement tools greatly assists in communicating about pain. The child's age is important in determining the appropriate pain assessment tool to use. Developmentally appropriate assessment tools need to be used to effectively identify and determine the level of pain felt by a child. Toddlers may use words such as "ouch" or "hurt" to identify pain, but infants and young children may not have the language or cognitive abilities to express pain. Pain assessment tools when used appropriately are successful and efficient in identifying and quantifying pain with children. Behavioral and physiologic signs and symptoms in combination with pain assessment tools are most effective in diagnosing pain levels in children.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 871 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

12. The nurse is caring for a 6-year-old girl who had surgery 12 hours ago. The child tells the nurse that she does not have pain, but a few minutes later tells her parent that she does. What should the nurse consider when interpreting this?
    a. Truthful reporting of pain should occur by this age.
    b. Inconsistency in pain reporting suggests that pain is not present.
    c. Children use pain experiences to manipulate their parents.
    d. Children may be experiencing pain even though they deny it to the nurse.

    ANS: D
    Children may deny pain to the nurse because they fear receiving an injectable analgesic or because they believe they deserve to suffer as a punishment for a misdeed. They may refuse to admit pain to a stranger but readily tell a parent. Myths about pain in children include that truthful reporting should occur at any age and inconsistencies suggest that pain is not present. Pain is whatever the experiencing person says it is, whenever the person says it exists. Pain is not questioned in an adult 12 hours after surgery.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 872 | Box 39.2 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

13. Which drug is usually the best choice for PCA for a child in the immediate postoperative period?
    a. Codeine
    b. Morphine
    c. Methadone
    d. Meperidine

    ANS: B
    The most commonly prescribed medications for PCA are morphine, hydromorphone, and fentanyl. Codeine, methadone, and meperidine are not commonly used for children and are not used in PCA pumps.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 881 OBJ: Nursing Process: Implementation

MSC: Client Needs: Physiologic Integrity

14. The nurse is caring for a child receiving intravenous (IV) morphine for severe postoperative pain. The nurse observes a slower respiratory rate, and the child cannot be aroused. What action by the nurse takes priority?
    a. Administer naloxone (Narcan) immediately.
    b. Notify the provider immediately.
    c. Discontinue morphine until the child is fully awake.
    d. Stimulate the child by calling his or her name and shaking gently.

    ANS: A
    Opioid-induced respiratory depression is managed by administering naloxone immediately and discontinuing the infusion. The nurse notifies the provider afterward. The provider may permanently discontinue the morphine or lower the dose. Since the child cannot be aroused, stimulating him or her is not appropriate.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 882 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Safe and Effective Care Environment

15. A nurse in the pediatric critical care unit assesses a child for pain using the COMFORT behavior scale. The child scores a 25. What action by the nurse is most appropriate?
    a. Ask a parent if the child is in pain.
    b. Medicate the patient for pain.
    c. Document and reassess in 4 hours.
    d. Notify the provider.

    ANS: B
    The COMFORT behavior scale assesses pain behavior in 6 categories. Each category is scored on a scale of 1 to 5, with the higher numbers indicating more pain. A score of 25 indicates severe pain, and the nurse should medicate the child. Asking the parent if the child is in pain is unnecessary. Of course all actions and assessments should be documented, but the nurse needs to provide pain relief. Notifying the provider is not needed unless pain control cannot be achieved.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 875 | Table 39.2 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. Which medications are the most effective choices for treating pain associated with inflammation in children? (*Select all that apply.*)
    a. Morphine
    b. Acetaminophen
    c. Ibuprofen
    d. Ketorolac
    e. Aspirin

    ANS: C, D

Ibuprofen, naproxen/naproxen sodium, and ketorolac are all types of NSAIDs, which are used primarily for pain associated with inflammation. Opioids, such as morphine, are the preferred drugs for the management of acute, severe pain, including postoperative pain, posttraumatic pain, pain from vaso-occlusive crisis, and chronic cancer pain. Acetaminophen lacks the anti-inflammatory effects of NSAIDs and provides only minimal anti-inflammatory relief. Although aspirin is an anti-inflammatory medication, because of its association with Reye's syndrome, its use is not recommended in children.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 881 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

2. The appropriate tool(s) to assess pain in a 3-year-old child is the (*Select all that apply.*)
   a. Visual Analogue Scale (VAS)
   b. adolescent and pediatric pain tool
   c. Oucher tool
   d. poker chip tool
   e. FACES pain rating scale

   ANS: C, E
   The Oucher tool and FACES tool can be used to assess pain in children 3 to 12 years of age. The VAS is indicated for use with older school-age children and adolescents. It can be used with younger school-age children, although less abstract tools are more appropriate. The poker chip tool can be used to assess pain in children 4 to 12 years of age. The adolescent and pediatric pain tool is indicated for use with children 8 to 17 years of age.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 875 | Table 39.2 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. A nurse is administering an opioid medication to a child. Which side effects should the nurse watch for with this classification of medication? (*Select all that apply.*)
   a. Respiratory depression
   b. Hepatic damage
   c. Constipation
   d. Pruritus
   e. Gastrointestinal bleeding

   ANS: A, C, D
   The nurse should remember opioids can produce sedation and respiratory depression in addition to analgesia. Other adverse effects can include constipation, pruritus, nausea, vomiting, cough suppression, and urinary retention. Acetaminophen is associated with hepatic damage, and NSAIDs are associated with gastrointestinal bleeding.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 882 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

4. A nurse uses the CRIES tool to assess pain in neonates. What categories does the nurse assess? (*Select all that apply.*)

a. Crying
b. Requires O_2
c. Increased respiratory rate
d. Expression
e. Sleepiness

ANS: A, B
CRIES stands for crying, requires O_2, increased vital signs, expression, and sleeplessness.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 875 | Table 39.2 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

COMPLETION

1. A student nurse is preparing to administer fentanyl 2-mcg/kg IV push to a child who weighs 26.4 pounds. The pharmacy delivers a vial with 50 mcg/10 mL. How much fentanyl does the student draw up?

ANS:
4.8 mL

First convert weight to kg: 26.4 pounds = 12 kg
Set up equation: 50 mcg = 2.4
mcg 10 mL × mL
X = 4.8 mL

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 883 | Drug Guide Box OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. The parents of a child with acid-base imbalance ask the nurse about mechanisms that regulate acid-base balance. Which statement by the nurse accurately explains the mechanisms regulating acid-base balance in children?
   a. The respiratory, renal, and chemical-buffering systems
   b. The kidneys balance acid; the lungs balance base.
   c. The cardiovascular and integumentary systems
   d. The skin, kidney, and endocrine systems

   ANS: A
   The acid-base system is regulated by chemical buffering, respiratory control of carbon dioxide, and renal regulation of bicarbonate and secretion of hydrogen ions. Both the kidneys and the lungs, along with the buffering system, contribute to acid-base balance. Neither system regulates acid or base balances exclusively. The cardiovascular and integumentary systems are not part of acid- base regulation in the body. Chemical buffers, the lungs, and the kidneys work together to keep the blood pH within normal range.

   PTS: 1 DIF: Cognitive Level: Application REF: p. 888
   OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

2. A child has a 2-day history of vomiting and diarrhea. He has hypoactive bowel sounds and an irregular pulse. Electrolyte values are sodium, 139 mEq/L; potassium, 3.3 mEq/L; and calcium, 9.5 mg/dL. This child is likely to have which of the following electrolyte imbalances?
   a. Hyponatremia
   b. Hypocalcemia
   c. Hyperkalemia
   d. Hypokalemia

   ANS: D
   A serum potassium level less than 3.5 mEq/L is considered hypokalemia. Clinical manifestations of hypokalemia include muscle weakness, decreased bowel sounds, cardiac irregularities, hypotension, and fatigue. The normal serum sodium level is 135 to 145 mEq/L. A level of 139 mEq/L is within normal limits. A serum calcium level less than 8.5 mg/dL is considered hypocalcemia. A serum potassium level greater than 5 mEq/L is considered hyperkalemia.

   PTS: 1 DIF: Cognitive Level: Analysis REF: p. 889
   OBJ: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

3. Which statement best describes why infants are at greater risk for dehydration than older children?
   a. Infants have an increased ability to concentrate urine.
   b. Infants have a greater volume of intracellular fluid.
   c. Infants have a smaller body surface area.

d. Infants have an increased extracellular fluid volume.

ANS: D
The larger ratio of extracellular fluid to intracellular fluid predisposes the infant to dehydration. Because the kidneys are immature in early infancy, there is a decreased ability to concentrate the urine. Infants have a larger proportion of fluid in the extracellular space. Infants have proportionately greater body surface area in relation to body mass, which creates the potential for greater fluid loss through the skin and gastrointestinal tract.

PTS: 1 DIF: Cognitive Level: Comprehension REF: p. 887
OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

4. Which assessment is most relevant to the care of an infant with dehydration?
   a. Temperature, heart rate, and blood pressure
   b. Respiratory rate, oxygen saturation, and lung sounds
   c. Heart rate, sensorium, and skin color
   d. Diet tolerance, bowel function, and abdominal girth

   ANS: C
   Changes in heart rate, sensorium, and skin color are early indicators of impending shock in the child. Children can compensate and maintain an adequate cardiac output when they are hypovolemic. Blood pressure is not as reliable an indicator of shock as are changes in heart rate, sensorium, and skin color. Respiratory assessments will not provide data about impending hypovolemic shock. Diet tolerance, bowel function, and abdominal girth are not as important indicators of shock as heart rate, sensorium, and skin color.

   PTS: 1 DIF: Cognitive Level: Analysis
   REF: p. 893 | Safety Alert Box OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

5. What is the most important factor in determining the rate of fluid replacement in the dehydrated child?
   a. The child’s weight
   b. The type of dehydration
   c. Urine output
   d. Serum potassium level

   ANS: B
   Isonatremic and hyponatremic dehydration resuscitation involves fluid replacement over 24 hours. Hypernatremic dehydration involves a slower replacement rate to prevent a sudden decrease in the sodium level. The child’s weight determines the amount of fluid needed, not the rate of fluid replacement. One milliliter of body fluid is equal to 1 g of body weight; therefore a loss of 1 kg (2.2 lb) is equal to 1 L of fluid. Urine output is not a consideration for determining the rate of administration of replacement fluids. Potassium level is not as significant in determining the rate of fluid replacement as the type of dehydration.

   PTS: 1 DIF: Cognitive Level: Analysis REF: p. 895
   OBJ: Nursing Process: Planning MSC: Client Needs: Physiologic Integrity

6. What is the priority nursing intervention for a 6-month-old infant hospitalized with diarrhea and dehydration?
   a. Estimating insensible fluid loss
   b. Collecting urine for culture and sensitivity
   c. Palpating the posterior fontanel
   d. Measuring the infant's weight

   ANS: D
   Weight is a crucial indicator of fluid status. It is an important criterion for assessing hydration status and response to fluid replacement. Infants have a greater total body surface area and therefore a greater potential for fluid loss through the skin. It is not possible to measure insensible fluid loss. Urine for culture and sensitivity is not usually part of the treatment plan for the infant who is dehydrated from diarrhea. The posterior fontanel closes by 2 months of age. The anterior fontanel can be palpated during an assessment of an infant with dehydration.

   PTS: 1 DIF: Cognitive Level: Application REF: p. 896
   OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

7. What assessment should the nurse make before initiating an intravenous (IV) infusion of dextrose 5% in 0.9% normal saline solution with 10 mEq of potassium chloride for a child hospitalized with dehydration?
   a. Fluid intake
   b. Number of stools
   c. Urine output
   d. Capillary refill

   ANS: C
   Potassium chloride should never be added to an IV solution in the presence of oliguria or anuria (urine output less than 0.5 mL/kg/hr). Fluid intake does not give information about renal function. Stool count sheds light on intestinal function. Renal function is the concern before potassium chloride is added to an IV solution. Assessment of capillary refill does not provide data about renal function.

   PTS: 1 DIF: Cognitive Level: Analysis REF: p. 895
   OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

8. A nurse is teaching parents about diarrhea. Which statement by the parents indicates understanding of the teaching?
   a. Diarrhea results from a fluid deficit in the small intestine.
   b. Organisms destroy intestinal mucosal cells, resulting in an increased intestinal surface area.
   c. Malabsorption results in metabolic alkalosis.
   d. Increased motility results in impaired absorption of fluid and nutrients.

   ANS: D

Increased motility and rapid emptying of the intestines result in impaired absorption of nutrients and water. Electrolytes are drawn from the extracellular space into stool, and dehydration results. Diarrhea results from fluid excess in the small intestine. Destroyed intestinal mucosal cells result in decreased intestinal surface area. Loss of electrolytes in the stool from diarrhea results in metabolic acidosis.

PTS: 1 DIF: Cognitive Level: Application
REF: p. 897 | Pathophysiology Box OBJ: Nursing Process: Evaluation
MSC: Client Needs: Physiologic Integrity

9. What is the best response by the nurse to a parent asking about antidiarrheal medication for her 18-month-old child?
   a. "It is okay to give antidiarrheal medication to a young child as long as you follow the directions on the box for correct dosage."
   b. "Antidiarrheal medication is not recommended for young children because it slows the body's attempt to rid itself of the pathogen."
   c. "I'm sure your child won't like the taste, so give extra fluids when you give the medication."
   d. "Antidiarrheal medication will lessen the frequency of stools, but give your child Gatorade to maintain electrolyte balance."

   ANS: B
   Antidiarrheal medications may actually prolong diarrhea because the body will retain the organism causing the diarrhea, further increasing fluid and electrolyte losses. The use of these medications is not recommended for children younger than 2 years old because of their binding nature and potential for toxicity. Antidiarrheal medications are not recommended for children younger than 2 years old. This action is inappropriate because antidiarrheal medications should not be given to a child younger than 2 years old. It is not appropriate to advise a parent to use antidiarrheal medication for a child younger than 2 years old. Education about appropriate oral replacement fluids includes avoidance of sugary drinks, apple juice, sports beverages, and colas.

   PTS: 1 DIF: Cognitive Level: Application REF: p. 899
   OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

10. Which action is the primary concern in the treatment plan for a child with persistent vomiting?
    a. Detecting the cause of vomiting
    b. Preventing metabolic acidosis
    c. Positioning the child to prevent further vomiting
    d. Recording intake and output

    ANS: A
    The primary focus of managing vomiting is detection of the cause and then treatment of the cause. Metabolic alkalosis results from persistent vomiting. Prevention of complications is the secondary focus of treatment. The child with persistent vomiting should be positioned upright or side-lying to prevent aspiration. Recording intake and output is a nursing intervention, but it is not the primary focus of treatment.

    PTS: 1 DIF: Cognitive Level: Application REF: p. 901

OBJ: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

11. What is the best response for the nurse to give a parent about contacting the physician regarding an infant with diarrhea?
    a. "Call your pediatrician if the infant has not had a wet diaper for 6 hours."
    b. "The pediatrician should be contacted if the infant has two loose stools in an 8-hour period."
    c. "Call the doctor immediately if the infant has a temperature greater than 100° F."
    d. "Notify the pediatrician if the infant naps more than 2 hours."

    ANS: A
    No urine output in 6 hours needs to be reported because it indicates dehydration. Two loose stools in 8 hours is not a serious concern. If blood is obvious in the stool or the frequency increases to one bowel movement every hour for more than 8 hours, the physician should be notified. A fever greater than 101° F should be reported to the infant's physician. It is normal for the infant who is not ill to nap for 2 hours. The infant who is ill may nap longer than the typical amount.

    PTS: 1 DIF: Cognitive Level: Application REF: p. 900
    OBJ: Nursing Process: Planning MSC: Client Needs: Physiologic Integrity

12. Which diet would the nurse recommend to the mother of a child who is having mild diarrhea?
    a. Rice, potatoes, yogurt, cereal, and cooked carrots
    b. Bananas, rice, applesauce, and toast
    c. Apple juice, hamburger, and salad
    d. Whatever the child would like to eat

    ANS: A
    Bland but nutritious foods including complex carbohydrates (rice, wheat, potatoes, cereals), yogurt, cooked vegetables, and lean meats are recommended to prevent dehydration and hasten recovery. Bananas, rice, applesauce, and toast used to be recommended for diarrhea (BRAT diet). These foods are easily tolerated, but the BRAT diet is low in energy, density, fat, and protein. Fatty foods, spicy foods, and foods high in simple sugars should be avoided. The child should be offered foods he or she likes but should not be encouraged to eat fatty foods, spicy foods, and foods high in simple sugars.

    PTS: 1 DIF: Cognitive Level: Application REF: p. 900
    OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. Which assessment findings indicate to the nurse that a child has excess fluid volume? (*Select all that apply.*)
    a. Weight gain
    b. Decreased blood pressure
    c. Moist breath sounds
    d. Poor skin turgor
    e. Rapid bounding pulse

ANS: A, C, E
A child with fluid volume excess will have a weight gain, moist breath sounds due to the excess fluid in the pulmonary system, and a rapid bounding pulse. Other signs seen with fluid volume excess are increased blood pressure, edema, and fatigue. Decreased blood pressure and poor skin turgor are signs of fluid volume deficit.

PTS: 1 DIF: Cognitive Level: Analysis REF: p. 890
OBJ: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

COMPLETION

1. Bodily fluids are composed of two elements: water and _____.

   ANS:
   Solutes

   Water is the primary constituent of bodily fluids. An infant's weight is approximately 75% water compared to the adult's weight, which is 55% to 60% water. *Solutes* are composed of both electrolytes and nonelectrolytes. The body's solutes include sodium, potassium, chloride, calcium, and magnesium.

   PTS: 1 DIF: Cognitive Level: Knowledge REF: p. 887
   OBJ: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

SHORT ANSWER

1. You are caring for a 44-lb child who is hospitalized with vomiting and severe dehydration. The physician has ordered parenteral rehydration therapy to restore circulation. The order is for sodium chloride (0.9%) solution in a 20-mL/kg bolus. How much will you give?

   ANS:
   400 mL

   The child's weight must first be converted from pounds to kilograms (1 kg = 2.2 lb): 44 lb = 20 kg. Next multiply 20 kg × 20 mL = 400 mL. The bolus will be 400 mL.

   PTS: 1 DIF: Cognitive Level: Analysis REF: NA
   OBJ: Nursing Process: Planning MSC: Client Needs: Physiologic Integrity

TRUE/FALSE

1. The nurse who provides care for young children with fluid and electrolyte imbalance understands that they are more vulnerable to changes in fluid balance than adults. Under normal conditions the amount of fluid ingested during the day should equal the amount of fluid lost. Sensible water loss is that which occurs through the respiratory tract and skin. Is this statement true or false?

ANS: F
Sensible water loss occurs through urine output. Insensible water loss occurs through the skin and respiratory tract. Insensible water loss per unit of body weight is significantly higher in infants and young children due to the faster respiratory rate and higher evaporative water losses.

PTS: 1 DIF: Cognitive Level: Comprehension REF: p. 887
OBJ: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

2. Alterations in acid-base balance can affect cellular metabolism and enzymatic processes. When alterations in pH become too much for buffer systems to handle, compensatory mechanisms are activated. If the pH drops below normal, then acidosis will occur. Is this statement true or false?

ANS: T
Acidosis is the result of a drop in blood pH. The respiratory rate and depth will increase, removing carbon dioxide and raising blood pH. Conversely, in the presence of alkalosis, respiratory rate and depth decrease, lowering blood pH.

PTS: 1 DIF: Cognitive Level: Knowledge REF: p. 889
OBJ: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. Which statement made by an adolescent girl indicates an understanding about the prevention of sexually transmitted diseases (STDs)?
   a. "I know the only way to prevent STDs is to not be sexually active."
   b. "I practice safe sex because I wash myself right after sex."
   c. "I won't get any kind of STD because I take the pill."
   d. "I only have sex if my boyfriend wears a condom."

   ANS: A
   Abstinence is the only foolproof way to prevent an STD. STDs are transmitted through body fluids (semen, vaginal fluids, blood). Perineal hygiene will not prevent an STD. Oral contraceptives do not protect women from contracting STDs. A condom can reduce but not eliminate an individual's chance of acquiring an STD. However, the nurse should encourage condom use 100% of the time to decrease the risk.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 926 | Patient-Centered Teaching Box
   OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Health Promotion and Maintenance

2. Which STD should the nurse suspect when an adolescent girl comes to the clinic because she has a vaginal discharge that is white with a fishy smell?
   a. Human papillomavirus
   b. Bacterial vaginosis
   c. *Trichomonas*
   d. *Chlamydia*

   ANS: B
   Bacterial vaginosis is characterized by a profuse, white, malodorous (fishy smelling) vaginal discharge that sticks to the vaginal walls. Manifestations of the human papillomavirus are anogenital warts that begin as small papules and grow into clustered lesions. Infections with *Trichomonas* are frequently asymptomatic. Symptoms in females may include dysuria, vaginal itching, burning, and a frothy, yellowish- green, foul-smelling discharge. Many people with chlamydial infection have few or no symptoms. Urethritis with dysuria, urinary frequency, or mucopurulent discharge may indicate chlamydial infection.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 928 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. A child taking oral corticosteroids for asthma is exposed to varicella. The child has not had the varicella vaccine and has never had the disease. What intervention should be taken to prevent varicella from developing?
   a. No intervention is needed unless varicella develops.
   b. Administer the varicella vaccine as soon as possible.

c. The child should begin a course of oral antibiotics.
d. The child should be prescribed acyclovir.

ANS: D
For children who are immunosuppressed (such as from corticosteroids), acyclovir is the treatment of choice to prevent infection. Action is needed due to the risk of serious complications. The varicella vaccine is a live virus vaccine and is contraindicated for an immunosuppressed child. An antibiotic is not effective in treating varicella zoster, which is a virus.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 914 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

4. A nurse is conducting a health education class for a group of school-age children. Which statement made by the nurse is correct about the body's first line of defense against infection in the innate immune system?
a. Nutritional status
b. Skin integrity
c. Immunization status
d. Proper hygiene practices

ANS: B
The first lines of defense in the innate immune system are the skin and intact mucous membranes. Nutritional status is an indicator of overall health, but it is not the first line of defense in the innate immune system. Immunizations provide artificial immunity or resistance to harmful diseases. Practicing good hygiene may reduce susceptibility to disease, but it is not a component of the innate immune system.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 904 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

5. The mother of an infant with multiple anomalies tells the nurse that she had a viral infection in the beginning of her pregnancy. Which viral infection is associated with fetal anomalies?
a. Measles
b. Roseola
c. Rubella
d. Herpes simplex virus (HSV)

ANS: C
The rubella virus can cross the placenta and infect the fetus, causing fetal anomalies. Measles is not associated with congenital defects. Most cases of roseola occur in children 6 to 18 months old. HSV can be transmitted to the newborn infant during vaginal delivery, causing multisystem disease. It is not transmitted transplacentally to the fetus during gestation.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 910 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

6. What is the best response to a parent of a 2-month-old infant who asks when the infant should first receive the measles vaccine?
   a. “Your baby can get the measles vaccine now.”
   b. “The first dose is given any time after the first birthday.”
   c. “She should be vaccinated between 4 and 6 years of age.”
   d. “This vaccine is administered when the child is 11 years old.”

   ANS: B
   The first measles, mumps, rubella (MMR) vaccine is recommended routinely at 1 year of age. The other statements are not correct.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 906 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

7. Which statement made by a parent about intervention for a child’s fever shows the need for further education?
   a. “I should keep her covered lightly when she has a fever.”
   b. “I’ll give her plenty of liquids to keep her hydrated.”
   c. “I can give her acetaminophen for a fever.”
   d. “I’ll look for over-the-counter aspirin or ibuprofen.”

   ANS: D
   Aspirin products are avoided because of the possibility of development of Reye’s syndrome. The parent should check labels on all over- the-counter products to be sure they do not contain aspirin. Ibuprofen is alright to give children. Dressing the child in light clothing and using lightweight covers will help reduce fever and promote the child’s comfort. Adequate hydration will help maintain a normal body temperature. Acetaminophen is also recommended for fever in children.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: p. 912 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Physiologic Integrity

8. A parent asks the nurse how she will know whether her child has fifth disease. The nurse should advise the parent to be alert for which manifestation?
   a. Bull’s-eye rash at the site of a tick bite
   b. Lesions in various stages of development on the trunk
   c. Maculopapular rash on the trunk that lasts for 2 days
   d. Bright red rash on the cheeks that looks like slapped cheeks

   ANS: D
   Fifth disease manifests with an intense, fiery red, edematous rash on the cheeks, which gives a “slapped cheek” appearance. The bull’s-eye rash at the site of a tick bite is a manifestation of Lyme disease. Varicella is manifested as lesions in various stages of development—macule, papule, then vesicle, first appearing on the trunk and scalp. Roseola manifests as a maculopapular rash on the trunk that can last for hours or up to 2 days.

   PTS: 1 DIF: Cognitive Level: Application REF: p. 911

OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

9. Which intervention is appropriate for a hospitalized child who has crops of lesions on the trunk that appear as a macular rash and vesicles?
   a. Place the child in strict isolation with airborne and contact precautions.
   b. Continue to practice Standard Precautions.
   c. Pregnant women should avoid contact with the child.
   d. Screen visitors for immunity to measles.

   ANS: A
   The child's skin lesions are characteristic of varicella. Varicella is transmitted through direct contact, droplets, and airborne particles. In the hospital setting, children with varicella should be placed in strict isolation, and on contact and airborne precautions. The purpose is to prevent transmission of microorganisms by inhalation of small -particle droplet nuclei and to protect other patients and health care providers from acquiring this disease. Standard Precautions are not sufficient for this disease. Certain viral illnesses such as rubella and fifth disease are known to affect the fetus if the woman contracts the disease during pregnancy. This child appears to have varicella. Pregnancy is not a contraindication to caring for a child with varicella. However, all health care personnel should be vaccinated or show immunity to varicella. Screening visitors for immunity to measles is irrelevant. It is important to screen visitors for immunity to varicella.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 915 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Safe and Effective Care Environment

10. How should the nurse respond to a parent who asks, "How can I protect my baby from whooping cough?"
    a. "Don't worry; your baby will have maternal immunity to pertussis that will last until approximately 18 months old."
    b. "Make sure your child gets the pertussis vaccine."
    c. "See the doctor when the baby gets a respiratory infection."
    d. "Have your pediatrician prescribe erythromycin."

    ANS: B
    Primary prevention of pertussis can be accomplished through administration of the pertussis vaccine. Infants do not receive maternal immunity to pertussis and are susceptible to pertussis. Pertussis is highly contagious and is associated with a high infant mortality rate. Prompt evaluation by the primary care provider for respiratory illness will not prevent pertussis. Erythromycin is used to treat pertussis. It will not prevent the disease.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 918 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

11. Which statement indicates that a father understands the treatment for his child who has scarlet fever?
    a. "I can stop the medicine when my child feels better."
    b. "I will apply antibiotic cream to her rash twice a day."
    c. "I will give the penicillin for the full 10 days."

d. “My child can go back to school after 7 days of antibiotics.”

ANS: C

It is necessary to give the entire course of antibiotic for 10 to 14 days. Penicillin is the preferred treatment for any streptococcal infection. The bacteria will not be eradicated if a partial course of antibiotics is given. Treatment of scarlet fever does not include topical antibiotic cream. The child is no longer contagious after 24 hours of antibiotic therapy and can return to daycare or school.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 919 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Physiologic Integrity

12. What should be included in the care for a neonate who was diagnosed with pertussis?
    a. Monitoring hemoglobin level
    b. Hearing test before discharge
    c. Serial platelet counts
    d. Prophylactic antibiotics for all close contacts

    ANS: D

    Erythromycin, azithromycin, or clarithromycin is given to all close contacts for the child diagnosed with pertussis. Pertussis does not affect the hemoglobin level. A complication of pertussis is not hearing impairment. Pertussis does not affect platelets.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 918 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

13. An adolescent has been diagnosed with the Epstein-Barr virus. What discharge information should the nurse give to the parents?
    a. It is important to protect the adolescent’s head during physical activities.
    b. The teen will feel like himself and be back to his usual routines in a week.
    c. Treatment of the Epstein-Barr virus is several months of prolonged bed rest.
    d. Fatigue may persist, so increase school activities gradually.

    ANS: D

    The recovery period is often lengthy and fatigue may continue, necessitating a gradual return to school activities. During the acute and recovery phases, activity restrictions, which include no contact sports or roughhousing, are implemented to protect the child’s enlarged spleen from rupture. The recovery process from infectious mononucleosis is a slow and gradual one. Prolonged rest (not bedrest) is indicated during the acute stage of the illness only.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 917 | Patient-Centered Teaching Box | p. 905
    OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

14. What should the nurse expect to observe in the prodromal phase of rubeola?
    a. Macular rash on the face
    b. Koplik spots

c. Petechiae on the soft palate
d. Crops of vesicles on the trunk

ANS: B
Koplik spots appear approximately 2 days before the appearance of a rash. The macular rash with rubeola appears after the prodromal stage. Petechiae on the soft palate occur with rubella. Crops of vesicles on the trunk are characteristic of varicella.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 925 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

15. What should be included in health teaching to prevent Lyme disease?
a. Complete the immunization series in early infancy.
b. Use insect repellant with DEET in heavily wooded areas.
c. Give low-dose antibiotics to the child before exposure.
d. Restrict activities that might lead to exposure for the child.

ANS: B
Insect repellant with DEET can prevent insect bites. Currently there is no vaccine available for Lyme disease. Antibiotics are used to treat, not prevent, Lyme disease. Children should be allowed to maintain normal growth and development with activities such as hiking.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 923 | Box 41.2 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

16. Which action is initiated when a child has been scratched by a potentially rabid animal?
a. No intervention unless the child becomes symptomatic
b. Administration of immune globulin around the wound
c. Administration of rabies vaccine on days 3, 7, 14, and 28
d. Administration of both immune globulin and vaccine as soon as possible after exposure

ANS: D
Human rabies immune globulin and the first dose of the rabies vaccine are given after exposure. Transmission of rabies can occur from bites with contaminated saliva, scratches from the claws of infected animals, airborne transmission in bat-infested caves, or in a laboratory setting. Rabies is fatal if no intervention is taken to prevent the disease. Human rabies immune globulin is infiltrated locally around the wound, and the other half of the dose is given intramuscularly. This is only part of the treatment after rabies exposure. The rabies vaccine is given within 48 hours of exposure and again on days 3, 7, 14, and 28.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 917 | Patient-Centered Teaching Box | p. 905
OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

17. Parents report their 3-year-old child appears restless at night and frequently scratches her anal area. What action by the nurse is best?
a. Educate parents on the cellophane tape test.

b. Review hygiene practices with the parents.
c. Suggest the child sleep only in pajama tops.
d. Ask parents to bring in a stool sample.

ANS: A
The cellophane tape test is used to diagnose pinworms. The parents place a strip of cellophane tape on the child's anus at bedtime and brings it to the clinic for microscopic evaluation. There is no need to review hygienic practices, suggest sleeping in a pajama top only, or to bring in a stool sample.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 925 | Table 41.2 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

18. A parent brings a child to the emergency department and reports fever, foul smell coming from the throat, and a gray covering over the tonsils. What action by the nurse takes priority?
a. Place the child on a cardiac monitor.
b. Attach a pulse oximeter to the child.
c. Assess respiratory status immediately.
d. Start an IV and draw blood cultures.

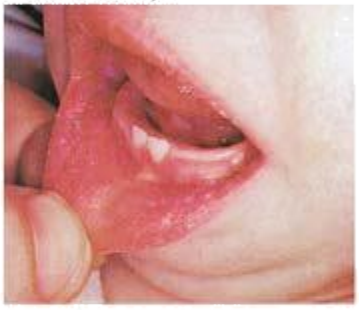
ANS: C
The manifestations are characteristic of diphtheria, which can cause respiratory compromise and airway obstruction. The nurse first assesses the child's respiratory status. Putting the child on a cardiac monitor and oximeter are important interventions, but first the nurse needs to assess the respiratory system. The child will need an IV, but that can be started after the respiratory assessment.

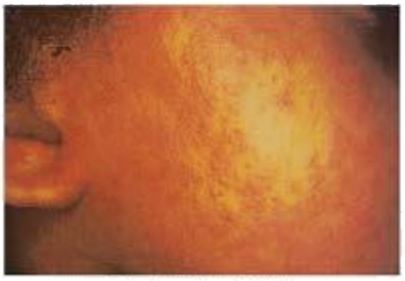
PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 922 | Table 41.1 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

19. The nurse in the pediatric clinic is caring for a child and assesses this skin rash. What action by the nurse is best?

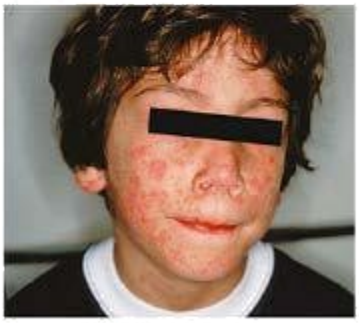
Measles Rash Distribution

- Preceded by Koplik spots on buccal mucosa
- Begins behind ears, at hairline, and on upper neck and spreads downward toward feet
- Red, maculopapular rash that gradually turns brownish
- Duration: 6 to 7 days





Measles Rash, Dark Skin



Measles Rash, Light Skin

Reprinted from Feigin, R., & Cherry, J. [Eds.], [2009]. *Feigin and Cherry's textbook of pediatric infectious diseases* [6th ed.]. Philadelphia: Saunders; from Paller, S.A. [2012]. *Hurwitz clinical pediatric dermatology: a textbook of skin disorders of childhood and adolescence* [4th ed.]. Philadelphia: Saunders.

a. Inform parents the child will be contagious for one week.
b. Arrange for immediate hospitalization and IV antibiotics.
c. Instruct parents to offer the child a soft, bland diet.
d. Advise parents the child can maintain normal activities.

ANS: C
This rash is characteristic of scarlet fever. The parents should provide soft, bland food. The child is not contagious 24 hours after starting antibiotics. There is no indication the child is sick enough to need hospitalization. The parents should encourage rest.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 919 | Figure 41.7 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. A preschooler is diagnosed with helminths. The child's mother is very upset and wants to know how her child could have contracted this illness. After obtaining a detailed history, the nurse identifies all possible transmission modes. What do they include? (*Select all that apply.*)
   a. Playing in the backyard sandbox
   b. Not washing hands before eating

c. Placing hands in the mouth and nail biting
d. Skin-to-skin contact with other children
e. Scratches from a neighborhood cat

ANS: A, B, C
Common helminths include roundworm, pinworm, tapeworm, and hookworm. Children are frequently infected as the result of frequent hand-mouth activity (unwashed hands, nail biting, not washing hands after using the toilet) and the likelihood of fecal contamination from sandboxes (especially if dogs and cats deposit fecal material in them). Other causes include not adequately washing fruits and vegetables before eating them and drinking contaminated water. Skin-to-skin contact with other children and scratches from a cat are not transmission modes for helminths.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 925 | Patient-Centered Teaching Box
OBJ: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

2. A hospitalized child has developed a methicillin-resistant *Staphylococcus aureus* (MRSA) infection. The nurse plans which interventions when caring for this child? (*Select all that apply.*)
a. Airborne isolation
b. Administration of vancomycin
c. Contact isolation
d. Administration of mupirocin ointment to the nares if colonized
e. Administration of cefotaxime (Cefotetan)

ANS: B, C, D
Vancomycin is used to treat MRSA along with mupirocin ointment to the nares. The patient is placed in contact isolation to prevent spread of the infection to other patients. The infection is not transmitted by the airborne route so only contact isolation is required. This infection is resistant to cephalosporins.

PTS: 1 DIF: Cognitive Level: Application REF: p. 921
OBJ: Nursing Process: Planning MSC: Client Needs: Physiologic Integrity

3. The nurse should provide which information to parents about preventing parasitic infections? (*Select all that apply.*)
a. Perform good handwashing.
b. Diaper a child when swimming.
c. Avoid cleaning the bathroom facilities with bleach.
d. Shoes should be worn outside.
e. Fruits and vegetables should be washed before eating.

ANS: A, D, E
Children are more commonly infected with parasites than adults, primarily as a result of frequent hand-to- mouth activity and the likelihood of fecal contamination. Good handwashing can prevent the transmission. Shoes should be worn when outside to prevent transmission, and fruits and vegetables should be washed before eating. The child should not swim in a pool that allows diapered children. The bathroom facilities should be cleaned with bleach to decrease the chance of transmission.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 925 | Patient-Centered Teaching Box
OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE CHOICE

1. A nurse in a well-child clinic is teaching parents about their child's immune system. Which statement by the nurse is correct?
   a. The immune system distinguishes and actively protects the body's own cells from foreign substances.
   b. The immune system is fully developed by 1 year of age.
   c. The immune system protects the child against communicable diseases in the first 6 years of life.
   d. The immune system responds to an offending agent by producing antigens.

   ANS: A
   The immune system responds to foreign substances, or antigens, by producing antibodies and storing information. Intact skin, mucous membranes, and processes such as coughing, sneezing, and tearing help maintain internal homeostasis. Children up to age 6 or 7 years have limited antibodies against common bacteria. The immunoglobulins reach adult levels at different ages. Immunization is the basis from which the immune system activates protection against some communicable diseases. Antibodies are produced by the immune system against invading agents, or antigens.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 932 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

2. A nurse is teaching parents about the importance of immunizations for infants because of immaturity of the immune system. The parents demonstrate that they understand the teaching if they make which statement?
   a. "We plan to opt out of most childhood vaccinations."
   b. "There are only a few diseases that have effective immunizations."
   c. "Babies are born with a sophisticated immune system so they need few, if any, immunizations."
   d. "Newborns have a hard time fighting infection so they need vaccinations."

   ANS: D
   Immaturity of the immune system places an infant and young child a greater risk of infection, so they need protection through a scheduled series of immunizations. Parents can opt out of many vaccinations, but the nurse should investigate why they plan to do so. Most communicable disease of childhood have immunizations.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: p. 935 | Pediatric Differences Box OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Health Promotion and Maintenance

3. Which organs and tissues control the two types of specific immune functions?
   a. The spleen and mucous membranes
   b. Upper and lower intestinal lymphoid tissue

c. The skin and lymph nodes
d. The thymus and bone marrow

ANS: D
The thymus controls cell-mediated immunity (cells that mature into T lymphocytes). The bone marrow controls humoral immunity (stem cells for B lymphocytes). Both the spleen and mucous membranes are secondary organs of the immune system that act as filters to remove debris and antigens and foster contact with T lymphocytes. Gut-associated lymphoid tissue is a secondary organ of the immune system. This tissue filters antigens entering the gastrointestinal tract. The skin and lymph nodes are secondary organs of the immune system.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 932 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

4. The nursing student learns how infants acquire immunity. Which statement about this process is correct?
   a. The infant acquires humoral and cell-mediated immunity in response to infections and immunizations.
   b. The infant acquires maternal antibodies that ensure immunity up to 12 months age.
   c. Active immunity is acquired from the mother and lasts 6 to 7 months.
   d. Passive immunity develops in response to immunizations.

   ANS: A
   Infants acquire long-term active immunity from exposure to antigens and vaccines. Immunity is acquired actively and passively. The term infant's passive immunity is acquired from the mother and begins to dissipate during the first 6 to 8 months of life. Passive immunity is acquired from the mother. Active immunity develops in response to immunizations.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 933 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

5. What is the most common mode of transmission of human immunodeficiency virus (HIV) in the pediatric population?
   a. Perinatal transmission
   b. Sexual abuse
   c. Blood transfusions
   d. Poor handwashing

   ANS: A

Perinatal transmission accounts for the highest percentage (91%) of HIV infections in children. Infected women can transmit the virus to their infants across the placenta during pregnancy, at delivery, and through breastfeeding. Cases of HIV infection from sexual abuse have been reported; however, perinatal transmission accounts for most pediatric HIV infections. Although in the past some children became infected with HIV through blood transfusions, improved laboratory screening has significantly reduced the probability of contracting HIV from blood products. Poor handwashing is not an etiology of HIV infection.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 938 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

6. Which is the Centers for Disease Control and Prevention (CDC, 2009) recommendation for immunizing infants who are HIV positive?
   a. Follow the routine immunization schedule.
   b. Routine immunizations are administered; assess $CD4^+$ counts before administering the MMR and varicella vaccinations.
   c. Do not give immunizations because of the infant's altered immune status.
   d. Eliminate the pertussis vaccination because of the risk of convulsions.

   ANS: B

   Routine immunizations are appropriate. $CD4^+$ cells are monitored when deciding whether to provide live virus vaccines. If the child is severely immunocompromised, the MMR vaccine is not given. The varicella vaccine can be considered on the basis of the child's $CD4^+$ counts. Only inactivated polio virus (IPV) should be used for HIV-infected children. The pertussis vaccination is not eliminated for an infant who is HIV positive.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 944 | Table 42.2 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

7. Which suggestion is appropriate to teach a mother who has a preschool child who refuses to take the medications for HIV infection?
   a. Mix medications with chocolate syrup or pudding
   b. Mix the medications with milk or an essential food.
   c. Skip the dose of medication if the child protests too much.
   d. Mix the medication in a syringe, hold the child down firmly, and administer the medication.

   ANS: A

   Adding medication to a small amount of nonessential food the child finds tasty may be helpful in gaining the child's cooperation. Doses of medication should never be skipped. Fighting with the child or using force should be avoided. A nonessential food that will make the taste of the medication more palatable for the child should be the correct action. The administration of medications for the child with HIV becomes part of the family's everyday routine for years.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 944 OBJ: Nursing Process: Implementation

MSC: Client Needs: Physiologic Integrity

8. What is the primary nursing concern for a hospitalized child with HIV infection?
   a. Maintaining growth and development
   b. Eating foods that the family brings to the child
   c. Consideration of parental limitations and weaknesses
   d. Resting for 2 to 3 hours twice a day

   ANS: A
   Maintaining growth and development is a major concern for the child with HIV infection. Frequent monitoring for failure to thrive, neurologic deterioration, or developmental delay is important for HIV-infected infants and children. Nutrition, which contributes to a child's growth, is a nursing concern; however, it is not necessary for family members to bring food to the child. Although an assessment of parental strengths and weaknesses is important, it will be imperative for health care providers to focus on the parental strengths, not weaknesses. This is not as important as the frequent assessment of the child's growth and development. Rest is a nursing concern, but it is not as high a priority as maintaining growth and development. Rest periods twice a day for 2 to 3 hours may or may not be appropriate.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 940 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Health Promotion and Maintenance

9. What should the nurse include in a teaching plan for the mother of a toddler who will be taking prednisone for several months?
   a. The medication should be taken between meals.
   b. The medication needs to be discontinued if side effects appear.
   c. The medication should not be stopped abruptly.
   d. The medication may lower blood glucose.

   ANS: C
   The dosage must be tapered before the drug is discontinued to allow the gradual return of function in the pituitary-adrenal axis. Prednisone should be taken with food to minimize or prevent gastrointestinal bleeding. Although there are adverse effects from long-term steroid use, the medication must not be discontinued without consulting a physician. Acute adrenal insufficiency can occur if the medication is withdrawn abruptly. The dosage needs to be tapered. The medication puts the child at risk for hyperglycemia.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 948 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

10. Children receiving long-term systemic corticosteroid therapy are most at risk for which condition?
    a. Hypotension
    b. Dilation of blood vessels in the cheeks
    c. Growth delays
    d. Decreased appetite and weight loss

    ANS: C

Growth delay is associated with long-term steroid use. Hypertension is a clinical manifestation of long-term systemic steroid administration. Dilation of blood vessels in the cheeks is associated with an excess of topically administered steroids. Increased appetite and weight gain are clinical manifestations of excess systemic corticosteroid therapy.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 947 | Drug Guide Box OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

11. A 5-year-old child has acquired immunodeficiency syndrome (AIDS). What statement by the mother indicates good understanding of medications used for this condition?
    a. "When my child's pain increases, I double the recommended dosage of antiretroviral medication."
    b. "Addiction is a risk, so I only use the medication as ordered."
    c. "Doses of the antiretroviral medication are selected on the basis of my child's age and growth."
    d. "By the time my child is an adolescent she will not need her antiretroviral medications any longer."

    ANS: C
    Doses of antiretroviral medication to treat HIV infection for infants and children are based on individualized age and growth considerations. Antiretroviral medications are not administered for pain relief. Addiction is not a realistic concern with antiretroviral medications. Antiretroviral medications are still needed during adolescence.

    PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
    REF: p. 941 OBJ: Nursing Process: Evaluation
    MSC: Client Needs: Physiologic Integrity

12. Which intervention is appropriate for a child receiving high doses of steroids?
    a. Limit activity and receive home schooling.
    b. Increase the amount of carbohydrates in the diet.
    c. Substitute a killed virus vaccine for live virus vaccines.
    d. Monitor for seizure activity.

    ANS: C
    The child on high doses of steroids should not receive live virus vaccines because of immunosuppression. Limiting activity and home schooling are not routine for a child receiving high doses of steroids. Children on high doses of steroids sometimes get carbohydrate intolerance; the diet should not contain high levels of carbohydrates. Children on steroids are not typically at risk for seizures.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 947 | Drug Guide Box OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

13. The nurse observes a rash on a teen's face which is characteristic of systemic lupus erythematosus (SLE). What action by the nurse is most appropriate?
    a. Teach the teen about using sunscreen.
    b. Prepare the teen for a bone marrow biopsy.

c. Educate the teen on proper use of antibiotics.
d. Demonstrate how to use an Epi-pen.

ANS: A
The nurse needs to provide education on managing the disease; one facet includes minimizing sun exposure so the nurse teaches the teen about the correct use of sunscreen. The teen will not have a bone marrow biopsy, need antibiotics, or have to use an Epi-pen.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 950 | Figure 42.1 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

14. What is the primary nursing concern for a child having an anaphylactic reaction?
a. Identifying the offending allergen
b. Ineffective breathing pattern
c. Increased cardiac output
d. Positioning to facilitate comfort

ANS: B
Laryngospasms resulting in ineffective breathing patterns is a life-threatening manifestation of anaphylaxis. The primary action is to assess airway patency, respiratory rate and effort, level of consciousness, oxygen saturation, and urine output. Determining the cause of an anaphylactic reaction is important to implement the appropriate treatment, but the primary concern is the airway. During anaphylaxis, the cardiac output is decreased. Positioning for comfort is not a primary concern during a crisis.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 952 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

15. What is the drug of choice the nurse should administer in the acute treatment of anaphylaxis?
a. Diphenhydramine
b. Histamine inhibitor (cimetidine)
c. Epinephrine
d. Albuterol

ANS: C
Epinephrine is the first drug of choice in immediate treatment of anaphylaxis. Treatment must be initiated immediately because it may only be a matter of minutes before shock occurs. Diphenhydramine and cimetidine may be used, but the drug of choice is epinephrine. Albuterol is not usually indicated.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 952 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

16. What disorder is caused by a virus that primarily infects a specific subset of T lymphocytes, the $CD4^+$ T cells?
a. Raynaud phenomenon

b. Idiopathic thrombocytopenic purpura
c. Acquired immunodeficiency syndrome (AIDS)
d. Severe combined immunodeficiency disease

ANS: C
Acquired immunodeficiency is caused by the human immunodeficiency virus (HIV), which primarily attacks the $CD4^+$ T cells. The other disorders are not viral in nature.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 938 | Pathophysiology Box OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

17. A young child with HIV is receiving several antiretroviral drugs. What is the purpose of these drugs?
a. Cure the disease.
b. Delay disease progression.
c. Prevent the spread of disease.
d. Treat *Pneumocystis jiroveci* pneumonia.

ANS: B
Although not a cure, these antiviral drugs can suppress viral replication, preventing further deterioration of the immune system, and delay disease progression. At this time, cure is not possible. These drugs do not prevent the spread of the disease. *Pneumocystis jiroveci* prophylaxis is accomplished with antibiotics.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 940 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

18. The nurse is planning care for an adolescent with AIDS. The priority nursing goal is to
a. prevent infection.
b. prevent secondary cancers.
c. restore immunologic defenses.
d. identify sources of infection.

ANS: A
As a result of the immunocompromise that is associated with HIV infection, the prevention of infection is paramount. Preventing secondary cancers is not currently possible. Current drug therapy is affecting the disease progression; although not a cure, these drugs can suppress viral replication and prevent further deterioration. Case finding is not a priority nursing goal.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 939 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

19. A nurse is working in an allergy clinic and has performed skin testing on an adolescent. Seventeen minutes after the procedure, the nurse note the presence of a wheal at one of the sites. What conclusion does the nurse make about this response?
a. The child is allergic to that substance.

b. This result is indeterminate.
c. The testing should be redone in another location.
d. Anaphylaxis is imminent.

ANS: A
The presence of a wheal within 30 minutes of skin testing is indicative of an allergy to the substance used. The test does not need to be repeated, and anaphylaxis is not imminent.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 937 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. The mother of an HIV-positive infant who is 2 months old questions the nurse about which childhood immunizations her child will be able to receive. Which immunizations should an HIV-positive child be able to receive? (*Select all that apply.*)
   a. Hepatitis B
   b. DTaP
   c. MMR
   d. IPV
   e. HIB

   ANS: A, B, D, E
   Routine immunizations are appropriate. The MMR vaccination is not given at 2 months of age. If it were indicated, $CD4^+$ counts are monitored when deciding whether to provide live virus vaccines. If the child is severely immunocompromised, the MMR vaccine is not given. The varicella vaccine can be considered on the basis of the child's $CD4^+$ counts. Only IPV should be used for HIV-infected children.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 941 | Table 42.1 OBJ: Nursing Process: Planning
   MSC: Client Needs: Health Promotion and Maintenance

2. Which home care instructions should the nurse provide to the parents of a child with acquired immunodeficiency syndrome (AIDS)? (*Select all that apply.*)
   a. Give supplemental vitamins as prescribed.
   b. Yearly influenza vaccination should be avoided.
   c. Administer any antibiotics as prescribed.
   d. Notify the provider if the child develops a cough or congestion.
   e. Missed doses of antiretroviral medication should just be skipped.

   ANS: A, C, D
   The parents are taught that vitamins are important, to have the child take all antibiotics (if prescribed) as ordered, and to notify the provider of coughs or congestion. The child should have yearly influenza vaccination, and if missed medication doses are noticed close to their scheduled time, they should be taken.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: pp. 942-944 | Nursing Care Plan OBJ: Integrated Process: Teaching-Learning

MSC: Client Needs: Physiologic Integrity

COMPLETION

1. A child weighs 30.8 pounds and is prescribed prednisolone syrup 0.5 mg/kg. The pharmacy delivers a syringe with 15 mg/5 mL. How many mL does the nurse administer? Round your answer to the nearest 10th.

   ANS:
   2.3333 mL or 2.3 mL

   First find the weight in kilograms: 30.8/2.2 = 14
   kg Multiply 0.5 × 14 = 7 mg
   Set up equation: 15 mg 7
   mg 5 mL = x mL
   Solve for x: 15x = (7 × 5) =
   35 x = 35/15 = 2.333333 mL

   PTS 1

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 947 | Drug Guide Box OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. What is the best response by the nurse to a mother asking about the cause of her infant's bilateral cleft lip?
   a. "Did you use alcohol during your pregnancy?"
   b. "Does anyone in your family have a cleft lip or palate?"
   c. "This defect is associated with intrauterine infection during the second trimester."
   d. "The prevalent of cleft lip is higher in Caucasians."

   ANS: B
   Cleft lip and palate result from embryonic failure resulting from multiple genetic and environmental factors. A genetic pattern or familial risk seems to exist. Tobacco during pregnancy (not drinking) has been associated with bilateral cleft lip. The defect occurred at approximately 6 to 8 weeks of gestation. Second-trimester intrauterine infection is not a known cause of bilateral cleft lip. The prevalence of cleft lip and palate is higher in Asian and Native American populations.

   PTS: 1 DIF: Cognitive Level: Application/Application
   REF: p. 960 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

2. The postoperative care plan for an infant with surgical repair of a cleft lip includes
   a. a clear liquid diet for 72 hours.
   b. nasogastric feedings until the sutures are removed.
   c. elbow restraints to keep the infant's fingers away from the mouth.
   d. rinsing the mouth after every feeding.

   ANS: C
   Keeping the infant's hands away from the incision reduces potential complications at the surgical site. The infant's diet is advanced from clear liquid to soft foods within 48 hours of surgery. After surgery, the infant can resume preoperative feeding techniques. Rinsing the mouth after feeding is an inappropriate intervention. Feeding a small amount of water after feedings will help keep the mouth clean. A cleft lip repair site should be cleansed with a wet sterile cotton swab after feedings.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 962 | Patient-Centered Teaching Box OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

3. The nurse is caring for a neonate with a suspected tracheoesophageal fistula (TEF). Nursing care should include which of the following?
   a. Elevating the head but give nothing by mouth
   b. Elevating the head for feedings
   c. Feeding glucose water only
   d. Avoiding suction unless infant is cyanotic

   ANS: A

When a newborn is suspected of having TEF, the most desirable position is supine with the head elevated on an incline plane of at least 30 degrees. It is imperative that any source of aspiration be removed at once; oral feedings are withheld. Feedings should not be given to infants suspected of having TEF. The oral pharynx should be kept clear of secretion by oral suctioning. This is to avoid cyanosis that is usually the result of laryngospasm caused by overflow of saliva into the larynx.

PTS: 1 DIF: Cognitive Level: Analysis REF: p. 966
OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

4. A nurse is teaching a group of parents about TEF. Which statement made by the nurse is accurate about TEF?
   a. This defect results from an embryonal failure of the foregut to differentiate into the trachea and esophagus.
   b. It is a fistula between the esophagus and stomach that results in the oral intake being refluxed and aspirated.
   c. An extra connection between the esophagus and trachea develops because of genetic abnormalities.
   d. The defect occurs in the second trimester of pregnancy.

   ANS: A
   When the foregut does not differentiate into the trachea and esophagus during the fourth to fifth week of gestation, a TEF occurs. A TEF is an abnormal connection between the esophagus and trachea. There is no connection between the trachea and esophagus in normal fetal development. This defect occurs early in pregnancy during the fourth to fifth week of gestation.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 965 | Pathophysiology Box OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

5. What maternal assessment is related to an infant's diagnosis of TEF?
   a. Maternal age more than 40 years
   b. First term pregnancy for the mother
   c. Maternal history of polyhydramnios
   d. Complicated pregnancy

   ANS: C
   A maternal history of polyhydramnios is associated with TEF. Advanced maternal age, first term pregnancy, or complicated pregnancy are not related.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 962 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

6. What clinical manifestation should a nurse be alert for when suspecting a diagnosis of esophageal atresia?
   a. A radiograph in the prenatal period indicates abnormal development.
   b. It is visually identified at the time of delivery.
   c. A nasogastric tube fails to pass at birth.
   d. The infant has a low birth weight.

ANS: C
Atresia is suspected when a nasogastric tube fails to pass 10 to 11 cm beyond the gum line. Abdominal radiographs will confirm the diagnosis. Prenatal radiographs do not provide a definitive diagnosis. The defect is not externally visible. Bronchoscopy and endoscopy can be used to identify this defect. Infants with esophageal atresia may have been born prematurely and with a low birth weight, but neither is suggestive of the presence of an esophageal atresia.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 962 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

7. What is the most important information to be included in the discharge planning for an infant with gastroesophageal reflux?
   a. Teach parents to position the infant on the left side.
   b. Reinforce the parents' knowledge of the infant's developmental needs.
   c. Teach the parents how to do infant cardiopulmonary resuscitation (CPR).
   d. Have the parents keep an accurate record of intake and output.

   ANS: C
   Risk of aspiration is a priority nursing diagnosis for the infant with gastroesophageal reflux. The parents must be taught infant CPR. Correct positioning minimizes aspiration. The correct position for the infant is supine for sleeping unless the risk of aspiration is great. Knowledge of developmental needs should be included in discharge planning for all hospitalized infants, but it is not the most important in this case. Keeping a record of intake and output is not a priority and may not be necessary.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 971 OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

8. What information should the nurse include when teaching the parents of a 5-week-old infant about pyloromyotomy?
   a. The infant will be in the hospital for a week.
   b. The surgical procedure is routine and "no big deal."
   c. The prognosis for complete correction with surgery is good.
   d. They will need to ask the physician about home care nursing.

   ANS: C
   Pyloromyotomy is the definitive treatment for pyloric stenosis. Prognosis is good with few complications. These comments reassure parents. The infant will remain in the hospital for a day or two postoperatively. Although the prognosis for surgical correction is good, telling the parents that surgery is "no big deal" minimizes the infant's condition. Home care nursing is not necessary after a pyloromyotomy.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 984 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

9. A nurse has admitted a child to the hospital with a diagnosis of "rule out" peptic ulcer disease. Which test will the nurse expect to be ordered to confirm the diagnosis of a peptic ulcer?
   a. A dietary history

b. A positive Hematest result on a stool sample
c. A fiberoptic upper endoscopy
d. An abdominal ultrasound

ANS: C
Endoscopy provides direct visualization of the stomach lining and confirms the diagnosis of peptic ulcer. Dietary history may yield information suggestive of a peptic ulcer. Blood in the stool indicates a gastrointestinal abnormality, but it does not conclusively confirm a diagnosis of peptic ulcer. An abdominal ultrasound is used to rule out other gastrointestinal alterations such as gallstones, tumor, or mechanical obstruction.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 975 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

10. What should the nurse teach a school-age child and his parents about the management of ulcer disease?
a. Eat a bland, low-fiber diet in small, frequent meals.
b. Eat three balanced meals a day with no snacking between meals.
c. The child needs to eat alone in a quiet spot to avoid stress.
d. Do not give antacids 1 hour before or after antiulcer medications.

ANS: D
Antacids can interfere with antiulcer medication if given less than 1 hour before or after antiulcer medications. A bland diet is not indicated for ulcer disease. The diet should be a regular diet that is low in caffeine, and the child should eat a meal or snack every 2 to 3 hours. The child should eat every 2 to 3 hours. Eating alone is not indicated.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 976 | Parents Want to Know Box
OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

11. What is the major focus of the therapeutic management for a child with lactose intolerance?
a. Compliance with the medication regimen
b. Providing emotional support to family members
c. Teaching dietary modifications
d. Administration of daily normal saline enemas

ANS: C
Simple dietary modifications are effective in management of lactose intolerance. Symptoms of lactose intolerance are usually relieved after instituting a lactose-free diet. Medications are not typically ordered in the management of lactose intolerance. Providing emotional support to family members is not specific to this medical condition. Diarrhea is a manifestation of lactose intolerance. Enemas are contraindicated for this alteration in bowel elimination.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 990 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

12. The child with lactose intolerance is most at risk for which imbalance? a. Hyperkalemia

b. Hypoglycemia
c. Hyperglycemia
d. Hypocalcemia

ANS: D
Because high-calcium dairy products containing lactose are restricted from the child's diet, alternative sources such as egg yolk, green leafy vegetables, dried beans, and cauliflower must be provided to prevent hypocalcemia. The child with lactose intolerance is not at risk for hyperkalemia. Lactose intolerance does not affect glucose metabolism. Hyperglycemia does not result from ingestion of a lactose-free diet.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 990 | Parents Want to Know Box
OBJ: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

13. What food choice by the parent of a 2-year-old child with celiac disease indicates a need for further teaching?
a. Oatmeal
b. Rice cake
c. Corn muffin
d. Meat patty

ANS: A
The child with celiac disease is unable to fully digest gluten, the protein found in wheat, barley, rye, and oats. Oatmeal contains gluten and is not an appropriate food selection. Rice, corn, and meat are appropriate selections.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 991 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Physiologic Integrity

14. Which assessment finding should the nurse expect in an infant with Hirschsprung disease?
a. "Currant jelly" stools
b. Constipation with passage of foul-smelling, ribbon-like stools
c. Foul-smelling, fatty stools
d. Diarrhea

ANS: B
Constipation results from absence of ganglion cells in the rectum and colon and is present since the neonatal period with passage of frequent foul-smelling, ribbon-like, or pellet-like stools. "Currant jelly" stools are associated with intussusception. Foul-smelling, fatty stools are associated with cystic fibrosis and celiac disease. Diarrhea is not typically associated with Hirschsprung disease but may result from impaction.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 987 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

15. What is an expected outcome for the parents of a child with encopresis?
a. The parents will give the child an enema daily for 3 to 4 months.
b. The family will develop a plan to achieve control over incontinence.
c. The parents will have the child launder soiled clothes.

d. The parents will supply the child with a low-fiber diet.

ANS: B
Parents of the child with encopresis often feel guilty and believe that encopresis is willful on the part of the child. The family functions effectively by openly discussing problems and developing a plan to achieve control over incontinence. Stool softeners or laxatives, along with dietary changes, are typically used to treat encopresis. Enemas are indicated when a fecal impaction is present. This action is a punishment and will increase the child's shame and embarrassment. The child should not be punished for an action that is not willful. Increasing fiber in the diet and fluid intake results in greater bulk in the stool, making it easier to pass.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 973 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Physiologic Integrity

16. Which intervention should be included in the nurse's plan of care for a 7-year-old child with encopresis who has cleared the initial impaction?
a. Have the child sit on the toilet for 30 minutes when he gets up in the morning and at bedtime.
b. Increase caffeine in the child's diet to promote bowel elimination.
c. Use a Fleet enema daily.
d. Give the child a choice of beverage to mix with a laxative.

ANS: D
Offering realistic choices is helpful in meeting the school-age child's sense of control. To facilitate bowel elimination, the child should sit on the toilet for 5 to 10 minutes after breakfast and dinner. Caffeine to stimulate the bowels is not recommended. Daily Fleet enemas can result in hypernatremia and hyperphosphatemia and are used only during periods of fecal impaction.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 972 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

17. A child has irritable bowel syndrome. The nurse is teaching the parents about the pathophysiology associated with the symptoms their child is experiencing. Which response indicates to the nurse that teaching has been effective?
a. "My child has an absence of ganglion cells in the rectum causing alternating diarrhea and constipation."
b. "The cause of my child's diarrhea and constipation is disorganized intestinal contractility."
c. "My child has an intestinal obstruction; that's why he has abdominal pain."
d. "My child has an intolerance to gluten, and this causes him to have abdominal pain."

ANS: B
Disorganized contractility and increased mucous production are precipitating factors of irritable bowel disease. The absence of ganglion cells in the rectum is associated with Hirschsprung disease. Intestinal obstruction is associated with pyloric stenosis. Intolerance to gluten is the underlying cause of celiac disease.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating

REF: p. 974 | Pathophysiology Box OBJ: Nursing Process: Evaluation
MSC: Client Needs: Physiologic Integrity

18. What is an expected outcome for the child with irritable bowel disease?
    a. Decreasing symptoms
    b. Adherence to a low-fiber diet
    c. Increasing milk products in the diet
    d. Adapting the lifestyle to the lifelong problems

    ANS: A
    Management of irritable bowel disease is aimed at identifying and decreasing exposure to triggers and decreasing bowel spasms, which will decrease symptoms. Management includes maintenance of a healthy, well -balanced, moderate-fiber, lower fat diet. A moderate amount of fiber in the diet is indicated for the child with irritable bowel disease. No modification in dairy products is necessary unless the child is lactose intolerant. Irritable bowel syndrome is typically self-limiting and resolves by age 20 years.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 974 | Pathophysiology Box OBJ: Nursing Process: Evaluation
    MSC: Client Needs: Physiologic Integrity

19. After an infant is born the nurse notices that the child has herniation of abdominal viscera into the base of the umbilical cord. What will the nurse document about this condition?
    a. Diaphragmatic hernia
    b. Umbilical hernia
    c. Gastroschisis
    d. Omphalocele

    ANS: D
    Omphalocele is the herniation of the abdominal viscera into the base of the umbilical cord. This does not describe a diaphragmatic hernia, umbilical hernia, or gastroschisis.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 968 | Table 43.2 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

20. What is an appropriate statement for the nurse to make to parents of a child who has had a barium enema to correct an intussusception?
    a. “I will call the physician when the baby passes his first stool.”
    b. “I am going to dilate the anal sphincter with a gloved finger to help the baby pass the barium.”
    c. “Your baby can’t have anything to eat or drink until bowel function returns.”
    d. “Add cereal to the baby’s formula to help him pass the barium.”

    ANS: C
    Post procedure, the child is kept NPO until bowel function returns. The physician does not need to be notified when the infant passes the first stool. Dilating the anal sphincter is not appropriate for the child after a barium enema.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 987 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

21. A baby is scheduled for abdominal surgery for hypertrophic pyloric stenosis and has an NG tube to intermittent suction. When the family asks why the child has the tube, what response by the nurse is best?
    a. "The nasogastric tube decompresses the abdomen and decreases vomiting."
    b. "We can keep a more accurate measure of intake and output with the tube."
    c. "The tube is used to decrease postoperative diarrhea."
    d. "The nasogastric tube makes the baby more comfortable after surgery."

    ANS: A
    The nasogastric tube provides decompression and decreases vomiting. A nursing responsibility when a patient has a nasogastric tube is measurement of accurate intake and output, but this is not why nasogastric tubes are inserted. Nasogastric tube placement does not decrease diarrhea. The presence of a nasogastric tube can be perceived as a discomfort by the patient.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 984 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

22. Which description of a stool is characteristic of intussusception?
    a. Ribbon-like stools
    b. Hard stools positive for guaiac
    c. "Currant jelly" stools
    d. Loose, foul-smelling stools

    ANS: C
    The characteristic stool of intussusception is described as "currant jelly." Ribbon-like stools are characteristic of Hirschsprung disease. With intussusception, passage of bloody mucous stools occurs. Stools will not be hard. Loose, foul-smelling stools may indicate infectious gastroenteritis.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 985 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

23. What is a priority concern for a 14-year-old child with inflammatory bowel disease?
    a. Compliance with antidiarrheal medication therapy
    b. Long-term complications
    c. Dealing with the embarrassment and stress of diarrhea
    d. Home schooling due to extreme absenteeism

    ANS: C
    Embarrassment and stress from chronic diarrhea are real concerns for the adolescent with inflammatory bowel disease. Antidiarrheal medications are not typically ordered for a child with inflammatory bowel disease. Long-term complications are not a priority concern for the adolescent with inflammatory bowel disease. Exacerbations may interfere with school attendance, but home schooling is not a usual consideration for the adolescent with inflammatory bowel disease.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 982 OBJ: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

24. Which statement about Crohn disease is the most accurate?
    a. The signs and symptoms of Crohn disease are usually present at birth.
    b. Signs and symptoms of Crohn disease include cramping, diarrhea, and weight loss.
    c. Edema usually accompanies this disease.
    d. Symptoms of Crohn disease usually disappear by late adolescence.

    ANS: B
    Common manifestations of Crohn disease include abdominal cramping, diarrhea, and weight loss. Signs and symptoms are not usually present at birth. Edema does not accompany this disease. Symptoms do not typically disappear by adolescence.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 981 | Table 43.4 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

25. Therapeutic management of the child with acute diarrhea and dehydration usually begins with
    a. clear liquids.
    b. IV solutions while the child is NPO.
    c. oral rehydration solution (ORS).
    d. antidiarrheal medications.

    ANS: C
    Orally administered rehydration solution is the first treatment for acute diarrhea. Clear liquids are not recommended because they contain too much sugar, which may contribute to diarrhea. The child might need an IV but would not be NPO. Antidiarrheals are not recommended because they do not get rid of pathogens.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 978 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

26. What is the most important action to prevent the spread of gastroenteritis in a daycare setting?
    a. Administering prophylactic medications to children and staff
    b. Frequent handwashing
    c. Having parents bring food from home
    d. Directing the staff to wear gloves at all times

    ANS: B
    Handwashing is the most the important measure to prevent the spread of infectious diarrhea. Prophylactic medications are not helpful in preventing gastroenteritis. Bringing food from home will not prevent the spread of infectious diarrhea. Gloves should be worn when changing diapers, soiled clothing, or linens. They do not need to be worn for interactions that do not involve contact with secretions. Handwashing after contact is indicated.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 976 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Safe and Effective Care Environment

27. What is an expected outcome for a 1-month-old infant with biliary atresia? a. Correction of the defect with the Kasai procedure

b. Adequate nutrition and age-appropriate growth and development
c. Adherence to a salt-free diet with vitamin B_{12} supplementation
d. Remaining compliant with a high-protein diet

ANS: B
Adequate nutrition, preventing skin breakdown, adequate growth and development, and family education and support are expected outcomes in an infant with biliary atresia. The goal of the Kasai procedure is to allow for adequate growth until a transplant can be done. It is not a curative procedure. Vitamin B_{12} supplementation is not indicated. A salt-restricted diet is appropriate. Protein intake may need to be restricted to avoid hepatic encephalopathy.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 997 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

28. Which assessment finding is the most significant to report to the physician for a child with cirrhosis?
a. Weight loss
b. Change in level of consciousness
c. Skin with pruritus
d. Black, foul-smelling stools

ANS: B
The child with cirrhosis must be assessed for encephalopathy, which is characterized by a change in level of consciousness. Encephalopathy can result from a buildup of ammonia in the blood from the incomplete breakdown of protein. One complication of cirrhosis is ascites. The child needs to be assessed for increasing abdominal girth and edema. A child who is retaining fluid will not exhibit weight loss. Biliary obstruction can lead to pruritus, which is a frequent finding. An alteration in the level of consciousness is of higher priority. Black, tarry stools may indicate blood in the stool. This needs be reported to the physician. This is not a higher priority than a change in level of consciousness.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 999 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

29. Which nursing diagnosis has the highest priority for the toddler with celiac disease?
a. Disturbed Body Image related to chronic constipation
b. Risk for Disproportionate Growth related to obesity
c. Excess Fluid Volume related to celiac crisis
d. Imbalanced Nutrition: Less than Body Requirements related to malabsorption

ANS: D
Imbalanced Nutrition: Less than Body Requirements is the highest priority nursing diagnosis because celiac disease causes gluten enteropathy, a malabsorption condition. A psychosocial diagnosis (Disturbed Body Image) would not take priority over a physical diagnosis. Celiac disease causes disproportionate growth and development associated with malnutrition, not obesity. Celiac crisis causes deficient fluid volume.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 992 OBJ: Nursing Process: Diagnosis
MSC: Client Needs: Physiologic Integrity

30. The nurse notes on assessment that a 1-year-old child is underweight, with abdominal distention, thin legs and arms, and foul-smelling stools. The nurse suspects failure to thrive is associated with
    a. Celiac disease
    b. Intussusception
    c. Irritable bowel syndrome
    d. Imperforate anus

    ANS: A
    These are classic symptoms of celiac disease. They are not related to intussusception, irritable bowel syndrome, or an imperforate anus.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 991 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

31. The nurse caring for a child with suspected appendicitis should question which order from the physician?
    a. Keep patient NPO.
    b. Start IV of D_5/0.45 normal saline at 60 mL/hr.
    c. Apply K-pad to abdomen prn for pain.
    d. Obtain CBC on admission to nursing unit.

    ANS: C
    A K-pad (moist heat device) is contraindicated for suspected appendicitis because it may contribute to the rupture of the appendix. NPO status, an IV, and a CBC are all appropriate for this child.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 980 OBJ: Integrated Process: Communication and Documentation
    MSC: Client Needs: Physiologic Integrity

32. Which order should the nurse question when caring for a 5-year-old child after surgery for Hirschsprung disease?
    a. Monitor rectal temperature every 4 hours.
    b. Assess stools after surgery.
    c. Keep the child NPO until bowel sounds return.
    d. Maintain IV fluids at ordered rate.

    ANS: A
    Rectal temperatures should not be taken after this surgery. Rectal temperatures are generally not the route of choice for children because of the route's traumatic nature. The other interventions are all appropriate after this operation.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 989 OBJ: Integrated Process: Communication and Documentation
    MSC: Client Needs: Physiologic Integrity

33. Which parasite causes acute diarrhea?
    a. *Shigella* organisms
    b. *Salmonella* organisms

c. *Giardia lamblia*
d. *Escherichia coli*

ANS: C
Giardiasis a parasite that represents 15% of nondysenteric illness in the United States. The other organisms are bacterial.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 977 | Table 43.3 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

34. What goal has the highest priority for a child with malabsorption associated with lactose intolerance?
a. The child will experience no abdominal spasms.
b. The child will not experience constipation and malabsorption syndrome.
c. The child will not experience diarrhea associated with malabsorption syndrome.
d. The child will receive adequate nutrition as evidenced by a weight gain of 1 kg/week.

ANS: C
The child with lactose intolerance will have diarrhea and malabsorption, so a good goal would be no longer having these manifestations. A child usually has abdominal cramping pain and distention rather than spasms. The child usually has diarrhea, not constipation. One kilogram every week may or may not be appropriate depending on the child's age and how long the goal is in place for.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 990 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

35. What should the nurse stress in a teaching plan for the mother of an 11-year-old boy with ulcerative colitis?
a. Preventing the spread of illness to others
b. Nutritional guidance and preventing constipation
c. Teaching daily use of enemas
d. Coping with stress and avoiding triggers

ANS: D
Coping with the stress of chronic illness and the clinical manifestations associated with ulcerative colitis (diarrhea, pain) are important teaching foci. Avoidance of triggers can help minimize the impact of the disease and its effect on the child. Ulcerative colitis is not infectious. Enemas are not used in this disease.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 982 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

36. Careful handwashing before and after contact can prevent the spread of which condition in daycare and school settings?
a. Irritable bowel syndrome
b. Ulcerative colitis
c. Hepatic cirrhosis

d. Hepatitis A

ANS: D
Hepatitis A is spread person to person, by the fecal-oral route, and through contaminated food or water. Good handwashing is critical in preventing its spread. The virus can survive on contaminated objects for weeks. The other conditions are not contagious.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 994 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

37. Which viral pathogen frequently causes acute diarrhea in young children?
a. *Giardia* organisms
b. *Shigella* organisms
c. Rotavirus
d. *Salmonella* organisms

ANS: C
Rotavirus is the most frequent viral pathogen that causes diarrhea in young children. The other organisms are bacterial.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 977 | Table 43.3 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

38. A stool specimen from a child with diarrhea shows the presence of neutrophils and red blood cells. This is most suggestive of
a. protein intolerance.
b. parasitic infection.
c. fat malabsorption.
d. bacterial gastroenteritis.

ANS: D
Neutrophils and red blood cells in stool indicate bacterial gastroenteritis. This does not signify protein intolerance, a parasitic infection, or fat malabsorption.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 976 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

39. A school-age child with diarrhea has been rehydrated. The nurse is discussing the child's diet with the family. Which statement by the parent indicates a correct understanding of the teaching?
a. "I will keep my child on a clear liquid diet for the next 24 hours."
b. "I should encourage my child to drink carbonated drinks but avoid food for the next 24 hours."
c. "I will offer my child bananas, rice, applesauce, and toast for the next 48 hours."
d. "I should have my child eat a normal diet with easily digested foods for the next 48 hours."

ANS: D

Easily digested foods such as cereals, cooked vegetables, and meats should be provided for the child. Early reintroduction of nutrients is desirable. Continued feeding or reintroduction of a regular diet has no adverse effects and actually lessens the severity and duration of the illness. Clear liquids and carbonated drinks have high carbohydrate content and few electrolytes. Caffeinated beverages should be avoided because caffeine is a mild diuretic. The BRAT diet (bananas, rice, applesauce, and toast) is no longer recommended.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 978 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Physiologic Integrity

40. Therapeutic management of most children with Hirschsprung disease is primarily
    a. daily enemas.
    b. low-fiber diet.
    c. permanent colostomy.
    d. surgical removal of the affected section of the bowel.

    ANS: D
    Most children with Hirschsprung disease require surgical rather than medical management. Surgery is done to remove the aganglionic portion of the bowel, relieve obstruction, and restore normal bowel motility and function of the internal anal sphincter. Preoperative management may include enemas and a low-fiber, high-calorie, high- protein diet, until the child is physically ready for surgery. The colostomy that is created in Hirschsprung disease is usually temporary.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 988 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

41. A 4-month-old infant has gastroesophageal reflux (GER) but is thriving without other complications. What should the nurse suggest to minimize reflux?
    a. Place in the Trendelenburg position after eating.
    b. Thicken formula with rice cereal.
    c. Give continuous nasogastric tube feedings.
    d. Give larger, less frequent feedings.

    ANS: B
    Small frequent feedings of formula combined with 1 teaspoon to 1 tablespoon of rice cereal per ounce of formula have been recommended. Milk thickening agents have been shown to decrease the number of episodes of vomiting and to increase the caloric density of the formula. This may benefit infants who are underweight as a result of GERD. Placing the child in a Trendelenburg position increases the reflux. Continuous nasogastric feedings are reserved for infants with severe reflux and failure to thrive. Smaller, more frequent feedings are recommended in reflux.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 970 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

42. A histamine-receptor antagonist such as cimetidine (Tagamet) or ranitidine (Zantac) is ordered for an infant with GER. What is the purpose of these drugs?

a. Prevent reflux
b. Prevent hematemesis
c. Reduce gastric acid production
d. Increase gastric acid production

ANS: C
The mechanism of action of histamine-receptor antagonists is to reduce the amount of acid present in gastric contents and to prevent esophagitis.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 970 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

43. What is used to treat moderate to severe inflammatory bowel disease?
a. Antacids
b. Antibiotics
c. Corticosteroids
d. Antidiarrheal medications

ANS: C
Corticosteroids, such as prednisone and prednisolone, are used in short bursts to suppress the inflammatory response in inflammatory bowel disease. Antacids and antidiarrheals are not used. Antibiotics may be used to treat complications.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 981 | Table 43.4 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

44. Bismuth subsalicylate, clarithromycin, and metronidazole are prescribed for a child with a peptic ulcer for what purpose?
a. Eradicate *Helicobacter pylori*
b. Coat gastric mucosa
c. Treat epigastric pain
d. Reduce gastric acid production

ANS: A
This combination of drug therapy is effective in the treatment of *H. pylori*, the most common cause of ulcers in children.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 975 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

45. Which statement best characterizes hepatitis A?
a. Incubation period is 6 weeks to 6 months.
b. Principal mode of transmission is through the parenteral route.
c. Onset is usually rapid and acute.
d. There is a persistent carrier state.

ANS: C

Hepatitis A is characterized by a rapid acute onset. The incubation period is approximately 3 weeks for hepatitis A. The principal mode of transmission for hepatitis A is the fecal-oral route. Hepatitis A does not have a carrier state.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 994 | Table 43.5 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

46. Which treatment provides the best chance of survival for a child with cirrhosis?
    a. Liver transplantation
    b. Treatment with corticosteroids
    c. Treatment with immune globulin
    d. Provision of nutritional support

ANS: A
The only successful treatment for end-stage liver disease and liver failure may be liver transplantation, which has improved the prognosis for many children with cirrhosis.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1000 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

47. The earliest clinical manifestation of biliary atresia is
    a. jaundice.
    b. vomiting.
    c. hepatomegaly.
    d. absence of stooling.

ANS: A
Jaundice is the earliest and most striking manifestation of biliary atresia. It is first observed in the sclera, may be present at birth, but is usually not apparent until age 2 to 3 weeks. Vomiting is not associated with biliary atresia. Hepatomegaly and abdominal distention are common but occur later. Stools are large and lighter in color than expected because of the lack of bile.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 997 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

48. Which type of hernia has an impaired blood supply to the herniated organ?
    a. Hiatal hernia
    b. Incarcerated hernia
    c. Omphalocele
    d. Strangulated hernia

ANS: D
A strangulated hernia is one in which the blood supply to the herniated organ is impaired. A hiatal hernia is the intrusion of an abdominal structure, usually the stomach, through the esophageal hiatus. An incarcerated hernia is a hernia that cannot be reduced easily. Omphalocele is the protrusion of intraabdominal viscera into the base of the umbilical cord. The sac is covered with peritoneum and not skin.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering

REF: p. 967 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

49. An infant with short bowel syndrome will be discharged home on total parenteral nutrition (TPN) and gastrostomy feedings. Nursing care should include
    a. preparing family for impending death.
    b. teaching family signs of central venous catheter infection.
    c. teaching family how to calculate caloric needs.
    d. securing TPN and gastrostomy tubing under the diaper to lessen risk of dislodgment.

    ANS: B
    During TPN therapy, care must be taken to minimize the risk of complications related to the central venous access device, such as catheter infections, occlusions, or accidental removal. This is an important part of family teaching. The prognosis for patients with short bowel syndrome depends in part on the length of residual small intestine. It has improved with advances in TPN. Although parents need to be taught about nutritional needs, the caloric needs and prescribed TPN and rate are the responsibility of the health care team. The tubes should not be placed under the diaper due to risk of infection.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 993 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

50. A nurse is teaching a student nurse in the pediatric clinic about vomiting in children. The nurse states that getting parents to estimate the amount a child has vomited is quite difficult. What is the best explanation for this problem?
    a. Parents are too upset by the vomiting to pay close attention.
    b. Parents don’t know how to accurately estimate the amount.
    c. Descriptions about vomitus are vague and non-specific.
    d. Infants and small children often swallow the vomitus.

    ANS: C
    Descriptive words used to describe vomitus are often vague and used inconsistently. The astute nurse uses specific questions to elicit the most accurate information. See Nursing Quality Alert Box 43-2 for examples of good questions to ask. Parents may or may not be too upset to pay attention. It is belittling to state that parents don’t know how to estimate amounts. Infants and children may swallow some vomitus, but that is not the main problem.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 984 | Nursing Quality Alert Box OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. The nurse has educated the parents of a child with celiac disease on diet modifications. Which food choices by the child’s parents indicate understanding of teaching? (*Select all that apply*.)
    a. Oatmeal
    b. Steamed rice
    c. Corn on the cob
    d. Baked chicken

e. Peanut butter and jelly sandwich on wheat bread

ANS: B, C, D
Rice, corn, and chicken do not contain gluten and so are appropriate choices. Oatmeal and wheat bread are not.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 991 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Physiologic Integrity

2. Which nursing interventions are significant for a child with cirrhosis who is at risk for bleeding? (*Select all that apply*.)
   a. Guaiac all stools
   b. Provide a safe environment
   c. Administer vitamin K
   d. Inspect skin for pallor and cyanosis
   e. Monitor serum liver panels

   ANS: A, B, C
   Identification of bleeding includes stool guaiac testing, which can detect if blood is present in the stool; protecting the child from injury by providing a safe environment; administering vitamin K to prevent bleeding episodes; and avoiding injections.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 1000 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

3. Which interventions should a nurse implement when caring for a child with hepatitis? (*Select all that apply*.)
   a. Provide a well-balanced low-fat diet.
   b. Schedule playtime in the playroom with other children.
   c. Teach parents not to administer any over-the-counter medications.
   d. Arrange for home schooling because the child will not be able to return to school.
   e. Instruct parents on the importance of good handwashing.

   ANS: A, C, E
   The child with hepatitis should be placed on a well-balanced low-fat diet. Parents should be taught to not give over-the-counter medications because of impaired liver function. Hand hygiene is the most important preventive measure for the spread of hepatitis. The child will be in contact isolation in the hospital so playtime with other hospitalized children is not scheduled. The child will be on contact isolation for a minimum of 1 week after the onset of jaundice. After that period, the child will be allowed to return to school.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: pp. 996-997 | Nursing Care Plan OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

4. The nurse is providing home care instructions to the parents of an infant being discharged after repair of a bilateral cleft lip. Which instructions should the nurse include? (*Select all that apply*.)
   a. Acetaminophen (Tylenol) should not be given to your infant.
   b. Feed your infant in an upright position.

c. Place your infant prone for a period of time each day.
d. Burp your child frequently during feedings.
e. Apply antibiotic ointment to the lip as prescribed.

ANS: B, D, E
After cleft lip surgery the parents are taught to feed the infant in an upright position to decrease the chance of choking. The parents are taught to burp the infant frequently during feedings because excess air is often swallowed. Parents are taught to cleanse the suture line area with a cotton swab using a rolling motion and apply antibiotic ointment with the same technique. Tylenol is used for pain, and the child should never be placed prone as this position can damage the suture line.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 961 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

5. The nurse cares for many children with different types of hepatitis. What information about this disease is correct? (*Select all that apply.*)
a. Hepatitis A can be contracted from contaminated water.
b. Only a small percentage of children infected with hepatitis B fully recover.
c. People infected with chronic hepatitis C are usually asymptomatic.
d. Hepatitis D is the most likely to cause a fulminating illness.
e. Hepatitis E is the most common type in children in the United States.

ANS: A, C, D
Hepatitis A can be contracted from contaminated food or water. Hepatitis C infections usually are asymptomatic. Hepatitis D is the strain most likely to cause a fulminating illness. Most children with hepatitis B recover fully. Hepatitis E is rate in the United States.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 994 | Table 43.5 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. Which statement by a school-age girl indicates the need for further teaching about the prevention of urinary tract infections (UTIs)?
   a. "I always wear cotton underwear."
   b. "I really enjoy taking a bubble bath."
   c. "I go to the bathroom every 3 to 4 hours."
   d. "I drink four to six glasses of fluid every day."

   ANS: B
   Bubble baths should be avoided because they tend to cause urethral irritation, which leads to UTI. It is desirable to wear cotton rather than nylon underwear. Nylon tends to hold in moisture and promote bacterial growth, whereas cotton absorbs moisture. Children should be encouraged to urinate at least four times a day. An adequate fluid intake prevents the buildup of bacteria in the bladder.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: p. 1009 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Health Promotion and Maintenance

2. The nurse assessing a child with acute poststreptococcal glomerulonephritis should be alert for which finding?
   a. Increased urine output
   b. Hypotension
   c. Tea-colored urine
   d. Weight gain

   ANS: C
   Acute poststreptococcal glomerulonephritis is characterized by hematuria, proteinuria, edema, and renal insufficiency. Tea-colored urine is an indication of hematuria. In acute poststreptococcal glomerulonephritis the urine output may be decreased. In acute poststreptococcal glomerulonephritis blood pressure may be increased. Edema may be noted around the eyelids and ankles in patients with acute post streptococcal glomerulonephritis and can contribute to weight gain; however, weight gain is associated more with nephrotic syndrome.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1016 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. The mother of a child who was recently diagnosed with acute glomerulonephritis asks the nurse why the physician keeps talking about "casts" in the urine. The nurse explains that casts in the urine indicate
   a. glomerular injury.
   b. glomerular healing.
   c. recent streptococcal infection.

d. excessive amounts of protein in the urine.

ANS: A
The presence of red blood cell casts in the urine indicates glomerular injury. Casts in the urine are abnormal findings and are indicative of glomerular injury, not glomerular healing. A urinalysis positive for casts does not confirm a recent streptococcal infection. Casts in the urine are unrelated to proteinuria.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1016 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

4. Which clinical finding warrants further intervention for the child with acute post streptococcal glomerulonephritis?
   a. Weight loss to within 1 lb of the preillness weight
   b. Urine output of 1 mL/kg/hr
   c. A positive antistreptolysin O (ASO) titer
   d. Inspiratory crackles

   ANS: D
   Children with excess fluid volume may have pulmonary edema. Inspiratory crackles indicate fluid in the lungs. Pulmonary edema can be a life-threatening complication. Weight loss is an indication that the child is responding to treatment. The urine output of 1 mL/kg/hr is acceptable. A positive ASO titer indicates the presence of antibodies to streptococcal bacteria; it is used to aid in diagnosis of acute post streptococcal glomerulonephritis. This is an expected finding if the child has this acute illness.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1016 OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

5. Which diagnostic finding is present when a child has primary nephrotic syndrome?
   a. Hyperalbuminemia
   b. Positive ASO titer
   c. Leukocytosis
   d. Proteinuria

   ANS: D
   Large amounts of protein are lost through the urine as a result of an increased permeability of the glomerular basement membrane. Hypoalbuminemia is present because of loss of albumin through the defective glomerulus and the liver's inability to synthesize proteins to balance the loss. ASO titer is negative in a child with primary nephrotic syndrome. Leukocytosis is not a diagnostic finding in primary nephrotic syndrome.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1018 | Nursing Quality Alert Box
   OBJ: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

6. Which finding indicates that a child receiving prednisone for primary nephrotic syndrome is in remission?

a. Urine is negative for casts for 5 days.
b. Urine has <1+ protein for 3 to 7 consecutive days.
c. Urine is positive for glucose for 1 week.
d. Urine is up to a trace for blood for 1 week.

ANS: B
The child receiving steroids for the treatment of primary nephrotic syndrome is considered in remission when the urine has <1+ protein for 3 to 7 consecutive days. The absence of casts, presence of glucose, and presence of hematuria do not constitute remission.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1019 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

7. Which statement by a parent of a child with nephrotic syndrome indicates an understanding of a no-added-salt diet?
a. "I can give my child sweet pickles."
b. "My child can put ketchup on his hotdog."
c. "I can let my child have potato chips."
d. "I do not put any salt in foods when I am cooking."

ANS: D
A no-added-salt diet means that no salt should be added to foods, either when cooking or before eating. Pickles of any type, hotdogs, and potato chips are all prohibited on this diet.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 1019 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Health Promotion and Maintenance

8. What is an appropriate intervention for a child with nephrotic syndrome who is edematous?
a. Teach the child to minimize body movements.
b. Change the child's position every 2 hours.
c. Avoid the use of skin lotions.
d. Bathe every other day.

ANS: B
Frequent position changes decrease pressure on body parts and help relieve edema in dependent areas. The child with edema is at risk for impaired skin integrity. It is important for the child to change position frequently to prevent skin breakdown. Good skin hygiene consists of daily baths to remove irritating body secretions and applying lotion.

PTS: 1 DIF: Cognitive Level: Comprehension REF: p. 1019
OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

9. What should the nurse include in a teaching plan for the parents of a child with vesicoureteral reflux?
a. The importance of taking prophylactic antibiotics if prescribed
b. Suggestions for how to maintain fluid restrictions
c. The use of bubble baths as an incentive to increase bath time
d. The need for the child to hold urine for 6 to 8 hours

ANS: A

Prophylactic antibiotics are sometimes used to prevent urinary infection in a child with vesicoureteral reflux, especially if they are waiting for the results of imaging studies or have recurrent UTIs. If prescribed, the parents should be taught that the child must finish the entire course of antibiotics to prevent bacterial resistance. Fluids are not restricted when a child has vesicoureteral reflux. In fact, fluid intake should be increased as a measure to prevent UTIs. Bubble baths should be avoided to prevent urethral irritation and possible UTI. To prevent UTIs, the child should be taught to void frequently and never resist the urge to urinate.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1011 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

10. Which intervention is appropriate when examining a male infant for cryptorchidism?
    a. Cooling the examiner's hands
    b. Taking a rectal temperature
    c. Eliciting the cremasteric reflex
    d. Warming the room

ANS: D

For the infant's comfort, the infant should be examined in a warm room with the examiner's hands warmed. Testes can retract into the inguinal canal if the infant is upset or cold. A rectal temperature yields no information about cryptorchidism. Testes can retract into the inguinal canal if the infant is upset or cold or if the cremasteric reflex is elicited. This can lead to an incorrect diagnosis.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1013 | Nursing Quality Alert Box
OBJ: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

11. Parents ask the nurse, "When should our child's hypospadias be corrected?" The nurse responds that correction of hypospadias should be accomplished by the time the child is
    a. 1 month of age.
    b. 6 to 12 months of age.
    c. school age.
    d. sexually mature.

ANS: B

The correction of hypospadias should ideally be accomplished by the time the child is 6 to 12 months of age and before toilet training. One month of age is too young for this procedure. It is preferable for hypospadias to be surgically corrected before the child enters school so that the child has normal toileting behaviors in the presence of his peers. Corrective surgery for hypospadias is done long before sexual maturity.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1014 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

12. You are the nurse caring for a 4-year-old child who has developed acute renal failure as a result of hemolytic-uremic syndrome (HUS). Which bacterial infection was most likely the cause of HUS?
    a. *Pseudomonas aeruginosa*
    b. *Escherichia coli*
    c. *Streptococcus pneumoniae*
    d. *Staphylococcus aureus*

    ANS: B
    Children with HUS become infected by *Escherichia coli*, which is usually contracted from eating improperly cooked meat or contaminated dairy products. *Pseudomonas aeruginosa*, *Streptococcus pneumoniae*, and *Staphylococcus aureus* are not associated with HUS.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1022 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

13. Which dietary modification is appropriate for a child with chronic renal failure?
    a. Decreased protein
    b. Decreased fat
    c. Increased potassium
    d. Increased phosphorus

    ANS: A
    Protein intake is restricted or strictly regulated because of the kidney's inability to remove waste products. A low-fat diet is not relevant to chronic renal failure. Potassium intake may be restricted because of the kidney's inability to remove it. Phosphorus is restricted to help prevent bone disease.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1023 OBJ: Nursing Process: Planning
    MSC: Client Needs: Health Promotion and Maintenance

14. Which condition is characterized by a history of bloody diarrhea, fever, abdominal pain, and low hemoglobin and platelet counts?
    a. Acute viral gastroenteritis
    b. Acute glomerulonephritis
    c. Hemolytic-uremic syndrome
    d. Acute nephrotic syndrome

    ANS: C
    Hemolytic-uremic syndrome is an acute disorder characterized by anemia, thrombocytopenia, and acute renal failure. Most affected children have a history of gastrointestinal symptoms, including bloody diarrhea. Anemia and thrombocytopenia are not associated with acute gastroenteritis. The symptoms described are not suggestive of acute glomerulonephritis. The symptoms described are not suggestive of nephrotic syndrome.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1023 | Pathophysiology Box OBJ: Nursing Process: Assessment

MSC: Client Needs: Physiologic Integrity

15. A child with secondary enuresis who complains of dysuria or urgency should be evaluated for which condition?
    a. Hypocalciuria
    b. Nephrotic syndrome
    c. Glomerulonephritis
    d. UTI

    ANS: D
    Complaints of dysuria or urgency from a child with secondary enuresis suggest the possibility of a UTI. An excessive loss of calcium in the urine (hypercalciuria) can be associated with complaints of painful urination, urgency, frequency, and wetting. Nephrotic syndrome is not usually associated with complaints of dysuria or urgency. Glomerulonephritis is not a likely cause of dysuria or urgency.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1009 | Box 44.1 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

16. A nurse is teaching a class on acute kidney injury. The nurse relates that acute kidney injury as a result of hemolytic-uremic syndrome (HUS) is classified as
    a. Intrinsic renal.
    b. Prerenal.
    c. Postrenal.
    d. Chronic.

    ANS: A
    Intrinsic renal acute renal failure is the result of damage to kidney tissue. Possible causes include HUS, glomerulonephritis, and pyelonephritis. Prerenal acute renal failure is the result of decreased perfusion to the kidney. Possible causes include dehydration, septic and hemorrhagic shock, and hypotension. Postrenal acute renal failure results from obstruction of urine outflow. Conditions causing postrenal failure include ureteropelvic obstruction, ureterovesical obstruction, or neurogenic bladder. Renal failure caused by HUS is of the acute nature. Chronic renal failure is an irreversible loss of kidney function, which occurs over months or years.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1021 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

17. Which of the following is a true statement describing the differences in the pediatric genitourinary system compared with the adult genitourinary system?
    a. The young infant’s kidneys can more effectively concentrate urine than an adult’s kidneys.
    b. After 6 years of age, kidney function is nearly like that of an adult.
    c. Unlike adults, most children do not regain normal kidney function after acute renal failure.
    d. Young children have shorter urethras, which can predispose them to UTIs.

ANS: D
Young children have shorter urethras, which can predispose them to UTIs. The young infant's kidneys cannot concentrate urine as efficiently as can those of older children and adults because the loops of Henle are not yet long enough to reach the inner medulla, where concentration and reabsorption occur. By 6 to 12 months of age, kidney function is nearly like that of an adult. Unlike adults, most children with acute renal failure regain normal function.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1003 | Pediatric Differences Box OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

18. Which factor predisposes the urinary tract to infection?
    a. Increased fluid intake
    b. Short urethra in young girls
    c. Prostatic secretions in males
    d. Frequent emptying of the bladder

ANS: B
The short urethra in females provides a ready pathway for invasions of organisms. Increased fluid intake offers protective measures against UTIs. Prostatic secretions have antibacterial properties that inhibit bacteria. Frequent emptying of the bladder also offers protection against UTIs.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1008 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

19. Hypospadias refers to
    a. absence of a urethral opening.
    b. penis shorter than usual for age.
    c. urethral opening along dorsal surface of penis.
    d. urethral opening along ventral surface of penis.

ANS: D
Hypospadias is a congenital condition in which the urethral opening is located anywhere along the ventral surface of the penis. The urethral opening is present in hypospadias but not at the glans. Hypospadias refers to the urethral opening, not to the size of the penis. Epispadias is where the urethral opening is along the dorsal surface of the penis.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1013 | Nursing Quality Alert Box
OBJ: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

20. The narrowing of preputial opening of foreskin is called
    a. chordee.
    b. phimosis.
    c. epispadias.
    d. hypospadias.

ANS: B
Phimosis is the narrowing or stenosis of the preputial opening of the foreskin. Chordee is the ventral curvature of the penis. Epispadias is the meatal opening on the dorsal surface of the penis. Hypospadias is a congenital condition in which the urethral opening is located anywhere along the ventral surface of the penis.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1008 | Table 44.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

21. The nurse closely monitors the temperature of a child with nephrotic syndrome. The purpose of this is to detect an early sign of which possible complication?
    a. Infection
    b. Hypertension
    c. Encephalopathy
    d. Edema

ANS: A
An exacerbation of the disease can occur after an infection. Temperature is not an indication of hypertension or edema. Encephalopathy is not a complication usually associated with nephrosis. The child will most likely have neurologic signs and symptoms. Edema does not manifest with an elevated temperature.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1019 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

22. A child is admitted with acute glomerulonephritis. The nurse expects the urinalysis during this acute phase to show which of the following?
    a. Bacteriuria and hematuria
    b. Hematuria and proteinuria
    c. Bacteriuria and increased specific gravity
    d. Proteinuria and decreased specific gravity

ANS: B
Urinalysis during the acute phase characteristically shows hematuria and proteinuria. Bacteriuria and changes is specific gravity would not be expected.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1016 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

23. The most appropriate nursing diagnosis for the child with acute glomerulonephritis is
    a. Risk for Injury related to malignant process and treatment.
    b. Deficient Fluid Volume related to excessive losses.
    c. Risk for Imbalanced Fluid Volume related to a decrease in plasma filtration.
    d. Excess Fluid Volume related to fluid accumulation in tissues and third spaces.

ANS: C

Glomerulonephritis has a decreased filtration of plasma. The resulting decrease in plasma filtration results in an excessive accumulation of water and sodium that expands plasma and interstitial fluid volumes, leading to circulatory congestion and edema. No malignant process is involved in acute glomerulonephritis. Excess fluid volume is found in this disease process. The fluid accumulation is related to the decreased plasma filtration.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1017 OBJ: Nursing Process: Diagnosis
MSC: Client Needs: Physiologic Integrity

24. The most common cause of acute kidney injury in children is
    a. pyelonephritis.
    b. tubular destruction.
    c. urinary tract obstruction.
    d. severe dehydration.

    ANS: D
    The most common cause of acute kidney injury in children is dehydration or other causes of poor perfusion that may respond to restoration of fluid volume. This is a prerenal cause. Pyelonephritis, tubular destruction, and urinary tract obstruction are not common causes of acute kidney injury in children.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1023 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

25. The primary clinical manifestations of acute kidney injury are which of the following?
    a. Oliguria and hypertension
    b. Hematuria and pallor
    c. Proteinuria and muscle cramps
    d. Bacteriuria and facial edema

    ANS: A
    The principal feature of acute kidney injury is oliguria, and many children are hypertensive. Hematuria, pallor, proteinuria, cramps, bacteriuria, and edema are not principal features.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1023 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

26. A major complication in a child with chronic renal failure is
    a. hypokalemia.
    b. metabolic alkalosis.
    c. water and sodium retention.
    d. excessive excretion of blood urea nitrogen.

    ANS: C

Chronic renal failure leads to water and sodium retention, which contributes to edema and vascular congestion. Hyperkalemia is a complication of chronic renal failure. Metabolic acidosis is a complication of chronic renal failure. Retention of blood urea nitrogen is a complication of chronic renal failure.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1024 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

27. The diet of a child with chronic renal failure is usually characterized as
    a. high in protein.
    b. low in vitamin D.
    c. low in phosphorus.
    d. supplemented with vitamins A, E, and K.

    ANS: C
    Dietary phosphorus is controlled to prevent or control the calcium/phosphorus imbalance by the reduction of protein and milk intake. Protein should be limited. Vitamin D is administered to children with chronic kidney failure. Supplementation of vitamins A, E, and K is not part of dietary management in chronic renal disease.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1024 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

28. Which statement is descriptive of renal transplantation in children?
    a. It is an acceptable means of treatment after age 10 years.
    b. It is preferred means of renal replacement therapy in children.
    c. Children can receive kidneys only from other children.
    d. The decision is difficult, since a normal lifestyle is not possible.

    ANS: B
    Renal transplant offers the opportunity for a relatively normal life and is the preferred means of renal replacement therapy in end-stage renal disease. It can be done in children as young as age 6 months. Both children and adults can serve as donors for renal transplant purposes. Renal transplantation affords the child a more normal lifestyle than dependence on dialysis.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1024 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

29. An infant is born with bladder exstrophy. What action by the nurse is the priority?
    a. Obtain surgical consent for the corrective operation.
    b. Cover the exposed bladder with non-adherent plastic wrap.
    c. Insert an indwelling catheter to collect all the urine.
    d. Obtain consent for genetic testing on parents and infant.

    ANS: B

In bladder exstrophy, the bladder is outside the body and must be covered with a non-adherent plastic wrap until surgical correction. This is the priority action. Consent will be obtained prior to surgery. A catheter is not needed. Genetic testing is not necessarily done.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1015 | Table 44.1 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

30. A nurse is assessing lab results on four patients in the general pediatric unit. What child should the nurse go see first?
    a. Urine specific gravity: 1.025
    b. Urine ketones: positive in large amounts
    c. Serum BUN 21 mg/dL
    d. Serum creatinine 0.7 mg/dL

    ANS: B
    Ketones should not be present in the urine. When found, they are indicative of starvation, diabetic ketoacidosis, fever, prolonged vomiting, anorexia, and severe diarrhea. The nurse should see this child first. The other lab values are normal.

    PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
    REF: p. 1005 | Laboratory Box OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. A child with secondary enuresis who complains of dysuria or urgency should be evaluated for what conditions? (*Select all that apply*.)
    a. Hypocalciuria
    b. Nephrotic syndrome
    c. Glomerulonephritis
    d. UTI
    e. Diabetes mellitus

    ANS: D, E
    Complaints of dysuria or urgency from a child with secondary enuresis suggest the possibility of a UTI. If accompanied by excessive thirst and weight loss, these symptoms may indicate the onset of diabetes mellitus. An excessive loss of calcium in the urine (hypercalciuria) can be associated with complaints of painful urination, urgency, frequency, and wetting. Nephrotic syndrome is not usually associated with complaints of dysuria or urgency. Glomerulonephritis is not a likely cause of dysuria or urgency.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1007 | Pathophysiology Box OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

2. A nurse is planning care for a child admitted with nephrotic syndrome. Which interventions should be included in the plan of care? (*Select all that apply*.)

a. Administration of antihypertensive medications
b. Daily weights
c. Salt-restricted diet
d. Frequent position changes
e. Teaching parents to expect tea-colored urine

ANS: B, C, D
A child with nephrotic syndrome will need to be monitored closely for fluid excess so daily weights are important. The diet is salt restricted to prevent further retention of fluid. Because of the fluid excess, frequent position changes are required to prevent skin breakdown. Nephrotic syndrome does not require antihypertensive medications. These are administered for acute glomerulonephritis. Tea-colored urine is expected with acute glomerulonephritis but not nephrotic syndrome. The urine in nephrotic syndrome is frothy, indicating that protein is being lost in the urine.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1019 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

3. A nurse is assessing an infant for urinary tract infection (UTI). Which assessment findings should the nurse expect? (*Select all that apply*.)
a. Change in urine odor or color
b. Enuresis
c. Fever or hypothermia
d. Voiding urgency
e. Poor weight gain

ANS: A, C, E
The signs of a UTI in an infant include fever or hypothermia, irritability, dysuria as evidenced by crying when voiding, change in urine odor or color, poor weight gain, and feeding difficulties. Enuresis and voiding urgency should be assessed in an older child.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1009 | Box 44.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. A child has had cold symptoms for more than 2 weeks, a headache, nasal congestion with purulent nasal drainage, facial tenderness, and a cough that increases during sleep. The nurse plans to teach the parents about which treatment regime?
   a. Antihistamine use
   b. Cold washcloths on the face for comfort
   c. Antibiotic treatment with amoxicillin
   d. Referral for a sinuplasty

   ANS: C
   These manifestations are those of a sinus infection. The parents need to be taught about antibiotic use. A common antibiotic used for sinusitis is amoxicillin. Antihistamines are not recommended because they dry up secretions, making them more difficult to remove. Warm wet washcloths can be used for comfort. A sinuplasty may be needed if the child does not improve or if sinus infections are recurrent or frequent.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 1035 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

2. For which problem should the child with chronic otitis media with effusion be evaluated?
   a. Brain abscess
   b. Meningitis
   c. Hearing loss
   d. Perforation of the tympanic membrane

   ANS: C
   Chronic otitis media with effusion is the most common cause of hearing loss in children. The other options are all possible complications but not seen frequently.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1037 | Pathophysiology Box OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. The nurse expects the initial plan of care for a 9-month-old child with an acute otitis media infection to include
   a. symptomatic treatment and observation for 48 to 72 hours after diagnosis.
   b. an oral antibiotic, such as amoxicillin, five times a day for 7 days.
   c. pneumococcal conjugate vaccine.
   d. myringotomy with tympanoplasty tubes.

   ANS: A

Select children 6 months of age or older with acute otitis media are treated by initiating symptomatic treatment and observation for 48 to 72 hours. Acute otitis media may be treated with a 5- to 10-day course of oral antibiotics. When treatment is indicated, amoxicillin at a divided dose of 80 to 90 mg/kg/day given either every 8 or 12 hours for 5 to 10 days may be ordered. Pneumococcal conjugate vaccine helps to prevent ear infections but is not included in the initial plan of care for a child with acute otitis media. Surgical intervention is considered when the child has persistent ear infection despite antibiotic therapy or with otitis media with effusion that persists for more than 3 months and is associated with hearing loss.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1038 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

4. Which statement made by a parent indicates an understanding about treatment of streptococcal pharyngitis?
   a. "I guess my child will need to have his tonsils removed."
   b. "A couple of days of rest and some ibuprofen will take care of this."
   c. "I should give the penicillin three times a day for 10 days."
   d. "I am giving my child prednisone to decrease the swelling of the tonsils."

   ANS: C
   Streptococcal pharyngitis is best treated with oral penicillin two to three times daily for 10 days. Surgical removal of the tonsils is a controversial issue. It may be warranted in cases of recurrent tonsillitis. It is not indicated for the treatment of acute tonsillitis. Comfort measures such as rest and analgesics are indicated, but these will not treat the bacterial infection. Corticosteroids are not used in the treatment of streptococcal pharyngitis.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: p. 1040 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Physiologic Integrity

5. An infant has laryngomalacia. What assessment finding correlates with this condition?
   a. Stridor
   b. High-pitched cry
   c. Nasal congestion
   d. Spasmodic cough

   ANS: A
   An infant with laryngomalacia has stridor. Stridor is usually present at birth but may begin as late as 2 months. Symptoms increase when the infant is supine or crying. High-pitched cries are consistent with neurologic abnormalities and are not usually respiratory in nature. Nasal congestion is nonspecific in relation to laryngomalacia. Spasmodic cough is associated with croup; it is not a common symptom of laryngomalacia.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1042 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

6. The nurse should assess a child who has had a tonsillectomy for which of the following as the priority?
   a. Frequent swallowing
   b. Inspiratory stridor
   c. Swelling of the throat
   d. Abnormal lung sounds

   ANS: A
   Frequent swallowing is indicative of postoperative bleeding. Inspiratory stridor is characteristic of croup. The nurse assesses the throat for clots or bleeding, not swelling. Lung sounds are assessed on every postoperative patient.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 1041 | Safety Alert Box OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

7. The parent of a toddler calls the nurse, asking about croup. What is a distinguishing manifestation of spasmodic croup?
   a. Wheezing is heard audibly.
   b. It has a harsh, barky cough.
   c. It is bacterial in nature.
   d. The child has a high fever.

   ANS: B
   Spasmodic croup is viral in origin; is usually preceded by several days of symptoms of upper respiratory tract infection; often begins at night; and is marked by a harsh, metallic, barky cough, sore throat, inspiratory stridor, and hoarseness. Wheezing is not a distinguishing manifestation of croup. It can accompany conditions such as asthma or bronchiolitis. Spasmodic croup is viral in origin. A high fever is not usually present.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1042 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

8. Which intervention for treating croup at home should be taught to parents as possibly helpful?
   a. Have a decongestant available.
   b. Have the child sleep in a dry room.
   c. Take the child outside.
   d. Give the child an antibiotic at bedtime.

   ANS: C
   Taking the child into the cool, humid, night air may relieve mucosal swelling and improve symptoms. Decongestants are inappropriate for croup, which affects the middle airway level. A dry environment may contribute to symptoms. Croup is caused by a virus. Antibiotic treatment is not indicated.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1043 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

9. A 5-year-old child is brought to the emergency department with copious drooling and a croaking sound on inspiration. Her mother states that the child is very agitated and only wants to sit upright. What action by the nurse takes priority?
   a. Prepare intubation equipment and call the provider.
   b. Examine the child's oropharynx and call the provider.
   c. Obtain a throat culture for respiratory syncytial virus (RSV).
   d. Obtain vital signs and listen to breath sounds.

   ANS: A
   This child has symptoms of epiglottitis, is acutely ill, and requires emergency measures. If epiglottitis is suspected, the nurse should not examine the child's throat. Inspection of the epiglottis is only done by a provider, because it could trigger airway obstruction. A throat culture could precipitate a complete respiratory obstruction. Vital signs can be assessed after emergency equipment is readied.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 1047 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Safe and Effective Care Environment

10. What intervention can be taught to the parents of a 3-year-old child with pneumonia who is not hospitalized?
   a. Offer the child only cool liquids.
   b. Offer the child favorite warm liquid drinks.
   c. Use a warm mist humidifier.
   d. Report a respiratory rate less than 28 breaths/min.

   ANS: B
   Offering the child favorite fluids will facilitate oral intake. Warm liquids help loosen secretions. A humidifier may or may not be helpful. Typically parents are not taught to count their children's respirations and report abnormalities to the physician. Even if this were the case, a respiratory rate of less than 28 breaths/min is normal for a 3-year-old child. The expected respiratory rate for a 3-year-old child is 20 to 30 breaths/min.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1052 | Patient-Centered Teaching Box
   OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

11. A nurse is caring for four infants. Which one should the nurse assess first?
   a. Nasal flaring
   b. Respiratory rate of 55 breaths/min
   c. Irregular respiratory pattern
   d. Abdominal breathing

   ANS: A
   Infants have difficulty breathing through their mouths; therefore nasal flaring is usually accompanied by extra respiratory efforts. A respiratory rate of 55 breaths/min is a normal assessment for an infant. Irregular respirations are normal in the infant. Abdominal breathing is common because the diaphragm is the neonate's major breathing muscle.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1044 OBJ: Nursing Process: Assessment
MSC: Client Needs: Safe and Effective Care Environment

12. Once an allergen is identified in a child with allergic rhinitis, the treatment of choice the nurse educates the parents about is which of the following?
    a. Using appropriate medications
    b. Beginning desensitization injections
    c. Eliminating the allergen
    d. Removing the adenoids

    ANS: C
    The first priority is to attempt to remove the causative agent from the child's environment. Medications are not a first -line treatment but can be helpful in controlling allergic rhinitis. Immunotherapy is usually the final component of controlling allergic rhinitis. Adenoids are tissues that can swell with constant rhinitis; however, a surgical procedure is not indicated for allergic rhinitis. Dealing with the cause is the first priority.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1034 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

13. Which assessment finding after tonsillectomy should be reported to the surgeon?
    a. Vomiting bright red blood
    b. Pain at surgical site
    c. Pain on swallowing
    d. The ability to only take small sips of liquids

    ANS: A
    Vomiting bright red blood and swallowing frequently are signs of bleeding postoperatively and should be reported to the surgeon. It is normal for the child to have pain at the surgical site and pain with swallowing after tonsillectomy. Small sips of liquid are preferred.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1041 | Safety Alert Box OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

14. Teaching safety precautions with the administration of antihistamines is important because of what common side effect?
    a. Dry mouth
    b. Excitability
    c. Drowsiness
    d. Dry mucous membranes

    ANS: C
    Drowsiness is a safety hazard when alertness is needed, especially with a teenage driver. Nonsedating brands should be used if possible. None of the other three problems is a safety issue.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering

REF: p. 1034 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

15. What is an appropriate beverage for the nurse to give to a child who had a tonsillectomy earlier in the day?
    a. Chocolate ice cream
    b. Orange juice
    c. Fruit punch
    d. Apple juice

    ANS: D
    The child can have clear, cool liquids when fully awake. Ice cream is not a clear liquid, and dairy products can cause the child to clear the throat repeatedly, increasing the risk of bleeding. Citrus drinks are not offered because they can irritate the throat. Red liquids are avoided because they give the appearance of blood if vomited.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1041 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

16. Which type of croup is always considered a medical emergency?
    a. Laryngitis
    b. Epiglottitis
    c. Spasmodic croup
    d. Laryngotracheobronchitis (LTB)

    ANS: B
    Epiglottitis is always a medical emergency that requires antibiotics and airway support for treatment. The other illnesses are not medical emergencies although LTB can progress to emergent status in some children.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1045 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

17. What information should the nurse teach workers at a daycare center about RSV?
    a. RSV is transmitted through particles in the air.
    b. RSV can live on skin or paper for up to a few seconds after contact.
    c. RSV can survive on nonporous surfaces for about 60 minutes.
    d. Frequent handwashing can decrease the spread of the virus.

    ANS: D
    Meticulous handwashing can decrease the spread of organisms. RSV infection is not airborne. It is acquired mainly through contact with contaminated surfaces. RSV can live on skin or paper for up to 1 hour. RSV can live on cribs and other nonporous surfaces for up to 6 hours.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1047 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

18. Which intervention is appropriate for the infant hospitalized with bronchiolitis?
    a. Position on the side with neck slightly flexed.
    b. Administer antibiotics as ordered.
    c. Restrict oral and parenteral fluids if tachypneic.
    d. Give cool, humidified oxygen.

    ANS: D
    Cool, humidified oxygen is given to relieve dyspnea, hypoxemia, and insensible fluid loss from tachypnea. The infant should be positioned with the head and chest elevated at a 30- to 40-degree angle and the neck slightly extended to maintain an open airway and decrease pressure on the diaphragm. The etiology of bronchiolitis is viral. Antibiotics are only given if there is a secondary bacterial infection. Tachypnea increases insensible fluid loss. If the infant is tachypneic, fluids are given parenterally to prevent dehydration.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1048 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

19. A child has a chronic, nonproductive cough and diffuse wheezing during the expiratory phase of respiration. What action by the nurse is most appropriate?
    a. Prepare to administer a bronchodilator.
    b. Give ordered antibiotics on time.
    c. Provide oxygen via face tent.
    d. Assess the airway for a foreign body.

    ANS: A
    Children with asthma usually have these chronic symptoms. The nurse will prepare to administer a bronchodilator. Antibiotics are not used in asthma unless the child also has a bacterial infection, but there is no indication that this is the case. There is also no indication the child needs oxygen at this point. These manifestations do not suggest a foreign body aspiration.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1057 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

20. The nurse encourages the mother of a toddler with acute LTB to stay at the bedside as much as possible. Which of the following best explains the nurse's rationale?
    a. Mothers of hospitalized toddlers often experience guilt.
    b. The mother's presence will reduce anxiety and ease the child's respiratory efforts.
    c. Separation from the mother is a major developmental threat at this age.
    d. The mother can provide constant observations of the child's respiratory efforts.

    ANS: B
    The family's presence will decrease the child's distress, which in turn helps decrease respiratory efforts. Guilt is not the main rationale. Toddlers do suffer from separation anxiety, but that is not the primary reason for the mother to stay. The child should have constant monitoring by cardiorespiratory monitor and noninvasive oxygen saturation monitoring, but the parent should not play this role in the hospital.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1045 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Adaptation

21. Which statement indicates that a parent of a toddler needs more education about preventing foreign body aspiration?
    a. "I keep objects with small parts out of reach."
    b. "My toddler loves to play with balloons."
    c. "I won't permit my child to have peanuts."
    d. "I never leave coins where my child could get them."

    ANS: B
    Latex balloons account for a significant number of deaths from aspiration every year. The other statements show good understanding.

    PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
    REF: p. 1052 | Box 45.1 OBJ: Nursing Process: Evaluation
    MSC: Client Needs: Health Promotion and Maintenance

22. What is a common trigger for asthma attacks in children?
    a. Febrile episodes
    b. Dehydration
    c. Exercise
    d. Seizures

    ANS: C
    Exercise is one of the most common triggers for asthma attacks, particularly in school-age children. Febrile episode, dehydration, and seizures are not triggers.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1057 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Health Promotion and Maintenance

23. Which child requires a Mantoux test?
    a. The child who has episodes of nighttime wheezing and coughing
    b. The child who has a history of allergic rhinitis
    c. The child whose babysitter has received a tuberculosis diagnosis
    d. The premature infant who is being treated for apnea of infancy

    ANS: C
    The Mantoux test is the initial screening mechanism for patients exposed to tuberculosis. Nighttime wheezing and coughing are consistent with a diagnosis of asthma. Allergic rhinitis requires an allergy workup. The Mantoux test is not used to evaluate apnea.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1073 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

24. What explanation should the nurse give to the parent of a child with asthma about using a peak flow meter?
    a. It is used to monitor the child's breathing capacity.
    b. It measures the child's lung volume.
    c. It will help the medication reach the child's airways.
    d. It measures the amount of air the child breathes in.

    ANS: A
    The peak flow meter is a device used to monitor breathing capacity in the child with asthma. A child with asthma would have a pulmonary function test to measure lung volume. A spacer used with a metered-dose inhaler prolongs medication transit so medication reaches the airways. The peak flow meter measures the flow of air in a forced exhalation in liters per minute.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1059 | Box 45.2 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

25. A parent of a child with asthma asks if his child can still participate in sports. What response by the nurse is best?
    a. "Children with asthma are usually restricted from physical activities."
    b. "Children can usually play any type of sport if their asthma is well controlled."
    c. "Avoid swimming because exhaling underwater is dangerous for people with asthma."
    d. "Even with good asthma control, I would advise limiting the child to one athletic activity per school year."

    ANS: B
    Children can usually play any type of sport if their asthma is well controlled. Children with asthma should not be restricted from physical activity. Sports participation depends on each child's response to the activity. Swimming is recommended as the ideal sport for children with asthma because the air is humidified and exhaling underwater prolongs exhalation and increases end-expiratory pressure.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1059 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

26. A school-age child had an upper respiratory tract infection for several days and then began having a persistent dry, hacking cough that was worse at night. The cough has become productive in the past 24 hours. What home care measure does the nurse educate parents about?
    a. Taking the full course of antibiotics
    b. Providing humidity and increased fluids
    c. Treating any fever with aspirin
    d. Isolation from family until symptoms resolve

    ANS: B

This child has bronchitis which is a viral illness treated symptomatically. Humidity and increased fluids provide comfort, ease symptoms, and prevent dehydration. Antibiotics are not used unless an overlying infection occurs as well. Aspirin is not given to children due to the association with Reye syndrome. The child does not need to be isolated.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1048 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

27. Which classification of drugs is used to relieve an acute asthma episode?
    a. Short-acting beta$_2$-adrenergic agonist
    b. Inhaled corticosteroids
    c. Leukotriene blockers
    d. Long-acting bronchodilators

    ANS: A
    A short-acting beta$_2$-adrenergic agonist is the first medication administered. Later, systemic corticosteroids decrease airway inflammation in an acute asthma attack. They are given for short courses of 5 to 7 days. Inhaled corticosteroids are used for long-term, routine control of asthma. Leukotriene blockers diminish the mediator action of leukotrienes and are used for long-term, routine control of asthma in children older than 12 years. A long-acting bronchodilator would not relieve acute symptoms.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1058 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

28. The nurse getting an end-of-shift report on a child with status asthmaticus should question which intervention?
    a. Administer oxygen by nasal cannula to keep oxygen saturation at 100%.
    b. Assess intravenous (IV) maintenance fluids and site every hour.
    c. Notify provider for signs of increasing respiratory distress.
    d. Organize care to allow for uninterrupted rest periods.

    ANS: A
    Supplemental oxygen should not be administered to maintain oxygen saturation at 100%. Keeping the saturation around 95% is adequate. Administration of too much oxygen to a child may lead to respiratory depression by decreasing the stimulus to breathe, leading to carbon dioxide retention. When the child cannot take oral fluids because of respiratory distress, IV fluids are administered. The child with a continuous IV infusion must be assessed hourly to prevent complications. A provider should be notified of any changes indicating increasing respiratory distress. A child in respiratory distress is easily fatigued. Nursing care should be organized so the child can get needed rest without being disturbed.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1063 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

29. What is the earliest recognizable clinical manifestation(s) of CF? a. Meconium ileus

b. History of poor intestinal absorption
c. Foul-smelling, frothy, greasy stools
d. Recurrent pneumonia and lung infections

ANS: A
The earliest clinical manifestation of CF is a meconium ileus, which is found in about 10% of children with CF. Clinical manifestations include abdominal distention, vomiting, failure to pass stools, and rapid development of dehydration. History of malabsorption is a later sign that manifests as failure to thrive. Foul-smelling stools are a later manifestation of CF. Recurrent respiratory infections are a later sign of CF.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1068 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

30. What should the nurse teach a child about using an albuterol metered-dose inhaler for exercise-induced asthma?
a. Take two puffs every 6 hours around the clock.
b. Use the inhaler only when the child is short of breath.
c. Use the inhaler 30 minutes before exercise.
d. Take one to two puffs every morning upon awakening.

ANS: C
The appropriate time to use an inhaled $beta_2$ -agonist is before an event that could trigger an attack. Taking the medication every 6 hours will not prevent the exercise-induced asthma. Waiting until symptoms are severe is too late to begin using a metered- dose inhaler. Taking puffs every morning may be the child's usual schedule for medication. If exercise causes symptoms, additional medication is indicated.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1060 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

31. The nurse is caring for an infant with bronchopulmonary dysplasia (BPD) who has RSV. Which treatment measure does the nurse prepare to provide?
a. Pancreatic enzymes
b. Cool humidified oxygen
c. Erythromycin intravenously
d. Intermittent positive pressure ventilation

ANS: B
Humidified oxygen is delivered if the oxygen saturation level drops to less than 90%. Pancreatic enzymes are used for patients with cystic fibrosis. Antibiotics are ineffective against viral illnesses. Assisted ventilation is not necessary in the treatment of RSV infections.

PTS: 1 DIF: Cognitive Level: Application/Application
REF: p. 1066 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

32. Which statement made by parents of a child with cystic fibrosis indicates that they understood the nurse's teaching on pancreatic enzyme replacement?
    a. "Enzymes will improve my child's breathing."
    b. "I should give the enzymes 1 hour after meals."
    c. "Enzymes should be given with meals and snacks."
    d. "The enzymes are stopped if my child begins wheezing."

    ANS: C
    Children with cystic fibrosis need to take enzymes with food for adequate absorption of nutrients. Pancreatic enzymes do not affect the respiratory system. Pancreatic enzymes are taken within 30 minutes of eating all meals and snacks. Giving the medication 1 hour after meals is inappropriate and ineffective for absorption of nutrients. Wheezing is not a reason to stop taking enzyme replacements.

    PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
    REF: p. 1070 OBJ: Nursing Process: Evaluation
    MSC: Client Needs: Physiologic Integrity

33. Why do infants and young children quickly have respiratory distress in acute and chronic alterations of the respiratory system?
    a. They have a widened, shorter airway.
    b. There is a defect in their sucking ability.
    c. The gag reflex increases mucous production.
    d. Mucus and edema obstruct small airways.

    ANS: D
    The airway in infants and young children is narrow, and respiratory distress can occur quickly because mucus and edema can cause obstruction to their small airways. Sucking is not necessarily related to problems with the airway. The gag reflex is necessary to prevent aspiration. It does not produce mucus.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1030 | Pediatric Differences Box OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

34. Which statement made by a parent indicates an understanding about the genetic transmission of cystic fibrosis (CF)?
    a. "Only one parent carries the cystic fibrosis gene."
    b. "Both parents are carriers of the cystic fibrosis gene."
    c. "The presence of the disease is most likely the result of a genetic mutation."
    d. "The mother is usually the carrier of the cystic fibrosis gene."

    ANS: B
    Cystic fibrosis follows a pattern of autosomal recessive transmission. Both parents must be carriers of the gene for the disease to be transmitted to the child. If both parents carry the CF gene, each pregnancy has a 25% chance of producing a CF-affected child. The disease will not be present if only one parent is a carrier of the cystic fibrosis gene. Cystic fibrosis is known to have a definite pattern of transmission. It is transmitted as an autosomal recessive trait. A carrier parent can transmit the carrier gene to the child. The disease is present when the carrier gene is transmitted from both parents.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 1067 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Physiologic Integrity

35. A small child with cystic fibrosis cannot swallow pancreatic enzyme capsules. The nurse should teach parents to mix enzymes with which food?
    a. Macaroni and cheese
    b. Tapioca
    c. Applesauce
    d. Hot chocolate

    ANS: C
    Enzymes can be mixed with a small amount of nonacidic foods. Macaroni and cheese and hot chocolate are not good choices because enzymes are inactivated by heat and starchy foods. Tapioca is also a starchy food.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1071 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

36. The nurse should teach parents of a child with cystic fibrosis to adjust enzyme dosage according to which indicator?
    a. Stool formation
    b. Vomiting
    c. Weight
    d. Urine output

    ANS: A
    When there is constipation, less enzyme is needed; with steatorrhea, more enzyme is needed for digestion of nutrients. Vomiting, weight, and urine output do not affect dosing.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1071 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

37. Which finding confirms a diagnosis of cystic fibrosis?
    a. Chest radiograph shows alveolar hyperinflation.
    b. Stool analysis indicates significant amounts of fecal fat.
    c. Sweat chloride is greater than 60 mEq/L.
    d. Liver function levels are abnormal.

    ANS: C
    The diagnosis of cystic fibrosis requires a positive sweat test. A chloride level greater than 60 mEq/L is considered diagnostic for cystic fibrosis. Hyperinflation is one of the first findings on a chest radiograph of a child with cystic fibrosis. It does not confirm a diagnosis. A 72-hour fecal fat determination may be included in a diagnostic workup. Inability to secrete digestive enzymes causes steatorrhea. Liver function tests may be part of the diagnostic workup for cystic fibrosis.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1068 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

38. Which statement is characteristic of acute otitis media (AOM)?
    a. The etiology is unknown.
    b. Permanent hearing loss often results.
    c. It can be treated by intramuscular (IM) antibiotics.
    d. It is treated with a broad range of antibiotics.

    ANS: D
    Historically AOM has been treated with a range of antibiotics, and it is the most common disorder treated with antibiotics in the ambulatory setting. The etiology of AOM may be *Streptococcus pneumoniae, Haemophilus influenzae,* and *Moraxella catarrhalis* or a viral agent. Recent concerns about drug-resistant organisms have caused authorities to recommend judicious use of antibiotics and that antibiotics are not required for initial treatment. Permanent hearing loss is not frequently caused by properly treated AOM. Intramuscular antibiotics are not necessary.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1038 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

39. An infant's parents ask the nurse about preventing OM. What should be recommended?
    a. Avoid tobacco smoke.
    b. Use nasal decongestant.
    c. Avoid children with OM.
    d. Bottle feed or breastfeed in supine position.

    ANS: A
    Eliminating tobacco smoke from the child's environment is essential for preventing OM and other common childhood illnesses. Nasal decongestants are not useful in preventing OM. Children with uncomplicated OM are not contagious unless they show other upper respiratory infection (URI) symptoms. Children should be fed in an upright position to prevent OM.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1039 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

40. The nurse is caring for a child with acute respiratory distress syndrome (ARDS) associated with sepsis. Nursing actions should include which of the following?
    a. Forcing fluids
    b. Monitoring pulse oximetry
    c. Instituting seizure precautions
    d. Encouraging a high-protein diet

    ANS: B

Monitoring cardiopulmonary status is an important evaluation tool in the care of the child with ARDS. Maintenance of vascular volume and hydration is important and should be done parenterally. Seizures are not a side effect of ARDS. Adequate nutrition is necessary, but a high-protein diet is not helpful.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1053 | Table 45.4 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

41. A home health care nurse is doing a home assessment for a family whose child is oxygen dependent. What finding by the nurse requires intervention?
    a. Tanks are stored only in an upright position.
    b. Oxygen tank is placed 3 feet away from the heater.
    c. Smoking is not allowed in the house.
    d. Fire extinguisher expires at the end of the month.

    ANS: B
    Oxygen tanks or sources should be at least 5 feet away from heat sources. The other findings are safe although the nurse might remind the family to replace the extinguisher prior to its expiration.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1068 | Patient-Centered Teaching Box
    OBJ: Nursing Process: Assessment
    MSC: Client Needs: Safe and Effective Care Environment

MULTIPLE RESPONSE

1. The mother of a newborn asks the nurse what causes the baby to begin to breathe after delivery. What changes in the respiratory system stimulating respirations postnatally can the nurse explain to the mother? (*Select all that apply.*)
    a. Low oxygen levels in the infant's blood
    b. Rubbing the newborn with a towel or blanket
    c. Surfactant, a special lubricant in the lungs
    d. Increased blood flow to the infant's lungs
    e. Cold environment in the delivery room

    ANS: A, B, E
    Hypoxemia, cold, and tactile stimulation all encourage the infant to breathe. Surfactant in the lungs lowers surface tension and facilitates lung expansion. It does not stimulate respirations. Pulmonary blood flow increases after birth, but this does not stimulate respirations in the newborn.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1029 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

2. What information should the nurse teach families about reducing exposure to pollens and dust? (*Select all that apply.*)

a. Replace wall-to-wall carpeting with wood and tile floors.
b. Use an air conditioner.
c. Put dust-proof covers on pillows and mattresses.
d. Keep humidity in the house above 60%.
e. Keep pets outside.

ANS: A, B, C
Carpets retain dust. To reduce exposure to dust, carpeting should be replaced with wood, tile, slate, or vinyl. These floors can be cleaned easily. For anyone with pollen allergies, it is best to keep the windows closed and to run the air conditioner. Covering mattresses and pillows with dust-proof covers will reduce exposure to dust. A humidity level above 60% promotes dust mites. It is recommended that household humidity be kept between 40% and 50% to reduce dust mites inside the house. Keeping pets outside will help to decrease exposure to dander but will not affect exposure to pollen and dust.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1034 | Patient-Centered Teaching Box
OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

3. The nurse should implement which interventions for an infant experiencing apnea? (*Select all that apply*.)
a. Stimulate the infant by gently tapping the foot.
b. Shake the infant vigorously.
c. Have resuscitative equipment available.
d. Suction the infant.
e. Maintain a neutral thermal environment.

ANS: A, C, E
An infant with apnea should be stimulated by gently tapping the foot. Resuscitative equipment should be available, and the infant should be maintained in a neutral thermal environment. The infant should not be shaken vigorously nor suctioned.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1055 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

4. A nurse is planning care for an asymptomatic child with a positive tuberculin test. What should the nurse include in the plan? (*Select all that apply*.)
a. Administration of daily isoniazid (INH)
b. Instructing family members about administration of INH to all close contacts of the child
c. Administration of the bacillus Calmette-Guérin vaccine
d. Reporting the case to the health department
e. Administration of INH and rifampin (Rifadin) simultaneously

ANS: A, B, D

After a chest radiograph is obtained, asymptomatic children with positive tuberculin tests and no previous history of TB receive daily INH for 9 months. Asymptomatic contacts should receive INH for at least 8 to 10 weeks after contact has been broken or until a negative skin test can be confirmed (a second test is taken at least 10 weeks after the last exposure). Reporting cases of TB is required by law in all states in the United States. Bacillus Calmette-Guérin vaccine is the only anti-TB vaccine available, but it is given only to children who have negative test results. For asymptomatic TB, only INH is administered, not both isoniazid and rifampin together. Rifampin is used if the child has resistance to isoniazid.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1073 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

5. Which vitamin supplements are necessary for children with cystic fibrosis?
   a. Vitamin C
   b. Vitamin D
   c. Vitamin A
   d. Vitamin E
   e. Vitamin K

   ANS: B, C, D, E
   Fat-soluble vitamins (A, D, E, and K) are poorly absorbed because of deficient pancreatic enzymes in children with cystic fibrosis; therefore supplements are necessary. Vitamin C is not fat soluble.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1067 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

6. A child has allergies to animal dander but is distraught at having to give away the family dog. What actions could the nurse suggest that might avoid this? (*Select all that apply*.)
   a. Choose a dander-free pet like a lizard.
   b. Keep the dog outside as much as possible.
   c. Install air cleaners in the house.
   d. Use dust-proof pillow covers.
   e. Keep the windows closed in the summer.

   ANS: B, C, D
   Options for the child with allergies to the household pet include keeping the dog outside as much as possible, installing air cleaners, and using dust -proof pillow covers. Getting a lizard won't help because this child has a dog he or she wants to keep. Ventilating the house will also help.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding p. 1034 |
   REF: Patient-Centered Teaching Box Integrated Process: Teaching-Learning
   OBJ: Client Needs: Physiologic Integrity
   MSC:

7. The nurse is assessing a child for epiglottitis. What findings are consistent with this condition? (*Select all that apply.*)
   a. Drooling
   b. Dysphagia
   c. Dysphonia
   d. Distressed inspiratory efforts
   e. Decreased oxygenation

   ANS: A, B, C, D
   The cardinal signs of epiglottitis are drooling, dysphagia, dysphonia, and distressed inspiratory efforts. While the child may develop decreased oxygenation if the airway is severely compromised, this is not a cardinal sign.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1045 | Safety Alert Box OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. Which postoperative intervention should be questioned for a child after a cardiac catheterization?
   a. Continue intravenous (IV) fluids until the infant is tolerating oral fluids.
   b. Check the dressing for bleeding.
   c. Assess peripheral circulation on the affected extremity.
   d. Keep the affected leg flexed and elevated.

   ANS: D
   The child should be positioned with the affected leg straight for 4 to 6 hours after the procedure. The other interventions are appropriate.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 1092 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

2. Which information should be included in the nurse's discharge instructions for a child who underwent a cardiac catheterization earlier in the day?
   a. Pressure dressing is changed daily for the first week.
   b. The child may soak in the tub beginning tomorrow.
   c. Contact sports can be resumed in 2 days.
   d. The child can return to school on the third day after the procedure.

   ANS: D
   The child can generally return to school on the third day after the procedure. The day after the cardiac catheterization, the pressure dressing is removed and replaced with a Band-Aid. Bathing is limited to a shower, a sponge bath, or a brief tub bath (no soaking) for the first 1 to 3 days after the procedure. Strenuous exercise such as contact sports, swimming, or climbing trees is avoided for up to 1 week after the procedure.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1092 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

3. The nurse is admitting a child to the hospital for a cardiac workup. What is the first step in a cardiac assessment?
   a. Percussion
   b. Palpation
   c. Auscultation
   d. History and inspection

   ANS: D

The assessment should begin with the least threatening interventions—the history and inspection. Assessment progression includes inspection, auscultation, and palpation because each step includes more touching. Percussion of the chest is usually deferred. Palpation can be threatening to the child because it requires a significant amount of physical contact. For this reason it is not the initial step in a cardiac assessment. Auscultation requires touching the child and is not the initial step in a cardiac assessment.

PTS: 1 DIF: Cognitive Level: Application REF: p. 1089
OBJ: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

4. In which situation is there a risk that a newborn infant will have a congenital heart defect (CHD)?
   a. Trisomy 21 detected on amniocentesis
   b. Family history of myocardial infarction
   c. Father has type 1 diabetes mellitus
   d. Older sibling born with Turner syndrome

   ANS: A
   The incidence of congenital heart disease is approximately 50% in children with trisomy 21 (Down syndrome). A family history of congenital heart disease, not acquired heart disease, increases the risk of giving birth to a child with CHD. Infants born to mothers who are insulin dependent have an increased risk of CHD. Infants identified as having certain genetic defects, such as Turner syndrome, have a higher incidence of CHD. A family history is not a risk factor.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1081 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

5. Before giving a dose of digoxin the nurse checked an infant's apical heart rate and it was 114 beats/minute. What should the nurse do next?
   a. Administer the dose as ordered.
   b. Hold the medication until the next dose.
   c. Wait and recheck the apical heart rate in 30 minutes.
   d. Notify the physician about the infant's heart rate.

   ANS: A
   The infant's heart rate is above the lower limit for which the medication is held (100 beats/minute in an infant). The dose can be given. No other action is needed.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 1084 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

6. What intervention should be included in the plan of care for an infant with the nursing diagnosis of excess fluid volume related to congestive heart failure?
   a. Weigh the infant every day on the same scale at the same time.
   b. Notify the physician when weight gain exceeds more than 20 g/day.
   c. Put the infant in a car seat to minimize movement.
   d. Administer digoxin as ordered by the physician.

   ANS: A

Excess fluid volume may not be overtly visible. Weight changes may indicate fluid retention. Weighing the infant on the same scale at the same time each day ensures consistency. An excessive weight gain for an infant is an increase of more than 50 g/day. With fluid volume excess, skin will be edematous. The infant's position should be changed frequently to prevent undesirable pooling of fluid in certain areas. Digoxin is used in the treatment of congestive heart failure to improve cardiac function. Diuretics will help the body get rid of excess fluid.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1084 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

7. The nurse assessing a premature newborn infant auscultates a continuous machinery-like murmur. What action by the nurse is most appropriate?
   a. Educate parents on daily low-dose aspirin regime.
   b. Prepare to administer indomethacin.
   c. Administer next dose of enalapril early.
   d. Position infant in the knee–chest position.

   ANS: B
   This murmur is characteristic of a patent ductus arteriosus, which is treated medically with indomethacin. A daily low-dose aspirin is indicated for 6 months following repair of an ASD. ACE inhibitors (enalapril) are used to reduce afterload in a VSD. The knee–chest position is helpful in tet spells that occur in tetralogy of Fallot.

   PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
   REF: p. 1093 | Table 46.3 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

8. What is an expected assessment finding in a child with coarctation of the aorta?
   a. Orthostatic hypotension
   b. Systolic hypertension in the lower extremities
   c. Blood pressure higher on the left side of the body
   d. Disparity in blood pressure between the upper and lower extremities

   ANS: D
   The classic finding in children with coarctation of the aorta is a disparity in pulses and blood pressures between the upper and lower extremities. Orthostatic hypotension is not present with coarctation of the aorta. Systolic hypertension may be detected in the upper extremities. The left arm may not accurately reflect systolic hypertension because the left subclavian artery can be involved in the coarctation.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1091 | Table 46.2 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

9. A child with pulmonary atresia exhibits cyanosis with feeding. On reviewing this child's laboratory values, the nurse is not surprised to notice which abnormality?
   a. Polycythemia
   b. Infection
   c. Dehydration
   d. Anemia

ANS: A
Polycythemia is a compensatory response to chronic hypoxia. The body attempts to improve tissue oxygenation by producing additional red blood cells and thereby increases the oxygen-carrying capacity of the blood. Infection, dehydration, and anemia are not clinical consequences of cyanosis.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1088 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

10. Which statement made by a parent indicates understanding of restrictions for a child after cardiac surgery?
    a. "My child needs to go to bed early for a few weeks."
    b. "My son is really looking forward to riding his bike next week."
    c. "I'm so glad we can attend religious services as a family this coming Sunday."
    d. "I am going to keep my child out of day care for 6 weeks."

ANS: D
Settings where large groups of people are present should be avoided for 4 to 6 weeks after discharge, including day care and other public places such as churches. The child should resume his regular bedtime and sleep schedule after discharge. Due to fatigue, the child may initially need some naps during the day.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 1104 | Patient-Centered Teaching Box OBJ: Nursing Process: Evaluation
MSC: Client Needs: Physiologic Integrity

11. A child had an aortic stenosis defect surgically repaired 5 months ago. Which antibiotic prophylaxis is indicated for an upcoming tonsillectomy?
    a. No antibiotic prophylaxis is necessary.
    b. Amoxicillin is taken orally 1 hour before the procedure.
    c. Oral penicillin is given for 7 to 10 days before the procedure.
    d. Parenteral antibiotics are administered for 5 to 7 days after the procedure.

ANS: B
The standard prophylactic agent is amoxicillin given orally 1 hour before the procedure. Antibiotic prophylaxis is indicated for the first 6 months after surgical repair. Antibiotic prophylaxis is not given for 7 to 10 days nor is it given parenterally.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1105 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

12. The nurse discovers a heart murmur in an infant 1 hour after birth. What does the nurse know about when fetal shunts close in the neonate?
    a. When the umbilical cord is cut
    b. Within several days of birth
    c. Within a month after birth
    d. By the end of the first year of life

ANS: B

In the normal neonate, fetal shunts functionally close in response to pressure changes in the systemic and pulmonary circulations and to increased oxygen content. This process may take several days to complete. With the neonate's first breath, gas exchange is transferred from the placenta to the lungs. The separation of the fetus from the umbilical cord does not contribute to the establishment of neonatal circulation.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1079 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

13. When assessing a child for possible congenital heart defects (CHDs), where should the nurse measure blood pressure?
    a. The right arm
    b. The left arm
    c. All four extremities
    d. Both arms while the child is crying

ANS: C
When a CHD is suspected, the blood pressure should be measured in all four extremities while the child is quiet. Discrepancies between upper and lower extremities may indicate cardiac disease.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1091 | Table 46.2 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

14. What is the nurse's first action when planning to teach the parents of an infant with a CHD?
    a. Assess the parents' anxiety level and readiness to learn.
    b. Gather literature for the parents.
    c. Secure a quiet place for teaching.
    d. Discuss the plan with the nursing team.

ANS: A
Any effort to organize the right environment, plan, or literature is of no use if the parents are not ready to learn or have high anxiety. Decreasing level of anxiety is often needed before new information can be processed. A baseline assessment of prior knowledge should be taken into consideration before developing any teaching plan. Locating a quiet place for meeting with parents is appropriate; however, an assessment should be done before any teaching is done. Discussing a teaching plan with the nursing team is appropriate after an assessment of the parents' knowledge and readiness.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1085 OBJ: Nursing Process: Planning
MSC: Client Needs: Health Promotion and Maintenance

15. Which statement best describes patent ductus arteriosus?
    a. Patent ductus arteriosus involves a defect that results in a right-to-left shunting of blood in the heart.
    b. Patent ductus arteriosus involves a defect in which the fetal shunt between the aorta and the pulmonary artery fails to close.
    c. Patent ductus arteriosus is a stenotic lesion that must be surgically corrected at

birth.

d. Patent ductus arteriosus causes an abnormal opening between the four chambers of the heart.

ANS: B
Patent ductus arteriosus is failure of the fetal shunt between the aorta and the pulmonary artery to close. Patent ductus arteriosus allows blood to flow from the high-pressure aorta to the low-pressure pulmonary artery, resulting in a left-to-right shunt. Patent ductus arteriosus is not a stenotic lesion. Patent ductus arteriosus can be closed both medically and surgically. Atrioventricular defect occurs when fetal development of the endocardial cushions is disturbed, resulting in abnormalities in the atrial and ventricular septa and the atrioventricular valves.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1093 | Table 46.3 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

16. For what reason might a newborn infant with a cardiac defect, such as coarctation of the aorta, that results in a right-to-left shunt receive prostaglandin E_1?
    a. To decrease inflammation
    b. To control pain
    c. To decrease respirations
    d. To improve oxygenation

ANS: D
Prostaglandin E_1 is given to infants with a right -to-left shunt to keep the ductus arteriosus patent. This will improve oxygenation. It is not given for inflammation, pain, or to decrease respirations.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1089 | p. 1091 | Table 46.3 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

17. Which CHD results in increased pulmonary blood flow?
    a. Ventricular septal defect
    b. Coarctation of the aorta
    c. Tetralogy of Fallot
    d. Pulmonary stenosis

ANS: A
Ventricular septal defect causes a left- to-right shunting of blood, thus increasing pulmonary blood flow. Coarctation of the aorta is a stenotic lesion that causes increased resistance to blood flow from the proximal to distal aorta. The defects associated with tetralogy of Fallot result in a right -to-left shunting of blood, thus decreasing pulmonary blood flow. Pulmonary stenosis causes obstruction of blood flow from the right ventricle to the pulmonary artery. Pulmonary blood flow is decreased.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1094 | Table 46.3 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

18. Which statement suggests that a parent understands how to correctly administer digoxin?

a. “I measure the amount I am supposed to give with a teaspoon.”
b. “I put the medicine in the baby’s bottle.”
c. “When she spits up right after I give the medicine, I give her another dose.”
d. “I give the medicine at 8 in the morning and evening every day.”

ANS: D
For maximum effectiveness, the medication should be given at the same time every day. The maintenance dose is given in two divided doses daily. To ensure the correct dosage, the medication should be measured with a syringe. To prevent toxicity, the parent should not repeat the dose without contacting the child’s physician.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 1083 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Physiologic Integrity

19. What is the appropriate priority nursing action for the infant with a CHD who has an increased respiratory rate, is sweating, and is not feeding well?
a. Recheck the infant’s blood pressure.
b. Alert the provider.
c. Withhold oral feeding.
d. Increase the oxygen rate.

ANS: B
These are signs of early congestive heart failure, and the provider should be notified. Rechecking the blood pressure is not necessary. Withholding the infant’s feeding is an incomplete response to the problem. Increasing oxygen may alleviate symptoms, but medications such as digoxin and furosemide are necessary to improve heart function and fluid retention. Notifying the provider is the priority nursing action.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1084 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

20. Nursing care for the child in congestive heart failure includes which of the following activities?
a. Counting the number of saturated diapers
b. Putting the infant in the Trendelenburg position
c. Removing oxygen while the infant is crying
d. Organizing care to provide rest periods

ANS: D
Nursing care should be planned to allow for periods of undisturbed rest. Diapers must be weighed for an accurate record of output. The head of the bed should be raised to decrease the work of breathing. Oxygen should be administered during stressful periods such as when the child is crying if needed.

PTS: 1 DIF: Cognitive Level: Application REF: p. 1084
OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

21. Which strategy is appropriate when feeding the infant with congestive heart failure?
a. Continue the feeding until a sufficient amount of formula is taken.
b. Limit feeding time to no more than 30 minutes.

c. Always bottle feed every 4 hours.
d. Feed larger volumes of concentrated formula less frequently.

ANS: B
The infant with congestive heart failure may tire easily, so the feeding should not continue beyond 30 minutes. If inadequate amounts of formula are taken, gavage feedings should be considered. The infant is fed smaller volumes of concentrated formula every 3 hours.

PTS: 1 DIF: Cognitive Level: Application REF: p. 1085
OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

22. A nurse is teaching an adolescent about primary hypertension. Which statement made by the adolescent indicates an understanding of primary hypertension?
a. Primary hypertension should be treated with diuretics as soon as it is detected.
b. Congenital heart defects are the most common cause of primary hypertension.
c. Primary hypertension may be treated with weight reduction.
d. Primary hypertension is not affected by exercise.

ANS: C
Primary hypertension in children may be treated with weight reduction and exercise programs. Primary hypertension is usually treated with weight reduction and exercise. If ineffective, pharmacologic intervention may be needed. An exercise program in conjunction with weight reduction can be effective in managing primary hypertension in children.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 1113 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Health Promotion and Maintenance

23. An adolescent being seen by the nurse practitioner for a sports physical is identified as having hypertension. On further testing, it is discovered the child has a cardiac abnormality. The initial treatment of secondary hypertension initially involves
a. weight control and diet.
b. treating the underlying disease.
c. administration of digoxin.
d. administration of beta-adrenergic receptor blockers.

ANS: B
Identification and treatment of the underlying disease should be the first step in treating secondary hypertension. Weight control and diet are non-pharmacologic treatments for primary hypertension. Digoxin is indicated in the treatment of congestive heart failure. Beta-adrenergic receptor blockers may be indicated in the treatment of secondary hypertension, but the main focus is on identifying and treating the underlying cause.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1114 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

24. What should the nurse include in discharge teaching as the highest priority for the child with a cardiac dysrhythmia?
a. CPR instructions
b. Repeating digoxin if the child vomits
c. Resting if dizziness occurs

d. Checking the child’s pulse after digoxin administration

ANS: A
This could potentially be life -saving for the child. The parents and significant others in the child’s life should have CPR training. The digoxin dose is not repeated if the child vomits. Dizziness is a symptom the child should be taught to report to adults so that the physician can be notified. It is not the priority intervention. The child’s pulse should be counted before the medication is given. The dose is withheld if the pulse is below the parameters set by the physician.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1108 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

25. A nurse is assigned to care for an infant with an unrepaired tetralogy of Fallot. What should the nurse do first when the baby is crying and becomes severely cyanotic?
a. Place the infant in a knee–chest position.
b. Administer oxygen.
c. Administer morphine sulfate.
d. Calm the infant.

ANS: D
Calming the crying infant is the first response. An infant with unrepaired tetralogy of Fallot who is crying and agitated may eventually lose consciousness. Placing the infant in a knee–chest position will decrease venous return so that smaller amounts of highly saturated blood reach the heart. This should be done after calming the infant. Administering oxygen is indicated after placing the infant in a knee–chest position. Administering morphine sulfate calms the infant and depresses respirations. It may be indicated sometime after the infant has been calmed.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1088 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

26. The nurse caring for a child diagnosed with acute rheumatic fever should assess the child for which of the following?
a. Sore throat
b. Elevated blood pressure
c. Desquamation of the fingers and toes
d. Tender, warm, inflamed joints

ANS: D
Arthritis, characterized by tender, warm, erythematous joints, is one of the major manifestations of acute rheumatic fever in the first 1 to 2 weeks of the illness. The child may have had a sore throat previously associated with a group A beta- hemolytic streptococcal infection a few weeks earlier. A sore throat is not a manifestation of rheumatic fever. Hypertension is not associated with rheumatic fever. Desquamation of the fingers and toes is a manifestation of Kawasaki syndrome.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1109 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

27. The nurse is admitting a child who has been diagnosed with Kawasaki disease. What is the most serious complication for which the nurse should assess in Kawasaki disease?
    a. Cardiac valvular disease
    b. Cardiomyopathy
    c. Coronary aneurysm
    d. Rheumatic fever

    ANS: C
    Coronary artery aneurysms are seen in 20% to 25% of children with untreated Kawasaki disease. Cardiac valvular disease can occur in rheumatic fever. Cardiomyopathies are diseases of the heart muscle, which can occur as a result of congenital heart disease, coronary artery disease, or other systemic disease. Rheumatic fever is not a complication of Kawasaki disease.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1111 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

28. A nurse is conducting a class for nursing students about fetal circulation. Which statement is accurate about fetal circulation and should be included in the teaching session?
    a. Oxygen is carried to the fetus by the umbilical arteries.
    b. Blood from the inferior vena cava is shunted directly to the right ventricle through the foramen ovale.
    c. Pulmonary vascular resistance is high because the lungs are filled with fluid.
    d. Blood flows from the ductus arteriosus to the pulmonary artery.

    ANS: C
    Resistance in the pulmonary circulation is very high because the lungs are collapsed and filled with fluid. Oxygen and nutrients are carried to the fetus by the umbilical vein. The inferior vena cava empties blood into the right atrium. The direction of blood flow and the pressure in the right atrium propel most of this blood through the foramen ovale into the left atrium. Most of the blood in the pulmonary artery flows though the ductus arteriosus into the descending aorta.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1079 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

29. Which defect results in increased pulmonary blood flow?
    a. Pulmonic stenosis
    b. Tricuspid atresia
    c. Atrial septal defect
    d. Transposition of the great arteries

    ANS: C
    The atrial septal defect results in increased pulmonary blood flow. Blood flows from the left atrium (higher pressure) into the right atrium (lower pressure) and then to the lungs via the pulmonary artery. The other three diseases do not result in increased pulmonary blood flow.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1093 | Table 46.3 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

30. A beneficial effect of administering digoxin is that it
    a. decreases edema.
    b. decreases cardiac output.
    c. increases heart size.
    d. increases venous pressure.

    ANS: A
    Digoxin improves cardiac output, which will lead to decreased edema although it is not a diuretic. It does not increase heart size or increase venous pressure.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1083 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

31. Which drug is an angiotensin-converting enzyme (ACE) inhibitor?
    a. Captopril
    b. Furosemide
    c. Spironolactone
    d. Chlorothiazide

    ANS: A
    Capoten is an ACE inhibitor. Furosemide is a loop diuretic. Spironolactone blocks the action of aldosterone. Chlorothiazide is a diuretic.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1083 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

32. What is the most common causative agent of bacterial endocarditis?
    a. *Staphylococcus albus*
    b. *Streptococcus hemolyticus*
    c. *Staphylococcus albicans*
    d. *Streptococcus viridans*

    ANS: D
    S. viridans and *S. aureus* are the most common causative agents in bacterial (infective) endocarditis. The others are not common causative agents.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1104 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

33. The primary nursing intervention to prevent bacterial endocarditis is which of the following?
    a. Institute measures to prevent dental procedures.
    b. Counsel parents of high-risk children about prophylactic antibiotics.
    c. Observe children for complications, such as embolism and heart failure.
    d. Encourage restricted mobility in susceptible children.

    ANS: B

The objective of nursing care is to counsel the parents of high-risk children about both the need for prophylactic antibiotics for dental procedures and the necessity of maintaining excellent oral health. The child's dentist should be aware of the child's cardiac condition. Dental procedures should be done to maintain a high level of oral health. Prophylactic antibiotics are necessary. Observing children for complications should be done, but maintaining good oral health and prophylactic antibiotics is important. Restricted mobility may or may not be necessary.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1105 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

34. A common, serious complication of rheumatic fever is
    a. seizures.
    b. cardiac dysrhythmias.
    c. pulmonary hypertension.
    d. cardiac valve damage.

    ANS: D
    Cardiac valve damage is the most significant complication of rheumatic fever. The other three are not common complications of rheumatic fever.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1109 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

35. The nurse is caring for a child with Kawasaki disease. The child weighs 33 pounds. When initiating aspirin therapy, what dose does the nurse prepare to administer?
    a. 75 mg orally once a day
    b. 81 mg orally twice a day
    c. 200 mg three times a day
    d. 375 mg orally four times a day

    ANS: D
    When initiating aspiring for Kawasaki disease, it is started at the anti-inflammatory dose of 80 to 100 mg/kg divided into four doses a day. This child weighs 15 kg so 100 mg × 15 kg = 1500 mg. Divided into four doses is 375 mg four times a day. 75 mg once a day is the maintenance dose used for antiplatelet aggregate purposes. 81 mg a day is the adult antiplatelet aggregate dose.

    PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
    REF: p. 1111 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. The nurse working in the newborn nursery notices an infant who is having circumoral cyanosis. Which CHD does the nurse suspect the child may have? (*Select all that apply.*)
    a. Patent ductus arteriosus (PDA)
    b. Tetralogy of Fallot
    c. Pulmonary atresia

d. Transposition of the great arteries
e. Ventricular septal defect

ANS: B, C, D
Tetralogy of Fallot is a cyanotic lesion with decreased pulmonary blood flow. The hypoxia results in baseline oxygen saturations as low as 75% to 85%. Even with oxygen administration, saturations do not reach the normal range. Pulmonary atresia is a cyanotic lesion with decreased pulmonary blood flow. The hypoxia results in baseline oxygen saturations as low as 75% to 85%. Even with oxygen administration, saturations do not reach the normal range. Transposition of the great arteries is a cyanotic lesion with increased pulmonary blood flow. PDA is failure of the fetal shunt between the aorta and the pulmonary artery to close. PDA is not classified as a cyanotic heart disease. Prostaglandin E_1 is often given to maintain ductal patency in children with cyanotic heart diseases. VSD is the most common type of cardiac defect. The VSD is a left-to-right shunting defect; however, it may be accompanied by other defects.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: pp. 1193-1197 | Table 46.3 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

2. A child has a total cholesterol level of 180 mg/dL. What dietary recommendations should the nurse make to the child and the child's parents? (*Select all that apply.*)
a. Replace whole milk with 1% milk.
b. Increase servings of red meat.
c. Increase servings of fish.
d. Avoid excessive intake of fruit juices.
e. Limit servings of whole grain.

ANS: A, C, D
A low-fat diet includes using nonfat or low-fat dairy products, limiting red meat intake, and increasing intake of fish, vegetables, whole grains, and legumes. Children should avoid excessive intake of fruit juices and other sweetened drinks, sugars, and saturated fats.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1115 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

3. A nurse is conducting discharge teaching to parents about the care of their infant after cardiac surgery. The nurse instructs the parents to notify the physician if which conditions occur? (*Select all that apply.*)
a. Respiratory rate of 36 at rest
b. Appetite slowly increasing
c. Temperature above 37.7° C (100° F)
d. New, frequent coughing
e. Turning blue or bluer than normal

ANS: C, D, E
The parents should be instructed to notify the physician after their infant's cardiac surgery for a temperature above 37.7° C; new, frequent coughing; and any episodes of the infant turning blue or bluer than normal. A respiratory rate of 36 at rest for an infant is within normal expectations, and it is expected that the appetite will increase slowly.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1104 | Patient-Centered Teaching Box
OBJ: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

COMPLETION

1. A child who weighs 37 pounds needs a dose of lidocaine prior to cardioversion for ventricular tachycardia. What dose does the nurse prepare to administer? Write your answer using a whole number. _____ mg

   ANS:
   17

   First determine the child's weight in kg: 37/2.2 = 16.6666. Lidocaine is dosed at 1 mg/kg 16.6666 × 1 = 16.6666. Round up to the nearest whole number = 17 mg.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 1107 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. What is the best response to a parent who asks the nurse whether her 5-month-old infant can have cow's milk?
   a. "You need to wait until she is 8 months old and eating solids well."
   b. "Yes, if you think that she will eat enough meat to get the iron she needs."
   c. "Infants younger than 12 months need iron-rich formula to get the iron they need."
   d. "Try it and see how she tolerates it."

   ANS: C
   Infants younger than 12 months need iron-fortified formula or breast milk. Infants who drink cow's milk do not get adequate iron and are at risk for iron-deficiency anemia. A 5- month- old infant cannot get adequate iron without drinking an iron-fortified formula or taking an iron supplement. Counseling a parent to give a 5-month-old infant cow's milk is inappropriate.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: pp. 1120-1121 | p. 1122 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

2. An assessment of a 7-month-old infant with a hemoglobin level of 6.5 mg/dL is likely to reveal an infant who is
   a. lethargic, pale, and irritable.
   b. thin, energetic, and sleeps little.
   c. anorexic, vomiting, and has watery stools.
   d. flushed, fussy, and tired.

   ANS: A
   Pallor, lethargy, irritability, and tachycardia are clinical manifestations of iron-deficiency anemia. A child with a hemoglobin level of 6.5 mg/dL has anemia. Typically these children will not be thin, energetic, anorexic, have GI complaints, or flushed. They may be tired, fussy, and sleep a lot.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1121 | Parents Want to Know Box
   OBJ: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

3. A nurse is evaluating parents' knowledge about caring for their child who has iron-deficiency anemia. Which action shows the parents need further education?
   a. Decreasing the infant's daily milk intake to 24 oz or less
   b. Giving oral iron supplements between meals with orange juice
   c. Including apricots, dark-green leafy vegetables, and egg yolk in the infant's diet
   d. Allowing the infant to drink the iron supplement from a small medicine cup

   ANS: D

Iron supplements should be administered through a straw or by a medicine dropper placed at the back of the mouth because iron temporarily stains the teeth. A daily milk intake in toddlers of less than 24 oz will encourage the consumption of iron-rich solid foods. Because food interferes with the absorption of iron, iron supplements are taken between meals. Administering this medication with foods rich in vitamin C facilitates absorption of iron. Apricots, dark-green leafy vegetables, and egg yolks are rich sources of iron. Other iron-rich foods include liver, dried beans, Cream of Wheat, iron-fortified cereal, and prunes.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 1118 | p. 1121 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Physiologic Integrity

4. Which of the following is an accurate description of anemia?
   a. Increased blood viscosity
   b. Depressed hematopoietic system
   c. Presence of abnormal hemoglobin
   d. Decreased oxygen-carrying capacity of blood

   ANS: D
   Anemia is a condition in which the number of red blood cells or hemoglobin concentration is reduced below the normal values for age. This results in a decreased oxygen- carrying capacity of blood. Increased blood viscosity is usually a function of too many cells or of dehydration, not of anemia. A depressed hematopoietic system or abnormal hemoglobin can contribute to anemia, but the definition is dependent on the deceased oxygen-carrying capacity of the blood. A depressed hematopoietic system or abnormal hemoglobin can contribute to anemia, but the definition is dependent on the decreased oxygen-carrying capacity of the blood.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1118 | p. 1121 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

5. What is true about the genetic transmission of sickle cell disease?
   a. Both parents must carry the sickle cell trait.
   b. Both parents must have sickle cell disease.
   c. One parent must have the sickle cell trait.
   d. Sickle cell disease has no known pattern of inheritance.

   ANS: A
   In this scenario, there is a 50% risk of having a child with sickle cell disease. The sickle cell trait, not the disease itself, must be present in the parents for the child to have the disease. An autosomal recessive pattern of inheritance means that both parents must be carriers of the sickle cell trait. Sickle cell disease is known to have an autosomal recessive pattern of inheritance.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1121 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

6. A condition in which the normal adult hemoglobin is partly or completely replaced by abnormal hemoglobin is known as
   a. aplastic anemia.

b. sickle cell anemia.
c. thalassemia major.
d. iron-deficiency anemia.

ANS: B
Sickle cell anemia is one of a group of diseases collectively called *hemoglobinopathies*, in which normal adult hemoglobin is replaced by an abnormal hemoglobin. Aplastic anemia is a lack of cellular elements being produced. Hemophilia refers to a group of bleeding disorders in which there is deficiency of one of the factors necessary for coagulation. Iron-deficiency anemia affects size and depth of color and does not involve an abnormal hemoglobin.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1121 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

7. What are the nursing priorities for a child with sickle cell disease in vaso-occlusive crisis?
a. Administration of antibiotics and nebulizer treatments
b. Hydration and pain management
c. Blood transfusions and an increased calorie diet
d. School work and diversion

ANS: B
Hydration and pain management decrease the cells' oxygen demands and prevent sickling. Antibiotics may be given prophylactically. Oxygen therapy rather than nebulizer treatments is used to prevent further sickling. Although blood transfusions and increased calories may be indicated, they are not primary considerations for vaso-occlusive crisis. School work and diversion are not major considerations when the child is in a vaso-occlusive crisis.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1126 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

8. What describes the pathologic changes of sickle cell anemia?
a. Sickle-shaped cells carry excess oxygen.
b. Sickle-shaped cells decrease blood viscosity.
c. Increased red blood cell destruction occurs.
d. Decreased red blood cell destruction occurs.

ANS: C
The clinical features of sickle cell anemia are primarily the result of increased red blood cell destruction and obstruction caused by the sickle-shaped red blood cells. Sickled red cells have decreased oxygen-carrying capacity and transform into the sickle shape in conditions of low oxygen tension. When the sickle cells change shape, they increase the viscosity in the area where they are involved in the microcirculation. Increased red blood cell destruction occurs.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1125 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

9. Which clinical manifestation should the nurse expect when a child with sickle cell anemia experiences an acute vaso-occlusive crisis?
a. Circulatory collapse

b. Cardiomegaly, systolic murmurs
c. Hepatomegaly, intrahepatic cholestasis
d. Painful swelling of hands and feet, painful joints

ANS: D
A vaso-occlusive crisis is characterized by severe pain in the area of involvement. If it is in the extremities, painful swelling of the hands and feet is seen; if in the abdomen, severe pain resembles that of acute surgical abdomen; and if in the head, stroke and visual disturbances occur. Circulatory collapse results from sequestration crises. Cardiomegaly, systolic murmurs, hepatomegaly, and intrahepatic cholestasis result from chronic vaso-occlusive phenomena.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1124 |Table 47.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

10. What should the discharge plan for a school-age child with sickle cell disease include?
a. Restricting the child's participation in outside activities
b. Administering aspirin for pain or fever
c. Limiting the child's interaction with peers
d. Administering penicillin daily as ordered

ANS: D
Children with sickle cell disease are at high risk for pneumococcal infections and should receive long-term penicillin therapy and preventive immunizations. Sickle cell disease does not prohibit the child from outdoor play. Active and passive exercises help promote circulation. Aspirin use should be avoided. Acetaminophen or ibuprofen should be administered for fever or pain. The child needs to interact with peers to meet his or her developmental needs.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1125 | Patient-Centered Teaching Box OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

11. A child has beta-thalassemia and is receiving deferoxamine. The parent asks what the purpose of this medication is. Which response by the nurse is best?
a. "To improve the anemia"
b. "To decrease liver and spleen swelling"
c. "To eliminate excessive iron being stored in the organs"
d. "To prepare your child for a bone marrow transplant"

ANS: C
Excessive iron overload (hemosiderosis) causes organ damage. Chelation therapy with deferoxamine removes the iron stored in organs. It is not a treatment for existing conditions such as hepatosplenomegaly nor is it used prior to a bone marrow transplant.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1128 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

12. Which statement best describes beta-thalassemia major (Cooley anemia)?
a. All formed elements of the blood are depressed.
b. Inadequate numbers of red blood cells are present.

c. Increased incidence occurs in families of Mediterranean extraction.
d. Increased incidence occurs in persons of West African descent.

ANS: C
Individuals who live near the Mediterranean Sea and their descendants have the highest incidence of thalassemia. An overproduction of red cells occurs. Although numerous, the red cells are relatively unstable. Sickle cell disease is common in blacks of West African descent.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1128 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

13. What is the priority nursing intervention for a child hospitalized with hemarthrosis resulting from hemophilia?
a. Immobilization and elevation of the affected joint
b. Administration of acetaminophen for pain relief
c. Assessment of the child's response to hospitalization
d. Assessment of the impact of hospitalization on the family system

ANS: A
Although acetaminophen may help with pain associated with the treatment of hemarthrosis, it is not the priority nursing intervention. Although acetaminophen may help with pain associated with the treatment of hemarthrosis, it is not the priority nursing intervention. Assessment of a child's response to hospitalization is relevant to all hospitalized children; however, in this situation, psychosocial concerns are secondary to physiologic concerns. A priority nursing concern for this child is the management of hemarthrosis. Assessing the impact of hospitalization on the family system is relevant to all hospitalized children, but it is not the priority in this situation.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: pp. 1131-1132 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

14. What is descriptive of most cases of hemophilia?
a. Autosomal dominant disorder causing deficiency in a factor involved in the blood-clotting reaction
b. X-linked recessive inherited disorder causing deficiency of platelets and prolonged bleeding
c. X-linked recessive inherited disorder in which a blood-clotting factor is deficient
d. Y-linked recessive inherited disorder in which the red blood cells become moon shaped

ANS: C
The inheritance pattern in 80% of all cases of hemophilia is X-linked recessive and results in deficient amounts of blood- clotting factors. The disorder involves coagulation factors, not platelets. The disorder does not involve red cells or the Y chromosome.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1302 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

15. The mother of a child with hemophilia asks the nurse how long her child will need to be treated for hemophilia. What is the best response to this question?
    a. “Hemophilia is a lifelong blood disorder.”
    b. “There is a 25% chance that your child will have spontaneous remission.”
    c. “Treatment continues until after the toddler years.”
    d. “Since your first child did not have hemophilia, treatment for this child is temporary.”

    ANS: A
    Hemophilia is a lifelong hereditary blood disorder with no cure. Treatment is life long.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1129 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

16. In teaching family members about their child’s von Willebrand disease, what is the priority outcome for the child that the nurse should discuss?
    a. Prevention of injury
    b. Maintaining adequate hydration
    c. Compliance with chronic transfusion therapy
    d. Prevention of respiratory infections

    ANS: A
    Hemorrhage as a result of injury is the child’s greatest threat to life. Fluid volume status becomes a concern when hemorrhage has occurred. The treatment of von Willebrand disease is desmopressin acetate (DDAVP), which is administered intranasally or intravenously. Respiratory infections do not constitute a major threat to the child with von Willebrand disease.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1132 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

17. A child who has been in good health has a platelet count of 45,000/mm^3, petechiae, and excessive bruising that covers the body. The nurse is aware that these signs are clinical manifestations of which disease?
    a. Erythroblastopenia
    b. von Willebrand disease
    c. Hemophilia
    d. Immune thrombocytopenic purpura (ITP)

    ANS: D
    Excessive bruising and petechiae, especially involving the mucous membranes and gums in a child who is otherwise healthy, are the clinical manifestations of ITP, resulting from decreased platelets. The etiology of ITP is unknown, but it is considered to be an autoimmune process. They are not characteristic of erythroblastopenia, von Willebrand disease, or hemophilia.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1134 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

18. What is the priority in the discharge plan for a child with immune thrombocytopenic purpura (ITP)?
    a. Teaching the parents to report excessive fatigue to the physician
    b. Monitoring the child's hemoglobin level every 2 weeks
    c. Providing a diet that contains iron-rich foods
    d. Establishing a safe, age-appropriate home environment

    ANS: D
    Prevention of injury is a priority concern for a child with ITP. Excessive fatigue is not a significant problem for the child with ITP. ITP is associated with low platelet levels, not hemoglobin. Increasing the child's intake of iron in the diet will not correct ITP.

    PTS: 1 DIF: Cognitive Level: Application/Application
    REF: p. 1135 | Patient-Centered Teaching Box
    OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

19. What is a priority intervention in planning care for the child with disseminated intravascular coagulation (DIC)?
    a. Hospitalization at the first sign of bleeding
    b. Teaching the child relaxation techniques for pain control
    c. Management in the intensive care unit
    d. Provision of adequate hydration to prevent complications

    ANS: C
    The child with DIC is seriously ill and needs to be monitored in an intensive care unit. DIC typically develops in a child who is already hospitalized. Relaxation techniques and pain control are not high priorities for the child with DIC. Hydration is not the major concern for the child with DIC.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1136 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

20. What is the nurse's best response to parents with questions about how her child's blood disorder will be treated?
    a. "Your child may be able to receive home care."
    b. "What did the provider tell you?"
    c. "Blood diseases are transient, so there is no need to worry."
    d. "Your child will be tired for a while and then be back to normal."

    ANS: B
    Providing the parents an opportunity to express what they were told by the physician allows the nurse to assess the parents' understanding and provide further information. Treatment depends on the child's condition and the type of blood disorder. Although it is possible that the child could be treated in the home, the child may need to be treated as an outpatient or in the hospital. It is best to first assess what the parents have been told by the physician. Minimizing the parents' concern is inappropriate. The nurse needs to assess the parents' knowledge before teaching about the disease.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1120 OBJ: Integrated Process: Communication and Documentation
    MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. The nurse is caring for a child with aplastic anemia. What nursing diagnoses are appropriate? (*Select all that apply*.)
   a. Acute Pain related to vaso-occlusion
   b. Risk for Infection related to inadequate secondary defenses or immunosuppression
   c. Ineffective Protection related to thrombocytopenia
   d. Ineffective Tissue Perfusion related to anemia
   e. Ineffective Protection related to abnormal clotting

   ANS: B, C, D
   These are appropriate nursing diagnosis for the nurse planning care for a child with aplastic anemia. Aplastic anemia is a condition in which the bone marrow ceases production of the cells it normally manufactures, resulting in pancytopenia. The child will have varying degrees of the disease depending on how low the values are for absolute neutrophil count (affecting the body's response to infection), platelet count (putting the child at risk for bleeding), and absolute reticulocyte count (causing the child to have anemia). Acute pain related to vaso-occlusion is an appropriate nursing diagnosis for sickle cell anemia for the child in vaso-occlusive crisis, but it is not applicable to a child with aplastic anemia. Ineffective protection related to abnormal clotting is an appropriate diagnosis for von Willebrand disease.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 1137 OBJ: Nursing Process: Diagnosis
   MSC: Client Needs: Physiologic Integrity

2. The nurse is caring for a child with iron-deficiency anemia. What should the nurse expect to find when reviewing the results of the complete blood count (CBC)? (*Select all that apply*.)
   a. Low hemoglobin levels
   b. Elevated red blood cell (RBC) levels
   c. Elevated mean cell volume (MCV) levels
   d. Low reticulocyte count
   e. Decreased MCV levels

   ANS: A, D, E
   The results of the complete blood count in a child with iron-deficiency anemia will show low hemoglobin levels (6 to 11 g/dL) and microcytic, hypochromic RBCs; this manifests as decreased MCV and decreased mean cell hemoglobin. The reticulocyte count is usually slightly elevated or normal, and MCV levels are decreased, not increased.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1120 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. A nurse is teaching home care instructions to parents of a child with sickle cell disease. Which instructions should the nurse include? (*Select all that apply*.)
   a. Limit fluid intake.
   b. Administer aspirin for fever.
   c. Administer penicillin as ordered.
   d. Avoid cold and extreme heat.
   e. Provide for adequate rest periods.

ANS: C, D, E
Parents should be taught to avoid cold, which can increase sickling, and extreme heat, which can cause dehydration. Adequate rest periods should be provided. Penicillin should be administered daily as ordered. The use of aspirin should be avoided; acetaminophen or ibuprofen should be used as an alternative. Fluids should be encouraged, and an increase in fluid intake is encouraged in hot weather or when there are other risks for dehydration.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1125 | Patient-Centered Teaching Box
OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

4. The nurse is caring for a child who has beta-thalassemia. What unique facial features does the nurse assess in this child? (*Select all that apply*.)
   a. Frontal bossing
   b. Strabismus
   c. Wide-set eyes
   d. Maxillary prominence
   e. Distinct overbite

   ANS: A, C, D
   Children with undertreated beta-thalassemia have distinct facial features including frontal bossing, wide-set eyes, and maxillary prominence. They do not have strabismus or overbites.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1128 | Box 47.1 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

5. The nurse assesses the lab values of a child hospitalized with DIC. What findings are consistent for this disorder? (*Select all that apply*.)
   a. Decreased platelet count
   b. Increased hemoglobin
   c. Prolonged prothrombin time
   d. Elevated D-dimer
   e. Pancytopenia

   ANS: A, C, D
   Laboratory findings in DIC include decreased platelet count, prolonged prothrombin time, and elevated D-dimer. Increased hemoglobin and pancytopenia are not seen.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1136 | Box 47.2 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. The nurse notes that a child's gums bleed easily and that the child has bruising and petechiae on his extremities. What laboratory values are consistent with these symptoms?
   a. Platelet count of 19,000/mm^3
   b. Prothrombin time of 11 to 15 seconds
   c. Hematocrit of 34
   d. Leukocyte count of 14,000/mm^3

   ANS: A

   The normal platelet count is 150,000 to 400,000/mm^3. This finding is very low, indicating an increased bleeding potential. The child should be monitored closely for signs of bleeding. The prothrombin time of 11 to 15 seconds is within normal limits. The normal hematocrit is 35 to 45, and although this finding is low, it would not create the symptoms presented. This value indicates the probable presence of infection, but it is not a reflection of bleeding tendency.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1151 | p. 1144 | Box 48.1 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

2. The nurse understands that the types of precautions needed for children receiving chemotherapy are based on which action of chemotherapeutic agents?
   a. Gastrointestinal upset
   b. Bone marrow suppression
   c. Decreased creatinine level
   d. Alopecia

   ANS: B

   Chemotherapy agents cause bone marrow suppression, which creates the need to institute precautions related to reduced white blood cell, red blood cell, and platelet counts. These precautions focus on preventing infection and bleeding. Although gastrointestinal upset may be an adverse effect of chemotherapy, it is not caused by all chemotherapeutic agents. No special precautions are instituted for gastrointestinal upset. A decreased creatinine level is consistent with renal pathologic conditions, not chemotherapy. Not all chemotherapeutic agents cause alopecia. No precautions are taken to prevent alopecia.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1143 | p. 1145 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Safe and Effective Care Environment

3. Parents of a child with acute lymphoblastic leukemia (ALL) ask about their child's prognosis. The nurse should base the response on the knowledge that
   a. leukemia is a fatal disease, although chemotherapy provides increasingly longer periods of remission.
   b. research to find a cure for childhood cancers is very active.
   c. the majority of children go into remission and remain symptom free when treatment is completed.

d. it usually takes several months of chemotherapy to achieve a remission.

ANS: C
Children diagnosed with the most common form of leukemia, ALL, can almost always achieve remission, with a 5-year disease- free survival rate approaching 85%. With the majority of children surviving 5 years or longer, it is inappropriate to refer to leukemia as a fatal disease. Telling parents about current research to answer their question does not address their concern. About 95% of children achieve remission within the first month of chemotherapy.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1148 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

4. Hematopoietic stem cell transplantation (HSCT) is the standard treatment for a child in his or her first remission with what cancer?
   a. Acute lymphocytic leukemias
   b. Non-Hodgkin lymphoma
   c. Wilms' tumor
   d. Acute myeloblastic leukemia (AML)

   ANS: D
   HSCT is often used interchangeably with bone marrow transplantation and is currently standard treatment for children in their first remission with AML. Transplantation is standard treatment for a specific type of ALL (Philadelphia chromosome positive). Standard treatment for non-Hodgkin lymphoma is chemotherapy. Bone marrow transplantation is used to treat non-Hodgkin lymphoma that is resistant to conventional chemotherapy and radiation. The treatment for Wilms' tumor consists of surgery and chemotherapy alone or in combination with radiation therapy.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1147 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

5. A child with a history of fever of unknown origin, excessive bruising, lymphadenopathy, anemia, and fatigue is exhibiting symptoms most suggestive of which of the following?
   a. Ewing sarcoma
   b. Wilms' tumor
   c. Neuroblastoma
   d. Leukemia

   ANS: D
   These symptoms reflect bone marrow failure and organ infiltration, which occur in leukemia. Symptoms of Ewing sarcoma involve pain and soft tissue swelling around the affected bone. Wilms' tumor usually manifests as an abdominal mass with abdominal pain and may include renal symptoms, such as hematuria, hypertension, and anemia. Neuroblastoma manifests primarily as an abdominal, chest, bone, or joint mass. Symptoms are dependent on the extent and involvement of the tumor.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1149 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

6. Which clinical finding is an overt sign of retinoblastoma in children?
   a. Whitish reflex in the eye
   b. Lymphadenopathy
   c. Bone pain
   d. Change in gait

   ANS: A
   A whitish reflex in the eye, leukocoria, is a common finding of retinoblastoma. It is an overt sign of cancer in children. Persistent lymphadenopathy is a manifestation of several forms of childhood cancers. It is a covert sign of cancer in children. Bone pain is not a sign of retinoblastoma and is considered a covert sign. A change in gait may be a sign of a brain tumor. It is considered a covert sign of cancer in children.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1166 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

7. What is a priority nursing diagnosis for the 4-year-old child newly diagnosed with leukemia?
   a. Ineffective Breathing Pattern related to mediastinal disease
   b. Risk for Infection related to immunosuppressed state
   c. Disturbed Body Image related to alopecia
   d. Impaired Skin Integrity related to radiation therapy

   ANS: B
   Leukemia is characterized by the proliferation of immature white blood cells, which lack the ability to fight infection. Ineffective Breathing Pattern applies to a child with non-Hodgkin lymphoma or any cancer involving the chest area. Disturbed Body Image relates to children taking chemotherapy or radiation therapy and does not occur for all children. It would not be the highest priority even if the child had the diagnosis. Radiation therapy is not a treatment for leukemia.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1148 OBJ: Nursing Process: Diagnosis
   MSC: Client Needs: Physiologic Integrity

8. A nurse has taught parents about diagnostic testing for their child who is suspected of having leukemia. What test described by the parents shows good understanding of this information?
   a. Complete blood cell count (CBC)
   b. Lumbar puncture
   c. Bone marrow biopsy
   d. Computed tomography (CT) scan

   ANS: C
   The confirming test for leukemia is microscopic examination of bone marrow obtained by bone marrow aspiration and biopsy. A CBC may show blast cells that would raise suspicion of leukemia. It is not a confirming diagnostic study. A lumbar puncture is done to check for central nervous system involvement in the child who has been diagnosed with leukemia. A CT scan may be done to check for bone involvement in the child with leukemia. It does not confirm a diagnosis.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating

REF: p. 1149 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Physiologic Integrity

9. A nurse has taught the parents about home care of their child who has leukemia. Which statement made by the parents indicates an understanding of this teaching?
   a. "We will take our child's blood pressure daily."
   b. "We will restrict fluids in case there is central nervous system involvement."
   c. "We will make sure our child gets all immunizations in a timely manner."
   d. "We will take our child's temperature frequently."

   ANS: D
   An elevated temperature may be the only sign of an infection in an immunosuppressed child. Parents should be instructed to monitor their child's temperature as often as necessary. It is not necessary to monitor blood pressure daily. Fluids are never withheld as a precautionary measure. Children who are immunosuppressed should not receive live virus vaccines.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: p. 1151 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Physiologic Integrity

10. The nurse notes a reddened area on the forearm of a neutropenic child with leukemia. What action by the nurse is most appropriate?
    a. Massage the area.
    b. Turn the child more frequently.
    c. Document the finding and continue to observe the area.
    d. Notify the provider.

    ANS: D
    Skin is the first line of defense against infection. Any signs of infection in a child who is immunosuppressed must be reported. When a child is neutropenic, pus may not be produced, and the only sign of infection may be redness. The area should never be massaged. The forearm is not a typical pressure area; therefore the likelihood of the redness being related to pressure is very small. The observation should be documented, but because it may be a sign of an infection and immunosuppression, the physician must also be notified.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1151 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

11. A child has just been diagnosed with acute lymphoblastic leukemia, and the mother is expressing guilt about not taking the child to the doctor right away. What response by the nurse is best?
    a. "Always call the physician when your child has a change in what is normal for him."
    b. "It is better to be safe than sorry."
    c. "It is common for parents not to notice subtle changes in their children's health."
    d. "I hope this delay does not affect the treatment plan."

    ANS: C
    This statement is not only true, but it will also help minimize the mother's guilt and help establish a therapeutic relationship with the nurse. Identifying concerns and clarifying misconceptions will help families cope with the stress of chronic illness.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1151 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

12. What is an appropriate nursing action before surgery when caring for a child diagnosed with a Wilms' tumor?
    a. Limit fluid intake.
    b. Do not palpate the abdomen.
    c. Force oral fluids.
    d. Palpate the abdomen every 4 hours.

    ANS: B
    Excessive manipulation of the tumor area can cause seeding of the tumor and spread of the malignant cells. Fluids are not routinely limited in a child with a Wilms' tumor. However, intake and output are important because of the kidney involvement. Fluids are not forced on a child with a Wilms' tumor. Normal intake for age is usually maintained. The abdomen of a child with a Wilms' tumor should never be palpated because of the danger of seeding the tumor and spreading malignant cells.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1165 | Nursing Quality Alert Box
    OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

13. Children with non-Hodgkin lymphoma are at risk for complications resulting from tumor lysis syndrome (TLS). What findings would the nurse assess for to identify this complication early?
    a. Increased ALT, AST
    b. Change in level of consciousness
    c. Elevated BUN and creatinine
    d. Oxygen saturation of 93%

    ANS: C
    In TLS, the tumor's intracellular contents are dumped into the child's extracellular fluid as the tumor cells are lysed in response to chemotherapy. Because of the large volume of these cells, their intracellular electrolytes overload the kidneys and, if not monitored, can cause kidney failure. Kidney failure would manifest in rising BUN and creatinine. This does not affect the liver so increased ALT and AST are not related. Changes in level of consciousness would not help identify this specific complication. An oxygen saturation of 93% is related to the lungs.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1157 | Nursing Quality Alert Box
    OBJ: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

14. While completing an assessment on a 6-month-old infant, which finding should the nurse recognize as a symptom of a brain tumor?
    a. Blurred vision
    b. Increased head circumference
    c. Vomiting when getting out of bed
    d. Headache

    ANS: B

Manifestations of brain tumors vary with tumor location and the child's age and development. Infants with brain tumors may be irritable or lethargic, feed poorly, and have increased head circumference with a bulging fontanel. Visual changes such as nystagmus, diplopia, and strabismus are manifestations of a brain tumor but would not be able to be verbalized by an infant. The change in position on awakening causes an increase in intracranial pressure, which is manifested as vomiting. Vomiting on awakening is considered a hallmark symptom of a brain tumor, but infants do not get themselves out of bed in the morning. Increased intracranial pressure resulting from a brain tumor is manifested as a headache but could not be verbalized by an infant.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1155 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

15. What is an expected physical assessment finding for an adolescent with a diagnosis of Hodgkin disease?
    a. Protuberant, firm abdomen
    b. Enlarged, painless, firm cervical lymph nodes
    c. Soft tissue swelling
    d. Soft to hard, nontender mass in pelvic area

    ANS: B
    Painless, firm, movable adenopathy (enlarged lymph nodes) palpated in the cervical region is an expected assessment finding in Hodgkin disease. Other systemic symptoms include unexplained fevers, weight loss, and night sweats. A protuberant, firm abdomen is present in many cases of neuroblastoma. Soft tissue swelling around the affected bone is a manifestation of Ewing sarcoma. A soft to hard, nontender mass can be palpated when rhabdomyosarcoma is present.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1160 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

16. A child had surgery for a brain tumor. Which provider orders does the nurse question?
    a. Place the child in the Trendelenburg position.
    b. Perform neurologic assessments.
    c. Assess dressings for drainage.
    d. Monitor temperature.

    ANS: A
    The child is never placed in the Trendelenburg position because it increases intracranial pressure and the risk of bleeding. Increased intracranial pressure is a risk in the postoperative period. The nurse would assess the child's neurologic status frequently. Hemorrhage is a risk in the postoperative period. The child's dressing would be inspected frequently for bleeding. Temperature is monitored closely because the child is at risk for infection in the postoperative period.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1158 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

17. A child with non-Hodgkin lymphoma will be starting chemotherapy. What intervention is initiated before chemotherapy to prevent tumor lysis syndrome?
    a. Insertion of a central venous catheter
    b. Intravenous (IV) hydration containing sodium bicarbonate
    c. Placement of an externalized ventriculoperitoneal (VP) shunt
    d. Administration of pneumococcal and *Haemophilus influenzae* type B vaccines

    ANS: B
    Intensive hydration with an IV fluid containing bicarbonate alkalinizes the urine to help prevent the formation of uric acid crystals, which damage the kidney. A central venous catheter is placed to assist in delivering chemotherapy. An externalized VP shunt may be placed to relieve intracranial pressure caused by a brain tumor. If a splenectomy is necessary for a child with Hodgkin disease, the pneumococcal and *Haemophilus influenzae* vaccines are administered before the surgery.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1150 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

18. The nurse is aware that an abdominal mass found in a 10-month-old infant corresponds with which childhood cancer?
    a. Osteogenic sarcoma
    b. Rhabdomyosarcoma
    c. Neuroblastoma
    d. Non-Hodgkin lymphoma

    ANS: C
    Neuroblastoma is found exclusively in infants and children. In most cases of neuroblastoma, a primary abdominal mass and protuberant, firm abdomen are present. Osteogenic sarcoma is a bone tumor. Bone tumors typically affect older children. Rhabdomyosarcoma is a malignancy of muscle or striated tissue. It occurs most often in the periorbital area, in the head and neck in younger children, or in the trunk and extremities in older children. Non-Hodgkin lymphoma is a neoplasm of lymphoid cells. Painless, enlarged lymph nodes are found in the cervical or axillary region. Abdominal signs and symptoms do not include a mass.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1161 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

19. A child with acute myeloblastic leukemia is scheduled to have a bone marrow transplant (BMT). The donor is the child's own umbilical cord blood that had been previously harvested and banked. This type of BMT is termed
    a. autologous.
    b. allogeneic.
    c. syngeneic.
    d. stem cell.

    ANS: A

In an autologous transplant, the child's own marrow or previously harvested and banked cord blood is used. In an allogeneic BMT, histocompatibility has been matched with a related or an unrelated donor. In a syngeneic transplant, the child receives bone marrow from an identical twin. A stem cell transplantation uses a unique immature cell present in the peripheral circulation.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1147 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

20. What should the nurse teach parents about oral hygiene for the child receiving chemotherapy?
    a. Brush the teeth briskly to remove bacteria.
    b. Use a mouthwash that contains alcohol.
    c. Inspect the child's mouth daily for ulcers.
    d. Perform oral hygiene twice a day.

    ANS: C
    The child's mouth is inspected regularly for ulcers. At the first sign of ulceration, an antifungal drug is initiated. The teeth should be brushed with a soft-bristled toothbrush. Excessive force with brushing should be avoided because delicate tissue could be broken, causing infection or bleeding. Mouthwashes containing alcohol may be drying to oral mucosa, thus breaking down the protective barrier of the skin. Oral hygiene should be performed four times a day.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1151 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

21. What fluid is the best choice when a child with mucositis asks for something to drink?
    a. Hot chocolate
    b. Lemonade
    c. Popsicle
    d. Orange juice

    ANS: C
    Cool liquids are soothing, and ice pops are usually well tolerated. A hot beverage can be irritating to mouth ulcers. Citrus products may be very painful to an ulcerated mouth.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1155 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

22. A child has a brain tumor. What assessment finding leads the nurse to request a physical therapy consultation?
    a. Dizziness
    b. Ataxia
    c. Slurred speech
    d. Visual changes

    ANS: B

A child with ataxia would benefit from a physical therapy consultation to help regain coordination. Physical therapy would not help with dizziness, slurred speech, or visual changes.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1158 | Box 48.3
OBJ: Integrated Process: Communication and Documentation
MSC: Client Needs: Safe and Effective Care Environment

23. A child is in the hospital receiving chemotherapy, and the nurse suspects the child has an infection. What action by the nurse takes priority?
    a. Monitor the child's temperature.
    b. Assess the daily white blood cell count.
    c. Administer antibiotics.
    d. Obtain blood and urine cultures.

ANS: D
For a child with a suspected infection, cultures are taken to determine the site and type of infection. Often these include blood and urine but may include sputum or wound drainage. Antibiotics are only started after cultures have been obtained. Monitoring temperature and WBCs is important, but cultures are the only way to specifically identify an organism so it can be effectively treated.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1159 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

MULTIPLE RESPONSE

1. When an adolescent with a new diagnosis of Ewing sarcoma asks the nurse about treatment, the nurse's response is based on the knowledge that (*Select all that apply.*)
    a. this type of tumor invades the bone.
    b. management includes chemotherapy, surgery, and radiation.
    c. Ewing sarcoma is usually not responsive to either chemotherapy or radiation.
    d. affected bones such as ribs and proximal fibula may be removed to excise the tumor.
    e. is the most common bone tumor seen in children.

ANS: A, B, D
Ewing sarcoma invades the bone and is found most often in the midshaft of long bones, especially the femur, vertebrae, ribs, and pelvic bones. Treatment for Ewing sarcoma begins with chemotherapy to decrease tumor bulk, followed by surgical resection of the primary tumor. Local control of the tumor can be achieved with surgery or radiation. The affected bone may be removed if it will not affect the child's functioning. Ribs and the proximal fibula are considered expendable and may be removed to excise the tumor without affecting function. Ewing sarcoma is responsive to both chemotherapy and radiation. Osteosarcoma is the most common primary bone malignancy in children. The second most common bone tumor seen in children is Ewing sarcoma.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1164 OBJ: Nursing Process: Implementation

MSC: Client Needs: Physiologic Integrity

2. What should the nurse recognize as symptoms of a brain tumor in a school-age child? (*Select all that apply*.)
   a. Blurred vision
   b. Increased head circumference
   c. Vomiting when getting out of bed
   d. Intermittent headache
   e. Declining academic performance

   ANS: A, C, D, E
   Visual changes such as nystagmus, diplopia, and strabismus are manifestations of a brain tumor. The change in position on awakening causes an increase in intracranial pressure, which is manifested as vomiting. Vomiting on awakening is considered a hallmark symptom of a brain tumor. Increased intracranial pressure resulting from a brain tumor is manifested as a headache. School-age children may exhibit declining academic performance, fatigue, personality changes, and symptoms of vague, intermittent headache. Other symptoms may include seizures or focal neurologic deficits. Manifestations of brain tumors vary with tumor location and the child's age and development. Infants with brain tumors may have increased head circumference with a bulging fontanel. School -age children have closed fontanels, and therefore their head circumferences do not increase with brain tumors.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: pp. 1155-1156 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. A child with a brain tumor is undergoing radiation therapy. What should the nurse include in the discharge instructions to the child's parents? (*Select all that apply*.)
   a. Apply over-the-counter creams to the area daily.
   b. Avoid excessive skin exposure to the sun.
   c. Use a washcloth when cleaning the area receiving radiation.
   d. Plan for adequate rest periods for the child.
   e. A darkening of the skin receiving radiation is expected.

   ANS: B, D, E
   Children receiving cranial radiation are particularly affected by fatigue and an increased need for sleep during and shortly after completion of the course of radiation. Skin damage can include changes in pigmentation (darkening), redness, peeling, and increased sensitivity. Extra care must be taken to avoid excessive skin exposure to heat, sunlight, friction (such as rubbing with a towel or washcloth), and creams or moisturizers. Only topical creams and moisturizers prescribed by the radiation oncologist should be applied to the radiated skin.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: pp. 1146-1147 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

4. A nurse routinely administers chemotherapy to hospitalized children with cancer. What safety measures does this nurse take as a routine part of practice? (*Select all that apply*.)
   a. Calculates child's body-surface area in meters squared
   b. Ensures a CBC is obtained within 72 hours of starting chemotherapy
   c. Double checks ordered doses against established protocols

d. Obtains emergency equipment
e. Monitors child based on provider orders

ANS: A, C, D
The nurse providing chemotherapy has many responsibilities including calculating the child's body-surface area, double checking orders against protocols, and having emergency equipment available. A CBC should be obtained within 48 hours of administering chemotherapy. The nurse should monitor the child based on the child's condition and not just follow the orders left by the provider.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1145 | Box 48.2 OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

MULTIPLE CHOICE

1. A child has small red macules and vesicles that become pustules around the child's mouth and cheek. Older lesions are crusted and honey-colored. What should the nurse teach the parents about this condition?
   a. Keep the child home from school for 24 hours after starting antibiotics.
   b. Clean the rash vigorously with Betadine three times a day.
   c. Notify the physician for any itching.
   d. Keep the child home from school until the lesions are healed.

   ANS: A
   This child has impetigo. To prevent the spread of impetigo to others, the child should be kept home from school for 24 hours after treatment is initiated. Good handwashing is imperative in preventing the spread of impetigo. The lesions should be washed gently with a warm soapy washcloth. Itching is common and does not necessitate medical treatment. Rather, parents should be taught to clip the child's nails to prevent maceration of the lesions. The washcloth should not be shared with other members of the family. The child may return to school 24 hours after initiation of antibiotic treatment.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1178 OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

2. When taking a history on a child with a possible diagnosis of cellulitis, what should be the priority nursing assessment to help establish a diagnosis?
   a. Any pain the child is experiencing
   b. Enlarged, mobile, and nontender lymph nodes
   c. Child's urinalysis results
   d. Recent infections or signs of infection

   ANS: D
   Cellulitis may follow an upper respiratory infection, sinusitis, otitis media, or a tooth abscess. The affected area is red, hot, tender, and indurated. Pain is important, but the history of recent infections is more relevant to the diagnosis. Lymph nodes may be enlarged (lymphadenitis), but they are not mobile and are nontender. Lymphangitis may be seen with red "streaking" of the surrounding area. An abnormal urinalysis result is not usually associated with cellulitis.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1179 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. Which statement made by a parent indicates an understanding about the management of a child with cellulitis on the arm?
   a. "I am supposed to continue the antibiotic until the redness and swelling disappear."
   b. "I have been putting ice on my son's arm to relieve the swelling."
   c. "I should call the doctor if the redness disappears."
   d. "I have been putting a warm soak on my son's arm every 4 hours."

ANS: D
Warm soaks applied every 4 hours while the child is awake increase circulation to the infected area, relieve pain, and promote healing. The parent should not discontinue antibiotics when signs of infection disappear. To ensure complete healing, the parent should understand that the entire course of antibiotics should be given as prescribed. A warm soak is indicated for the treatment of cellulitis. Ice will decrease circulation to the affected area and inhibit the healing process. The disappearance of redness indicates healing and is not a reason to seek medical advice.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 1179 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Physiologic Integrity

4. What should the parents of an infant with thrush (oral candidiasis) be taught about medication administration?
   a. Give nystatin suspension with a syringe without a needle.
   b. Apply nystatin cream to the affected area twice a day.
   c. Give nystatin before the infant is fed.
   d. Swab nystatin suspension onto the oral mucous membranes after feedings.

   ANS: D
   It is important to apply the nystatin suspension to the affected areas, which is best accomplished by rubbing it onto the gums and tongue, after feedings, until 3 to 4 days after symptoms have disappeared. Medication may not reach the affected areas when it is squirted into the infant's mouth. Rubbing the suspension onto the gum ensures contact with the affected areas. Nystatin cream is used for diaper rash caused by *Candida*. To prolong contact with the affected areas, the medication should be administered after a feeding.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1180 OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

5. With what beverage should the parents of a child with ringworm be taught to give griseofulvin?
   a. Water
   b. A carbonated drink
   c. Milk
   d. Fruit juice

   ANS: C
   Griseofulvin is insoluble in water. Giving the medication with a high-fat meal or milk increases absorption. Carbonated drinks do not contain fat, which aids in the absorption of griseofulvin. Fruit juice does not contain any fat; fat aids absorption of the medication.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1182 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

6. Which nursing assessment is applicable to the care of a child with herpetic gingivostomatitis?
   a. Comparison of range of motion of the extremities
   b. Urine output, mucous membranes, and skin turgor

c. Growth pattern since birth
d. Bowel elimination pattern

ANS: B
The child with herpetic gingivostomatitis is at risk for deficient fluid volume. Painful lesions on the mouth make drinking unpleasant and undesirable, with subsequent dehydration becoming a real danger. An oral herpetic infection does not affect joint function. Herpetic gingivostomatitis is not a chronic disorder that would affect the child's long-term growth pattern. Although constipation could be caused by dehydration, it is more important to assess urine output, skin turgor, and mucous membranes to identify dehydration before constipation is a problem.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1185 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

7. Parents of a child with lice infestation should be instructed carefully in the use of antilice products because of which potential side effect?
a. Nephrotoxicity
b. Neurotoxicity
c. Ototoxicity
d. Bone marrow depression

ANS: B
Because of the danger of absorption through the skin and potential for neurotoxicity, antilice treatment must be used with caution. A child with many open lesions can absorb enough to cause seizures. Antilice products are not known to be nephrotoxic or ototoxic and do not cause bone marrow depression.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1186 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

8. When assessing the child with atopic dermatitis, the nurse should ask the parents about a history of which of the following?
a. Asthma
b. Nephrosis
c. Lower respiratory tract infections
d. Neurotoxicity

ANS: A
Most children with atopic dermatitis have a family history of asthma, hay fever, or atopic dermatitis, and up to 80% of children with atopic dermatitis have asthma or allergic rhinitis. Complications of atopic dermatitis relate to the skin. The renal system is not affected by atopic dermatitis. There is no link between lower respiratory tract infections and atopic dermatitis. Atopic dermatitis does not have a relationship to neurotoxicity.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1175 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

9. What should the nurse teach an adolescent who is taking tretinoin (Retin-A) to treat acne?

a. The medication should be taken with meals.
b. Apply sunscreen before going outdoors.
c. Wash with benzoyl peroxide before application.
d. The effect of the medication should be evident within 1 week.

ANS: B
Tretinoin causes photosensitivity, and sunscreen should be applied before sun exposure. Tretinoin is a topical medication. Application is not affected by meals. If applied together, benzoyl peroxide and tretinoin have reduced effectiveness and a potentially irritant effect. Optimal results from tretinoin are not achieved for 3 to 5 months.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1189 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

10. When changing an infant's diaper, the nurse notices small bright red papules with satellite lesions on the perineum, anterior thigh, and lower abdomen. This rash is characteristic of
a. candidiasis.
b. irritant contact dermatitis.
c. intertrigo.
d. seborrheic dermatitis.

ANS: A
Small red papules with peripheral scaling in a sharply demarcated area involving the anterior thighs, lower abdomen, and perineum are characteristic of candidiasis. A shiny, parchment-like erythematous rash on the buttocks, medial thighs, mons pubis, and scrotum, but not in the folds, is suggestive of irritant contact dermatitis. Intertrigo is identified by a red macerated area of sharp demarcation in the groin folds. It can also develop in the gluteal and neck folds. Seborrheic dermatitis is recognized by salmon- colored, greasy lesions with a yellowish scale found primarily in skinfold areas or on the scalp.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1180 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

11. The depth of a burn injury may be classified as
a. localized or systemic.
b. superficial, superficial partial thickness, deep partial thickness, or full thickness.
c. electrical, chemical, or thermal.
d. minor, moderate, or major.

ANS: B
The vocabulary to classify the depth of a burn is superficial, partial thickness, or full thickness. A partial-thickness burn can be either superficial or deep. The other terms do not relate to depth of burn.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: pp. 1195-1196 | Table 49.4 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

12. What best describes a full-thickness (third-degree) burn? a. Erythema and pain

b. Skin showing erythema followed by blister formation
c. Destruction of all layers of skin evident with extension into subcutaneous tissue
d. Destruction injury involving underlying structures such as muscle, fascia, and bone

ANS: C
A third-degree or full-thickness burn is a serious injury that involves the entire epidermis and dermis and extends into the subcutaneous tissues. Erythema and pain are characteristic of a first-degree burn or superficial burn. Erythema with blister formation is characteristic of a second-degree or partial-thickness burn. A fourth-degree burn is a full-thickness burn that also involves underlying structures such as muscle, fascia, and bone.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: pp. 1195-1196 | Table 49.4 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

13. What procedure is contraindicated in the care of a child with a minor partial-thickness burn injury wound?
a. Cleaning the affected area with mild soap and water
b. Applying antimicrobial ointment to the burn wound
c. Changing dressings daily
d. Leaving all loose tissue or skin intact

ANS: D
All loose skin and tissue should be debrided, because it can become a breeding ground for infectious organisms. Cleaning with mild soap and water is important to the healing process. Antimicrobial ointment is used on the burn wound to fight infection. Clean dressings are applied daily to prevent wound infection. When dressings are changed, the condition of the burn wound can be assessed.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1199 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

14. The process of burn shock continues until what physiologic mechanism occurs?
a. Heart rate returns to normal.
b. Airway swelling decreases.
c. Body temperature regulation returns to normal.
d. Capillaries regain their seal.

ANS: D
Within minutes of the burn injury, the capillary seals are lost with a massive fluid leakage into the surrounding tissue, resulting in burn shock. The process of burn shock continues for approximately 24 to 48 hours, when capillary seals are restored. The heart rate will be increased throughout the healing process because of increased metabolism. Airway swelling subsides over a period of 2 to 5 days after injury. Body temperature regulation will not be normal until healing is well under way.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1202 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

15. What assessment finding best indicates that a 66-pound child with a serious burn has met goals for the priority nursing diagnosis?
    a. Distal pulses are equal and strong bilaterally.
    b. Oxygen saturation is 94% on room air.
    c. Urine output is 45 mL/hour.
    d. Mucous membranes are pink and moist.

    ANS: C
    This child weighs 30 kilograms, so a normal urine output is 30 to 60 mL/hour. This child's urine output indicates that fluid resuscitation is adequate and perfusion to organs is good. All the other assessment findings are normal, but for this situation the finding associated with good perfusion to the kidneys best shows the child has met the goal for Fluid Volume Deficit.

    PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
    REF: p. 1185 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

16. What nursing intervention holds the highest priority in the initial care of a child with a major burn injury?
    a. Establishing and maintaining the child's airway
    b. Establishing and maintaining intravenous access
    c. Inserting a catheter to monitor hourly urine output
    d. Inserting a nasogastric tube to supply adequate nutrition

    ANS: A
    Establishing and maintaining the child's airway is always the priority focus for assessment and care. Establishing intravenous access is the second priority in this situation, after the airway has been established. Inserting a catheter and monitoring hourly urine output is the third most important nursing intervention. Nasogastric feedings are not begun initially on a child with major or severe burns. The initial assessment and care focus for a child with major burn injuries is the ABCs.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1202 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

17. Which is an important nursing consideration when caring for a child with impetigo?
    a. Apply topical corticosteroids to decrease inflammation.
    b. Carefully remove dressings so as not to dislodge undermined skin, crusts, and debris.
    c. Carefully wash hands and maintain cleanliness when caring for an infected child.
    d. Examine child under a Wood lamp for possible spread of lesions.

    ANS: C
    A major nursing consideration related to bacterial skin infections, such as impetigo, is to prevent the spread of the infection and complications. This is done by thorough handwashing before and after contact with the affected child. Corticosteroids are not indicated in bacterial infections. Dressings are usually not indicated. The undermined skin, crusts, and debris are carefully removed after softening with moist compresses. A Wood lamp is used to detect fluorescent materials in the skin and hair. It is used in certain disease states, such as tinea capitis. It is not used in impetigo.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1179 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

18. Impetigo ordinarily results in
    a. no scarring.
    b. pigmented spots.
    c. slightly depressed scars.
    d. atrophic white scars.

    ANS: A
    Impetigo tends to heal without scarring unless a secondary infection occurs or the child picks at the lesions. Hyperpigmentation may occur but only in dark-skinned children.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1178 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

19. The pediatric nurse understands that cellulitis is most often caused by
    a. herpes zoster.
    b. *Candida albicans.*
    c. human papillomavirus.
    d. *Streptococcus* or *Staphylococcus* organisms.

    ANS: D
    Streptococcus, *Staphylococcus*, and *Haemophilus influenzae* are the organisms usually responsible for cellulitis. Herpes zoster is the virus associated with varicella and shingles. *Candida albicans* is associated with candidiasis or thrush. Human papillomavirus is associated with various types of human warts.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1179 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

20. The skin condition commonly known as “warts” is the result of an infection by which organism?
    a. Bacteria
    b. Fungus
    c. Parasite
    d. Virus

    ANS: D
    Human warts are caused by the human papillomavirus, not by bacteria, funguses, or parasites.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1191 | Table 49.1 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

21. The primary treatment for warts is
    a. vaccination.
    b. local destruction.

c. corticosteroids.
d. specific antibiotic therapy.

ANS: B
Topical treatments include chemical cautery, which is especially useful for the treatment of warts. Local destructive therapy individualized according to location, type, and number. Surgical removal, electrocautery, curettage, cryotherapy, caustic solutions, x-ray treatment, and laser therapies are used. Vaccinations, corticosteroids, and antibiotics will not eradicate warts.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1191 | Table 49.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

22. A child has painful, fluid-filled vesicles on the upper lip. What medication does the nurse anticipate teaching parents about?
a. Corticosteroids
b. Oral griseofulvin
c. Oral antiviral agent
d. Topical antibiotic

ANS: C
This child has a herpes infection. Oral antiviral agents are effective for viral infections such as herpes simplex. Corticosteroids are not effective for viral infections. Griseofulvin is an antifungal agent and not effective for viral infections. Antibiotics are not effective in viral diseases.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1184 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

23. Ringworm, frequently found in schoolchildren, is caused by a(n)
a. virus.
b. fungus.
c. allergic reaction.
d. bacterial infection.

ANS: B
Ringworm is caused by a group of closely related filamentous fungi, which invade primarily the stratum corneum, hair, and nails. They are superficial infections that live on, not in, the skin. Ringworm is not caused by a virus, an allergic reactions, or a bacterial infection.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1181 | Pathophysiology Box OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

24. The primary clinical manifestation of scabies is
a. edema.
b. redness.
c. pruritus.
d. maceration.

ANS: C
Scabies is caused by the scabies mite. The inflammatory response and intense itching occur after the host has become sensitized to the mite. This occurs approximately 30 to 60 days after initial contact. In the previously sensitized person, the response occurs within 48 hours. Edema, redness, and maceration are not seen in scabies.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1188 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

25. The management of a child who has just been stung by a bee or wasp should include the application of which of the following?
    a. Cool compresses
    b. Warm compresses
    c. Antibiotic cream
    d. Corticosteroid cream

ANS: A
Bee or wasp stings are initially treated by carefully removing the stinger, cleansing with soap and water, application of cool compresses or ice, and the use of common household agents such as lemon juice or a paste made with aspirin and baking soda. Warm compresses are avoided. Antibiotic cream is unnecessary unless a secondary infection occurs. Corticosteroid cream is not part of the initial therapy. If a severe reaction occurs, systemic corticosteroids may be indicated.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1192 | Table 49.2 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

26. A father calls the clinic nurse because his 2-year-old child was bitten by a black widow spider. The nurse should advise the father to
    a. apply warm compresses.
    b. carefully scrape off the stinger.
    c. take the child to the emergency department.
    d. apply a thin layer of corticosteroid cream.

ANS: C
The black widow spider has a venom that is toxic enough to be harmful. The father should take the child to the emergency department for immediate treatment. The other actions are contraindicated.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1193 | Table 49.2 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

27. A mother calls the emergency department nurse because her child was stung by a scorpion. The nurse should recommend
    a. administering antihistamine.
    b. cleansing with soap and water.
    c. keeping child quiet and coming to emergency department.
    d. removing stinger and applying cool compresses.

ANS: C
Most scorpions in the US are not venomous but their stings are painful and some species' stings can produce systemic manifestations so the child should be seen in the ED. The other actions are not warranted.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1193 | Table 49.2 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

28. Rocky Mountain spotted fever is caused by the bite of a
    a. flea.
    b. tick.
    c. mosquito.
    d. mouse or rat.

ANS: B
Rocky Mountain spotted fever is caused by a tick. The tick must attach and feed for at least 1 to 2 hours to transmit the disease. The usual habitat of the tick is in heavily wooded areas. The other organisms do not transmit Rocky Mountain spotted fever.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1193 | Table 49.2 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

29. A child experiences frostbite of the fingers after prolonged exposure to the cold. Which intervention should the nurse implement first?
    a. Rapid rewarming of the fingers by placing in warm water
    b. Placing the hand in cool water
    c. Slow rewarming by wrapping in warm cloth
    d. Using an ice pack to keep cold until medical intervention is possible

ANS: A
Rapid rewarming is accomplished by immersing the part in well-agitated water at 37.8° C to 42.2° C (100° F to 108° F). Cool water will worsen the problem. Rapid rewarming results in less tissue necrosis than slow thawing. The frostbitten area should be rewarmed as soon as possible to avoid further tissue damage. The frostbitten area should be rewarmed, as soon as possible, to avoid further tissue damage.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1192 | Table 49.1 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

30. A burned child is in the emergency department. The nurse calculates the fluid requirement for the next 24 hours to be 2700 mL. At what rate does the nurse set the pump for initially?
    a. 50 mL/hour
    b. 100 mL/hour
    c. 152.1 mL/hour
    d. 168.8 mL/hour

ANS: D

The amount of fluid needed for fluid resuscitation is generally divided so that half is given in the first 8 hours. This child needs 2700 mL total; half of that volume is 1350 mL, and that volume divided by 8 is 168.75, which is rounded to 168.8 mL/hour.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1202 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. Where do the lesions of atopic dermatitis most commonly occur in the infant? (*Select all that apply*.)
   a. Cheeks
   b. Buttocks
   c. Extensor surfaces of arms and legs
   d. Back
   e. Scalp

   ANS: A, C, E
   The lesions of atopic dermatitis are generalized in the infant. They are most commonly on the cheeks, scalp, and extensor surfaces of the extremities. These lesions are not typically on the back or the buttocks.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1175 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

2. A nurse is teaching parents about prevention of diaper dermatitis. Which should the nurse include in the teaching plan? (*Select all that apply*.)
   a. Clean the diaper area gently after every diaper change with a mild soap.
   b. Use a protective ointment to clean dry intact skin.
   c. Use a steroid cream after each diaper change.
   d. Use rubber or plastic pants over the diaper.
   e. Wash cloth diapers in hot water with a mild soap and double rinse.

   ANS: A, B, E
   Prompt, gentle cleaning with water and mild soap (e.g., Dove, Neutrogena Baby Soap) after each voiding or defecation rids the skin of ammonia and other irritants and decreases the chance of skin breakdown and infection. A bland, protective ointment (e.g., A&D, Balmex, Desitin, zinc oxide) can be applied to clean, dry, intact skin to help prevent diaper rash. If cloth diapers are laundered at home, the parents should wash them in hot water, using a mild soap and double rinsing. Occlusion increases the risk of systemic absorption of a steroid; thus steroid creams are rarely used for diaper dermatitis because the diaper functions as an occlusive dressing. Rubber or plastic pants increase skin breakdown by holding in moisture and should be used infrequently. A steroid cream is not recommended.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1175 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

3. A nurse is instructing parents on the treatment of pediculosis (head lice). Which should the nurse include in the teaching plan? (*Select all that apply*.)
   a. Bedding should be washed in warm water and dried on a low setting.
   b. After treating the hair and scalp with a pediculicide, shampoo the hair with regular shampoo.
   c. Retreat the hair and scalp with a pediculicide in 7 to 10 days.
   d. Items that cannot be washed should be dry cleaned or sealed in plastic bags for 2 to 3 weeks.
   e. Combs and brushes should be boiled in water for at least 10 minutes.

   ANS: C, D, E
   An over-the-counter pediculicide, permethrin 1% (Nix, Elimite, Acticin), kills head lice and eggs with one application and has residual activity (i.e., it stays in the hair after treatment) for 10 days. Nix crème rinse is applied to the hair after it is washed with a conditioner-free shampoo. The product should be rinsed out after 10 minutes. The hair should not be shampooed for 24 hours after the treatment. Even though the kill rate is high and there is residual action, retreatment should occur after 7 to 10 days. Combs and brushes should be boiled or soaked in antilice shampoo or hot water (greater than 60° C [140° F]) for at least 10 minutes. Advise parents to wash clothing (especially hats and jackets), bedding, and linens in hot water and dry at a hot dryer setting.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1186 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

4. A nurse working in a trauma center would facilitate referrals to a burn center for which of the following children? (*Select all that apply*.)
   a. Electrical burn
   b. Chemical burn
   c. Burn from child abuse
   d. Burn in the perineal area
   e. 5% second-degree burn

   ANS: A, B, D
   Specific criteria exist for transferring a child to a burn center for treatment, including electrical and chemical burns and burns in the perineal area. Burns from child abuse and a second-degree burn <10% in total body surface area do not need transfers.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1195 | Box 49.2
   OBJ: Integrated Process: Communication and Documentation
   MSC: Client Needs: Safe and Effective Care Environment

MULTIPLE CHOICE

1. Which statement is accurate concerning a child's musculoskeletal system and how it may be different from an adult's?
   a. Growth occurs in children as a result of an increase in the number of muscle fibers.
   b. Infants are at greater risk for fractures because their epiphyseal plates are not fused.
   c. Because soft tissues are resilient in children, dislocations and sprains are less common than in adults.
   d. Their bones have less blood flow.

   ANS: C
   Because soft tissues are resilient in children, dislocations and sprains are less common than in adults. A child's growth occurs because of an increase in size rather than an increase in the number of the muscle fibers. Fractures in children younger than 1 year are unusual because a large amount of force is necessary to fracture their bones. A child's bones have greater blood flow than an adult's bones.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1208 | Pediatric Differences Box OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

2. When infants are seen for fractures, which nursing intervention is a priority?
   a. No intervention is necessary. It is not uncommon for infants to fracture bones.
   b. Assess the family's safety practices. Fractures in infants usually result from falls.
   c. Assess for child abuse. Fractures in infants are often nonaccidental.
   d. Assess for genetic factors.

   ANS: C
   Fractures in infants warrant further investigation to rule out child abuse. Fractures in children younger than 1 year are unusual because of the cartilaginous quality of the skeleton; a large amount of force is necessary to fracture their bones. Safety practices are important to assess as well, but the priority is checking for child abuse. Genetic factors are a rare cause of fractures.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 1208 | Pediatric Differences Box
   OBJ: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

3. Which nursing intervention is appropriate to assess for neurovascular competency in a child who fell off the monkey bars at school and hurt his arm?
   a. The degree of motion and ability to position the extremity
   b. The length, diameter, and shape of the extremity
   c. The amount of swelling noted in the extremity and pain intensity
   d. The skin color, temperature, movement, sensation, and capillary refill of the extremity

   ANS: D

A neurovascular evaluation includes assessing skin color and temperature, ability to move the affected extremity, degree of sensation experienced, and speed of capillary refill in the extremity. The degree of motion in the affected extremity and ability to position the extremity are incomplete assessments of neurovascular competency. The length, diameter, and shape of the extremity are not assessment criteria in a neurovascular evaluation. Although the amount of swelling is an important factor in assessing an extremity, it is not a criterion for a neurovascular assessment.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1217 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

4. A mother whose 7-year-old child has been placed in a cast for a fractured right arm reports that the child will not stop crying even after taking acetaminophen with codeine. The child also will not straighten the fingers on the right arm. What advice by the nurse is best?
   a. Take the child to the emergency department.
   b. Put ice on the injury.
   c. Avoid letting the child get so tired.
   d. Wait another hour; if the child is still crying, call back.

   ANS: A
   Unrelieved pain and the child's inability to extend his fingers are signs of compartment syndrome, which requires immediate attention. Placing ice on the extremity is an inappropriate action for the symptoms. Telling the mother not to let her child get tired is an inappropriate response to a concern. A child who has signs and symptoms of compartment syndrome should be seen immediately. Waiting an hour could compromise the recovery of the child.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 1213 | p. 1216 | Parents Want to Know Box
   OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

5. A 4-year-old child with a long leg cast complains of "fire" in his cast. Which action by the nurse is most appropriate?
   a. Notify the provider on his or her next rounds.
   b. Note the complaint in the nurse's notes.
   c. Notify the provider immediately.
   d. Report the complaint to the next nurse on duty.

   ANS: C
   A burning sensation under the cast is an indication of tissue ischemia. It may be an early indication of serious neurovascular compromise, such as compartment syndrome, that requires immediate attention. The child's symptom requires immediate attention. Notifying the physician on the next rounds is inappropriate. Charting the complaint in the nurse's notes is an appropriate action but not the priority. The priority action is to contact the provider. Communication across shifts is important to the continuing assessment of the child; however, this symptom requires immediate evaluation, and the provider should be contacted.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 1216 | Parents Want to Know Box
   OBJ: Integrated Process: Communication and Documentation

MSC: Client Needs: Physiologic Integrity

6. When a child with a musculoskeletal injury on the foot is assessed, what is most indicative of a fracture?
   a. Increased swelling after the injury is iced
   b. The presence of localized tenderness distal to the site
   c. The presence of an elevated temperature for 24 hours
   d. The inability of the child to bear weight

   ANS: D
   An inability to bear weight on the affected extremity is indicative of a more serious injury. With a fracture, general manifestations include pain or tenderness at the site, immobility or decreased range of motion, deformity of the extremity, edema, and inability to bear weight. Although edema is often present with a fracture, it would be unusual for swelling to increase after application of ice, and this would not be most indicative of a fracture. Swelling after icing does not identify the degree of the injury. Localized tenderness along with limited joint mobility may indicate serious injury, but inability to bear weight on the extremity is a more reliable sign. Tenderness is not a usual complaint distal to the affected site. Elevated temperature is associated with infection but not a fracture.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1216 | Parents Want to Know Box
   OBJ: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

7. A child with osteomyelitis asks the nurse, “What is a ‘sed’ rate?” What is the best response for the nurse?
   a. “It tells us how you are responding to the treatment.”
   b. “It tells us what type of antibiotic you need.”
   c. “It tells us whether we need to immobilize your extremity.”
   d. “It tells us how your nerves and muscles are doing.”

   ANS: A
   The erythrocyte sedimentation rate (ESR) indicates the presence of inflammation and infectious process and is one of the best indicators of the child’s response to treatment. Although the ESR indirectly identifies whether an antibiotic is needed, the organism involved dictates the type of antibiotic and the length of treatment. The ESR does not direct whether the extremity will be immobilized. An ESR rate will not evaluate neuromuscular status.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1208 | Pediatric Differences Box
   OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Physiologic Integrity

8. Which instruction is part of the discharge plan for a school-age child with osteomyelitis who is receiving home antibiotic therapy?
   a. Instructions for a low-calorie diet
   b. Arrange for tutoring and school work
   c. Instructions for a high-fiber diet
   d. Instructions to return the child to school as soon as possible

   ANS: B

Promoting optimal growth and development in the school-age child is important. It is important to continue school work and arrange for tutoring if indicated. The child with osteomyelitis is on a high-calorie, high-protein diet. A high-fiber diet may or may not be indicated. The bone must heal before the child returns to school.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1222 OBJ: Nursing Process: Planning
MSC: Client Needs: Health Promotion and Maintenance

9. The nurse is assessing a 14-year-old who plays football and complains of knee pain when running and climbing stairs during football practice. The nurse should anticipate which action for this condition?
   a. Bedrest with range-of-motion exercises
   b. Prolonged IV antibiotics
   c. Electromyography
   d. NSAIDs or knee immobilizer

   ANS: D
   This child most likely has Osgood-Schlatter disease, a self-limiting disorder that resolves with skeletal maturity. NSAIDs and possible knee immobilizers are the treatment. Bedrest with range of motion in indicated for Legg-Calvé-Perthes disease. IV antibiotics are used in osteomyelitis. Electromyography is used to diagnose muscular dystrophy.

   PTS: 1 DIF: Cognitive Level: Application REF: p. 1228 | Table 50.5
   OBJ: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

10. A child is upset because, when the cast is removed from her leg, the skin surface is caked with desquamated skin and sebaceous secretions. What should the nurse suggest to remove this material?
    a. Wash the area with warm water and soap.
    b. Vigorously scrub the leg.
    c. Apply powder to absorb the material.
    d. Carefully pick the material off the leg.

    ANS: A
    Washing with soap and warm water will remove the desquamated skin and secretions. The parents and child should be advised not to scrub the leg vigorously or forcibly remove this material because it may cause excoriation and bleeding. Oil or lotion, but not powder, may provide comfort for the child.

    PTS: 1 DIF: Cognitive Level: Comprehension
    REF: p. 1216 | Parents Want to Know Box
    OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

11. Which factor is important to include in the teaching plan for parents of a child with Legg-Calvé-Perthes disease?
    a. It is an acute illness lasting 1 to 2 weeks.
    b. It affects primarily adolescents.
    c. There is a disturbance in the blood supply to the femoral epiphysis.
    d. It is caused by a virus.

    ANS: C

Legg-Calvé-Perthes disease is a self-limiting disease that affects the blood supply to the femoral epiphysis. The most serious problem associated is the risk of permanent deformity. The disease process usually lasts between 1 and 2 years and is a disorder of growth. Legg-Calvé-Perthes disease is seen in children between 2 and 12 years of age. Most cases occur between 4 and 9 years of age. The etiology is unknown.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1232 OBJ: Nursing Process: Planning
MSC: Client Needs: Health Promotion and Maintenance

12. What is the major concern guiding treatment for the child with Legg-Calvé-Perthes disease?
    a. Avoid permanent deformity.
    b. Minimize pain.
    c. Maintain normal activities.
    d. Encourage new hobbies.

ANS: A
The major concern related to Legg-Calvé-Perthes disease is to prevent an arthritic process resulting from the flattening of the femoral head of the femur when it protrudes outside the acetabulum. The pain associated with Legg-Calvé-Perthes disease decreases with increased rest, making activity restriction an important factor for these children. The priority concern for treatment is to prevent deformity. In Legg-Calvé-Perthes disease, the major concern is to prevent deformity through decreased activity. Prevention of deformity is the major concern for children with Legg-Calvé-Perthes disease, and rest is a mandatory treatment. Selected hobbies that do not require physical activity are encouraged.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1232 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

13. A neonate is born with mild clubfeet. When the parents ask the nurse how this will be corrected, what response by the nurse is best?
    a. Traction is tried first.
    b. Surgical intervention is needed.
    c. Frequent, serial casting is tried first.
    d. Children outgrow this condition when they learn to walk.

ANS: C
Serial casting is begun shortly after birth before discharge from the nursery. Successive casts allow for gradual stretching of skin and tight structures on the medial side of the foot. Manipulation and casting of the leg are repeated frequently (every week) to accommodate the rapid growth of early infancy. Surgical intervention is done only if serial casting is not successful. Children do not improve without intervention.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1234 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

14. Discharge planning for the child with juvenile arthritis includes the need for
    a. routine ophthalmologic examinations to assess for visual problems.
    b. a low-calorie diet to decrease or control weight in the less mobile child.

c. avoiding the use of NSAIDs to decrease gastric irritation.
d. immobilizing the painful joints, which is the result of the inflammatory process.

ANS: A
The systemic effects of juvenile arthritis can result in visual problems, making routine eye examinations important. Children with juvenile arthritis do not have problems with increased weight and often are anorexic and in need of high- calorie diets. Children with arthritis are often treated with NSAIDs. Children with arthritis can immobilize their own joints. Range-of-motion exercises are important for maintaining joint flexibility and preventing restricted movement in the affected joints.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1239 OBJ: Nursing Process: Planning
MSC: Client Needs: Health Promotion and Maintenance

15. During painful episodes of juvenile arthritis, a plan of care should include what nursing intervention?
a. A weight-control diet to decrease stress on the joints
b. Proper positioning of the affected joints to prevent musculoskeletal complications
c. Complete bed rest to decrease stress to joints
d. High-resistance exercises to maintain muscular tone in the affected joints

ANS: B
Proper positioning is important to support and protect affected joints. Isometric exercises and passive range-of-motion exercises will prevent contractures and deformities. Children in pain often are anorexic and need high-calorie foods. Children with juvenile arthritis need a combination of rest and exercise. Children with juvenile arthritis need to avoid high-resistance exercises, and they benefit from low-resistance exercises, such as swimming.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1238 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

16. When assessing a child for an upper extremity fracture, the nurse should know that these fractures most often result from
a. automobile crashes.
b. falls.
c. physical abuse.
d. sports injuries.

ANS: B
The major cause of children's fractures is falls. Because of the protection reflexes, the outstretched arm often receives the full force of the fall. Crashes, physical abuse, and sports injuries can also occur but not as often.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1217 | Figure 50.3 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

17. In caring for a child with an open fracture, the nurse should carefully assess for
a. infection.
b. osteoarthritis.

c. epiphyseal disruption.
d. periosteum thickening.

ANS: A
Because the skin has been broken, the child is at risk for organisms to enter the wound. The incidence of osteoarthritis does not increase with an open fracture. The chance of epiphyseal disruption is not increased with an open fracture. Periosteum thickening is part of the healing process and not a complication.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1220 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

18. A nurse is teaching parents the difference between pediatric fractures and adult fractures. Which observation is true about pediatric fractures?
a. They seldom are complete breaks.
b. They are often open fractures.
c. They are often at the epiphyseal plate.
d. They are often the result of decreased mobility of the bones.

ANS: A
Pediatric fractures seldom are complete breaks. Rather, children's bones tend to bend or buckle. Open fractures and epiphyseal plate fractures are no more common than simple fractures in children. Increased mobility of the bones prevents children from having complete fractures.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1218 | Pathophysiology Box OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

19. Patient and parent education for the child who has a synthetic cast should include which of the following?
a. Applying a heating pad to the cast if the child has swelling in the affected extremity
b. Wrapping the outer surface of the cast with an Ace bandage
c. Splitting the cast if the child complains of numbness or pain
d. Covering the cast with plastic and waterproof tape to keep it dry while bathing or showering

ANS: D
Damp skin is more susceptible to breakdown. Cast should be kept clean and dry. To prevent swelling, elevate the extremity and apply bagged ice to the casted area. Wrapping the outer surface with an Ace bandage is not indicated. If the child complains of numbness or pain, the child should return immediately to the clinic or emergency department for an evaluation of neurovascular status.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1216 | Parents Want to Know Box OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

20. A 6-year-old patient who has been placed in skeletal traction has pain, edema, and fever. The nurse should assess which of the following?

a. Neurologic status
b. Range of motion of all extremities
c. Warmth at site of pain
d. Blood pressure

ANS: C
The most serious complication of skeletal traction is osteomyelitis. Clinical manifestations include complaints of localized pain, swelling, warmth, tenderness, or unusual odor. An elevated temperature may accompany the symptoms. Assessing neurologic status is not required. Range of motion may or may not be affected with osteomyelitis, but this child is in skeletal traction so range of motion will be limited. Blood pressure is assessed with other vital signs.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1213 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

21. A boy who has fractured his forearm is unable to extend his fingers. The nurse knows that this
a. is normal following this type of injury.
b. may indicate compartment syndrome.
c. may indicate fat embolism.
d. may indicate damage to the epiphyseal plate.

ANS: B
Swelling causes pressure to rise within the immobilizing device leading to compartment syndrome. Signs include severe pain, often unrelieved by analgesics, and neurovascular impairment. It is not uncommon in the forearm, so the inability to extend the fingers may indicate compartment syndrome. This is not normal and indicates neurovascular compromise of some type. Paresthesia or numbness or loss of feeling can indicate a serious problem and can result in paralysis. The inability to extend the fingers often indicates neurovascular compromise. Fat embolism causes respiratory distress with hypoxia and respiratory acidosis. This is not related to damage to the epiphyseal plate.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1214 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

22. Which term is used to describe an abnormally increased convex angulation in the curvature of the thoracic spine?
a. Scoliosis
b. Ankylosis
c. Lordosis
d. Kyphosis

ANS: D
Kyphosis is an abnormally increased convex angulation in the curve of the thoracic spine. Scoliosis is a complex spinal deformity usually involving lateral curvature, spinal rotation causing rib asymmetry, and thoracic hypokyphosis. Ankylosis is the immobility of a joint. Lordosis is an accentuation of the cervical or lumbar curvature beyond physiologic limits.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1223 | Figure 50.4 OBJ: Nursing Process: Assessment

MSC: Client Needs: Physiologic Integrity

23. When assessing the child with osteogenesis imperfecta, the nurse should expect to observe
    a. discolored teeth.
    b. below-normal intelligence.
    c. increased muscle tone.
    d. above-average stature.

    ANS: A
    Children with osteogenesis imperfecta have incomplete development of bones, teeth, ligaments, and sclerae. Teeth are discolored because of abnormal enamel. Despite their appearance, children with osteogenesis imperfecta have normal or above -normal intelligence. The child with osteogenesis imperfecta has weak muscles and decreased muscle tone. Because of compression fractures of the spine, the child appears short.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1240 | Table 50.8 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

24. A nurse knows that which exercise is best for a child with juvenile arthritis?
    a. Jogging
    b. Tennis
    c. Gymnastics
    d. Swimming

    ANS: D
    The warmth of the water (especially if the pool is heated), coupled with mild resistance, makes swimming the perfect medium for strengthening and range-of-motion exercises while protecting the joints. Jogging, tennis, and gymnastics jar the hip, knee, and ankle joints and can cause joint damage.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1238 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

25. Juvenile arthritis should be suspected in a child who exhibits
    a. frequent fractures.
    b. joint swelling and pain lasting longer than 6 weeks.
    c. increased joint mobility.
    d. lurching and abnormal gait with limited abduction.

    ANS: B
    Intermittent joint pain lasting longer than 6 weeks is indicative of juvenile arthritis. Frequent fractures are indicative of osteogenesis imperfecta. Lurching to the affected side and an abnormal gait and limited abduction are associated with developmental dysplasia of the hip (DDH).

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1236 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

26. When providing education for the parents of a child with Duchenne muscular dystrophy, the nurse plans to include
    a. testing all female children for the disease.
    b. testing the father for the presence of the trait on the Y chromosome.
    c. genetic counseling for all female children.
    d. testing the parents to determine the carrier.

    ANS: C
    Duchenne muscular dystrophy is a recessive sex-linked disease carried on the X chromosome, so only males are affected with the disease. Because it is a recessive X-linked disorder, females can only be carriers and do not have the disease. The disease is an X-linked recessive disorder and would not be found on the Y chromosome. The disease is a recessive X-linked disease and is always carried by the mother.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1235 | Table 50.6 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

27. The nurse knows that treatment of Osgood-Schlatter disease includes
    a. limitation of knee bending or kneeling.
    b. increasing range of motion (ROM) of the knee.
    c. encouraging flexion of the hip.
    d. limitation of adduction of the hip.

    ANS: A
    Limitation of knee bending or kneeling provides pain control and allows the knees to heal. Increasing ROM of the knee increases pain and exacerbates the disease. Encouraging flexion of the hip will have no effect on the process affecting the knees. Limitation of hip adduction will not help the child with Osgood-Schlatter disease.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1228 | Table 50.5 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

28. What is the most appropriate intervention for an adolescent with a mild scoliosis?
    a. Long-term monitoring
    b. Surgical intervention
    c. Bracing
    d. No follow-up

    ANS: A
    The child with mild scoliosis requires long-term follow-up to determine whether the curve will progress or remain stable. Surgical intervention is not needed for mild scoliosis. Mild scoliosis is not braced if it is stable. Follow-up to monitor the curve is important until skeletal maturity has occurred.

    PTS: 1 DIF: Cognitive Level: Application REF: p. 1224
    OBJ: Nursing Process: Planning MSC: Client Needs: Physiologic Integrity

29. Which statement by the mother of an adolescent being discharged after spinal fusion for severe scoliosis indicates the need for further teaching?
    a. “I am glad we chose surgery. Now it is all over and done.”

b. “I’ll see you in a month; we’ll be back fairly regularly.”
c. “I have to pick up some more T-shirts on the way home.”
d. “Those exercises the physical therapist showed us were not too hard.”

ANS: A
Spinal fusion requires long- term follow-up to assess the stability of the spinal correction. The other statements show good understanding of discharge instructions.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 1225 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Physiologic Integrity

30. Which factor should the nurse include when teaching a parent about the care of a newborn in a Pavlik harness for hip dysplasia?
a. The harness may be removed with every diaper change.
b. The harness maintains the hips in flexion, abduction, and external rotation.
c. The harness is only the first step of treatment.
d. The harness is worn for 2 weeks.

ANS: B
The harness is used to maintain the infant’s hips in flexion and external rotation to allow the hips (femoral head and acetabulum) to mold and grow normally. The harness must be worn for 23 hours per day and should be removed only according to the physician’s recommendation. Hips that remain unstable become progressively more deformed as maturity takes place. With early diagnosis and treatment, the Pavlik harness is often the only treatment necessary. The length of treatment is determined by radiographic documentation of the maturity of the hips.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1229 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

31. A priority nursing intervention when caring for a child in a Pavlik harness is
a. skin care.
b. bowel function.
c. feeding patterns.
d. respiratory function.

ANS: A
The child in a Pavlik harness needs special attention to skin care because the infant’s skin is sensitive and the harness may cause irritation. The harness should not affect normal bowel function in the infant. Families are typically instructed on techniques for holding and feeding. The harness should not affect feeding patterns in the infant. The harness should not affect normal respiratory function in the infant.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1229 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

32. During a well-child visit, the nurse identifies that an 18-month-old infant is bowlegged. What action by the nurse is most appropriate?
a. Assess the infant’s diet history.

b. Document the finding in the chart.
c. Facilitate a referral to an orthopedist.
d. Perform further assessment of the musculoskeletal system.

ANS: B
Bowlegs are common in infants and toddlers. The nurse only needs to document the findings. No other actions are required.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1228 | Table 50.5 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

33. A nurse is assessing cranial nerve VII. How does the nurse perform this assessment?
a. Ask the child to smile or "show your teeth."
b. Have the child shrug shoulders against resistance.
c. Tell the child to squeeze your hands hard.
d. Instruct the child to stick out the tongue.

ANS: A
Cranial nerve VII (facial nerve) is assessed by having the child smile. Shrugging the shoulders against resistance is testing cranial nerve XI (spinal accessory nerve). Squeezing the hands assesses grip strength. The ability to stick out the tongue shows that cranial nerve XII (hypoglossal) is intact.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1214 | Table 50.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. A child has a cast applied to the left forearm. Which interventions should the nurse include in the home care instructions for the parents? (*Select all that apply*.)
a. Keep small toys away from the cast.
b. Use a padded ruler to scratch the skin under the cast if it itches.
c. Assess the cast daily for unusual odors.
d. Elevate the extremity on pillows for the first 24 to 48 hours.
e. Numbness and tingling in the extremity are expected.

ANS: A, C, D
Small toys should be kept away from the cast because they can become lodged inside the cast. The cast should be inspected daily for any unusual odors, which can indicate infection. The extremity should be elevated for the first 24 to 48 hours to decrease edema. Nothing should be placed inside the cast. If numbness or tingling is experienced, the physician should be notified.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1216 | Parents Want to Know Box
OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

2. A child is in skeletal traction. Which interventions should the nurse implement to prevent complications of immobility? (*Select all that apply*.)

a. Reposition the child every 2 hours.
b. Avoid use of an egg-crate or sheepskin mattress.
c. Limit fluid intake.
d. Administer stool softeners as prescribed.
e. Encourage coughing and deep breathing.

ANS: A, D, E
Complications of immobility can affect the skin, the gastrointestinal system, and the respiratory system. The child should be repositioned every 2 hours to prevent skin breakdown. Stool softeners should be administered to avoid constipation, and the child should cough and deep breathe to maintain respiratory function. Egg-crate or sheepskin mattresses can be useful in preventing skin breakdown, and fluids should be increased to prevent constipation, not decreased.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1215 | Table 50.2 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

3. What actions should the nurse perform while caring for a school-age child who sprained his ankle playing football? (*Select all that apply*.)
   a. Turn the child every 1 to 2 hours.
   b. Assist with range-of-motion exercises every 2 hours.
   c. Apply ice to the affected ankle.
   d. Wrap the ankle with an ACE bandage.
   e. Elevate the affected extremity.

   ANS: C, D, E
   The child with a soft tissue injury in the first 6 to 12 hours is treated by controlling the swelling and reducing muscle damage. The acronym RICE summarizes the care needed: rest, ice, compression, and elevation. During the acute phase of the injury, the child is not moved frequently, and range-of-motion exercises would not be done. The child with a soft tissue injury in the first 6 to 12 hours is treated by controlling the swelling and reducing muscle damage.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 1220 | Nursing Quality Alert Box
   OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

COMPLETION

1. A nurse is preparing to administer naproxen to a toddler weighing 29 pounds. The pharmacy delivers a bottle containing 125 mg/5 mL. Based on knowledge of the safe dose, how much liquid does the nurse prepare to administer? Display your answer using a whole number.
   _____ mL

   ANS:
   66 mL

   First find the child's weight in kilograms. 29 pounds = 13.1818 kilograms. Next, take the dose (10 mg/kg) and multiply by 13.1818 = 131.81. Now, divide in half as this dose is given in two divided doses daily = 65.905 mL. Finally round to the nearest whole number = 66 mL.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1238 | Drug Guide Box OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. New parents ask the nurse, "Why is it necessary for our baby to have the newborn blood test?" The nurse explains that the priority outcome of mandatory newborn screening for inborn errors of metabolism is
   a. appropriate community referral for affected infants.
   b. parental education about raising a special needs child.
   c. early identification of serious genetically transmitted metabolic diseases.
   d. early identification of electrolyte imbalances.

   ANS: C
   Mandatory genetic screening allows early identification of genetically transmitted metabolic disorders. These disorders can be managed best with early diagnosis and in some cases, early treatment prevents serious physical and cognitive delays. Community referral is appropriate after a diagnosis is made. Parental education will be important, but that is not the goal of screening. Although electrolyte imbalances could occur with some of the inborn errors of metabolism, this is not the priority outcome, nor would the newborn screen detect electrolyte imbalances.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 1248 OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

2. What is the priority nursing goal for a 14-year-old with Graves' disease?
   a. Relieving constipation
   b. Allowing the adolescent to make decisions about whether or not to take medication
   c. Verbalizing the importance of adherence to the medication regimen
   d. Developing alternative educational goals

   ANS: C
   A priority goal is for the adolescent to verbalize the need to remain adherent to the medication regime. The adolescent with Graves' disease is not constipated. Adherence to the medication schedule is important to ensure optimal health and wellness. Medications should not be skipped, and dose regimens should not be tapered by the child without consultation with the child's medical provider. The management of Graves' disease does not interfere with school attendance and does not require alternative educational plans.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1252 OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

3. What information provided by the nurse would be helpful to a 15-year-old adolescent taking methimazole three times a day?
   a. Pill dispensers and alarms on a watch can be effective reminders to take the medication.
   b. She can take the medication when she is feels symptomatic.
   c. She can take two pills before school and one pill at dinner, which is easier to

remember.

d. The mother can be responsible for reminding her to take her medication.

ANS: A

Methimazole is an antithyroid medication that should be taken three times a day. Reminders will facilitate taking medication as ordered. This medication needs to be taken regularly, not on an as-needed basis. The dosage cannot be combined to reduce the frequency of administration. An adolescent is old enough and mature enough to be responsible for taking medications.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1253 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

4. Diabetes insipidus is a disorder of the
   a. anterior pituitary.
   b. posterior pituitary.
   c. adrenal cortex.
   d. adrenal medulla.

ANS: B

The principal disorder of posterior pituitary hypofunction is diabetes insipidus. ADH is produced in the hypothalamus and stored in the posterior pituitary gland. When ADH is not released appropriately by the posterior pituitary gland, DI occurs. The anterior pituitary produces hormones such as growth hormone, thyroid-stimulating hormone, adrenocorticotropic hormone, gonadotropin, prolactin, and melanocyte-stimulating hormone. The adrenal cortex produces aldosterone, sex hormones, and glucocorticoids. The adrenal medulla produces catecholamines.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1243 | p. 1253 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

5. A child is hospitalized after a serious motor vehicle crash and has developed increased urination. What action by the nurse takes priority?
   a. Weigh the child daily.
   b. Monitor the child’s intake and output.
   c. Assess the daily serum sodium level.
   d. Restrict dietary sodium intake.

ANS: C

This child might have diabetes insipidus; being in a car crash has the potential for a head injury. That coupled with frequent urination leads the nurse to suspect DI. A high serum sodium and low urine specific gravity are hallmarks of this condition. The priority action for the nurse is to review the child’s most recent serum sodium. Daily weights and I&O are also important for many children but is not as specific for this condition as assessing the sodium level. The child may or may not need a sodium restriction, but assessment comes first.

PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
REF: p. 1254 | Nursing Quality Alert Box
OBJ: Nursing Process: Assessment
MSC: Client Needs: Safe and Effective Care Environment

6. What should the nurse include in the teaching plan for parents of a child with diabetes insipidus who is receiving DDAVP?
   a. Increase the dosage of DDAVP as the urine specific gravity (SG) increases.
   b. Give DDAVP only if urine output decreases.
   c. The child should have free access to water and toilet facilities at school.
   d. Cleanse skin before administering the transdermal patch.

   ANS: C
   The child's teachers should be aware of the diagnosis and treatment plan, and the child should have free access to water and toilet facilities at school. DDAVP needs to be given as ordered by the physician. If the parents are monitoring urine SG at home, they would not increase the medication dose for increased SG; the physician may order an increased dosage for very dilute urine with decreased SG. DDAVP needs to be given continuously as ordered by the physician. DDAVP is typically given intranasally or by subcutaneous injection. For nocturnal enuresis, it may be given orally.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1254 | Nursing Quality Alert Box OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

7. A child with growth hormone deficiency is receiving GH therapy. What is the best time for the GH to be administered?
   a. At bedtime
   b. After meals
   c. Before meals
   d. On arising in the morning

   ANS: A
   Injections are best given at bedtime to more closely approximate the physiologic release of GH.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1259 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

8. A nurse is explaining growth hormone deficiency to parents of a child admitted to rule out this problem. Which metabolic alteration that is related to growth hormone deficiency should the nurse explain to the parent?
   a. Hypocalcemia
   b. Hypoglycemia
   c. Diabetes insipidus
   d. Hyperglycemia

   ANS: B
   Growth hormone helps maintain blood sugar at normal levels. Calcium is not affected. Diabetes insipidus is a disorder of the posterior pituitary. Growth hormone is produced by the anterior pituitary. Hyperglycemia results from an insufficiency of insulin, which is produced by the beta cells in the islets of Langerhans in the pancreas.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1259 OBJ: Nursing Process: Implementation

MSC: Client Needs: Physiologic Integrity

9. At what age is sexual development in boys and girls considered to be precocious?
   a. Boys, 11 years; girls, 9 years
   b. Boys, 12 years; girls, 10 years
   c. Boys, 9 years; girls, 8 years
   d. Boys, 10 years; girls, 9 1/2 years

   ANS: C
   Manifestations of sexual development before age 9 in boys and age 8 in girls is considered precocious and should be investigated. The other ages fall within the expected range of pubertal onset.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1256 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

10. What is the most appropriate intervention for the parents of a 6-year-old child with precocious puberty?
    a. Advise the parents to consider birth control for their daughter.
    b. Explain the importance the child having relationships with same-age peers.
    c. Reassure parents that there are no long-term consequences.
    d. Counsel parents that there is no treatment currently available for this disorder.

    ANS: B
    Despite the child's appearance, the child needs to be treated according to her chronologic age and to interact with children in the same age- group. An expected outcome is that the child will adjust socially by exhibiting age-appropriate behaviors and social interactions. Advising the parents of a 6-year-old to put their daughter on birth control is not appropriate and will not reverse the effects of precocious puberty. There may be both long-term physical and emotional consequences of this disorder. Treatment for precocious puberty is the administration of gonadotropin-releasing hormone blocker, which slows or reverses the development of secondary sexual characteristics and slows rapid growth and bone aging.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1257 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

11. A neonate is displaying mottled skin, has a large fontanel and tongue, is lethargic, and is having difficulty feeding. The nurse recognizes that this is most suggestive of which disorder?
    a. Hypocalcemia
    b. Hypothyroidism
    c. Hypoglycemia
    d. Phenylketonuria (PKU)

    ANS: B

An infant with hypothyroidism may exhibit skin mottling, a large fontanel, a large tongue, hypotonia, slow reflexes, a distended abdomen, prolonged jaundice, lethargy, constipation, feeding problems, and coldness to touch. When hypocalcemia is present, neonates may display twitching, tremors, irritability, jitteriness, electrocardiographic changes, and, rarely, seizures. Hypoglycemia causes the neonate to exhibit jitteriness, poor feeding, lethargy, seizures, respiratory alterations including apnea, hypotonia, high-pitched cry, bradycardia, cyanosis, and temperature instability. Infants with PKU may initially have digestive problems with vomiting, and they may have a musty or mousy odor to the urine, infantile eczema, hypertonia, and hyperactive behavior.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1249 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

12. A common clinical manifestation of congenital hypothyroidism is
    a. insomnia.
    b. diarrhea.
    c. hoarse cry.
    d. jitteriness.

    ANS: C
    Infants with congenital hypothyroidism often have a hoarse cry. They also sleep excessively, are constipated and lethargic.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1249 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

13. A goiter is an enlargement or hypertrophy of which gland?
    a. Thyroid
    b. Adrenal
    c. Anterior pituitary
    d. Posterior pituitary

    ANS: A
    A goiter is an enlargement or hypertrophy of the thyroid gland.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1252 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

14. Exophthalmos (protruding eyeballs) may occur in children with which condition?
    a. Hypothyroidism
    b. Hyperthyroidism
    c. Hypoparathyroidism
    d. Hyperparathyroidism

    ANS: B
    Exophthalmos is a clinical manifestation of hyperthyroidism. It is not associated with the other conditions.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering

REF: p. 1252 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

15. A neonate born with ambiguous genitalia is diagnosed with congenital adrenal hyperplasia. Therapeutic management includes administration of
    a. vitamin D.
    b. cortisone acetate.
    c. stool softeners.
    d. calcium carbonate.

    ANS: B
    Cortisone acetate is the treatment for congenital adrenal hyperplasia, and treatment is lifelong. Vitamin D, stool softeners, and calcium carbonate are not used in therapy for this condition.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1248 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

16. Type 1 diabetes mellitus is suspected in an adolescent. Which clinical manifestation may be present?
    a. Moist skin
    b. Weight gain
    c. Fluid overload
    d. Blurred vision

    ANS: D
    Blurred vision is one manifestation of diabetes mellitus type 1. Other manifestations include dehydration with dry skin and weight loss, polyuria, and polyphagia.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1260 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

17. A parent asks the nurse why self-monitoring of blood glucose is being recommended for her child with diabetes. The nurse should base the explanation on the knowledge that
    a. it is a less expensive method of testing.
    b. it is not as accurate as laboratory testing.
    c. children are better able to manage the diabetes.
    d. the parents are better able to manage the disease.

    ANS: C
    Blood glucose self-management has improved diabetes management and can be used successfully by children from the time of diagnosis. Insulin dosages can be adjusted based on blood sugar results. The child learns to be in better control by utilizing blood glucose monitoring. Blood glucose monitoring may be more expensive but provides improved management. It is as accurate as equivalent testing done in laboratories. The ability to self-test allows the child to balance diet, exercise, and insulin. The parents are partners in the process, but the child should be taught how to manage the disease.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1264 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

18. What is the best time for the nurse to assess the peak effectiveness of subcutaneously administered regular insulin?
    a. Two hours after administration
    b. Four hours after administration
    c. Immediately after administration
    d. Thirty minutes after administration

    ANS: A
    The peak action for regular (short-acting) insulin is 2 to 3 hours after subcutaneous administration. The other times do not correspond to the peak action time.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1263 | Table 51.4 OBJ: Nursing Process: Evaluation
    MSC: Client Needs: Physiologic Integrity

19. What is the primary concern for a 7-year-old child with type 1 diabetes mellitus who asks his mother not to tell anyone at school that he has diabetes?
    a. The child's safety
    b. The privacy of the child
    c. Development of a sense of industry
    d. Peer group acceptance

    ANS: A
    Safety is the primary issue. School personnel need to be aware of the signs and symptoms of hypoglycemia and hyperglycemia and the appropriate interventions. While privacy is a concern, for the child's safety, key personnel need to know about the diagnosis and what to do in an emergency. The treatment of type 1 diabetes should not interfere with the school-age child's development of a sense of industry. Peer group acceptance, along with body image, are issues for the early adolescent with type 1 diabetes. This is not of greater priority than the child's safety.

    PTS: 1 DIF: Cognitive Level: Analysis/Analyzing
    REF: p. 1266 OBJ: Nursing Process: Planning
    MSC: Client Needs: Safe and Effective Care Environment

20. What is the best nursing action when a child with type 1 diabetes mellitus is sweating, trembling, and pale?
    a. Offer the child a glass of water.
    b. Give the child 5 units of regular insulin subcutaneously.
    c. Give the child a glass of orange juice.
    d. Give the child glucagon subcutaneously.

    ANS: C
    Four ounces of orange juice is an appropriate treatment for the conscious child who is exhibiting signs of hypoglycemia. This contains 15 grams of carbohydrate. A glass of water is not indicated in this situation. An easily digested carbohydrate is indicated when a child exhibits symptoms of hypoglycemia. Insulin would lower blood glucose and is contraindicated for a child with hypoglycemia. Subcutaneous injection of glucagon is used to treat hypoglycemia when the child is unconscious.

    PTS: 1 DIF: Cognitive Level: Application/Applying

REF: p. 1267 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

21. Which sign is the nurse most likely to assess in a child with hypoglycemia?
    a. Urine positive for ketones and serum glucose greater than 300 mg/dL
    b. Normal sensorium and serum glucose greater than 160 mg/dL
    c. Irritability and serum glucose less than 60 mg/dL
    d. Increased urination and serum glucose less than 120 mg/dL

    ANS: C
    Irritability and serum glucose less than 60 mg/dL are manifestations of hypoglycemia. Serum glucose greater than 300 mg/dL and urine positive for ketones are indicative of diabetic ketoacidosis. Normal sensorium and serum glucose greater than 160 mg/dL are associated with hyperglycemia. Increased urination is an indicator of hyperglycemia. A serum glucose level less than 120 mg/dL is within normal limits.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1261 | Table 51.3 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

22. When would a child diagnosed with type 1 diabetes mellitus most likely demonstrate a decreased need for insulin?
    a. During the “honeymoon” phase
    b. During adolescence
    c. During growth spurts
    d. During minor illnesses

    ANS: A
    During the “honeymoon” phase, which may last from a few weeks to a year or longer, the child is likely to need less insulin. Insulin requirements are generally higher during adolescence, growth spurts, and illnesses.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1261 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

23. What should a nurse advise the parents of a child with type 1 diabetes mellitus who is not eating as a result of a minor illness?
    a. Give the child half his regular morning dose of insulin.
    b. Substitute simple carbohydrates or calorie-containing liquids for solid foods.
    c. Give the child plenty of unsweetened, clear liquids to prevent dehydration.
    d. Take the child directly to the emergency department.

    ANS: B
    A sick-day diet of simple carbohydrates or calorie-containing liquids will maintain normal serum glucose levels and decrease the risk of hypoglycemia. The child should receive his regular dose of insulin even if he does not have an appetite. If the child is not eating as usual, he needs calories to prevent hypoglycemia. During periods of minor illness, the child with type 1 diabetes mellitus can be managed safely at home.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1268 | Box 51.4 OBJ: Nursing Process: Implementation

MSC: Client Needs: Physiologic Integrity

24. Which is the nurse's best response to the parents of a 10-year-old child newly diagnosed with type 1 diabetes mellitus who are concerned about the child's continued participation in soccer?
    a. "Consider the swim team as an alternative to soccer."
    b. "Encourage intellectual activity rather than participation in sports."
    c. "It is okay to play sports such as soccer unless the weather is too hot."
    d. "Give the child an extra 15 to 30 g of carbohydrate snack before soccer practice."

    ANS: D
    Exercise lowers blood glucose levels. A snack with 15 to 30 g of carbohydrates before exercise will decrease the risk of hypoglycemia. Soccer is an appropriate sport for a child with type 1 diabetes as long as the child prevents hypoglycemia by eating a snack. Participation in sports is not contraindicated for a child with type 1 diabetes. The child with type 1 diabetes may participate in sports activities regardless of climate.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1264 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

25. Which comment by a 12-year-old child with type 1 diabetes indicates deficient knowledge?
    a. "I rotate my insulin injection sites every time I give myself an injection."
    b. "I keep records of my glucose levels and insulin sites and amounts."
    c. "I'll be glad when I can take a pill for my diabetes like my uncle does."
    d. "I keep Lifesavers in my school bag in case I have a low-sugar reaction."

    ANS: C
    Children with type 1 diabetes will require life-long insulin therapy. Rotating sites may help with variable insulin absorption. Rotating spots within the same major site is important. Keeping records of serum glucose and insulin sites and amounts is appropriate. Prompt treatment of hypoglycemia reduces the possibility of a severe reaction. Keeping hard candy on hand is an appropriate action.

    PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
    REF: p. 1263 OBJ: Nursing Process: Evaluation
    MSC: Client Needs: Physiologic Integrity

26. Which laboratory finding confirms that a child with type 1 diabetes is experiencing diabetic ketoacidosis?
    a. No urinary ketones
    b. Low arterial pH
    c. Elevated serum carbon dioxide
    d. Elevated serum phosphorus

    ANS: B
    Severe insulin deficiency produces metabolic acidosis, which is indicated by a low arterial pH. Urinary ketones, often in large amounts, are present when a child is in diabetic ketoacidosis. Serum carbon dioxide is decreased in diabetic ketoacidosis. Serum phosphorus is decreased in diabetic ketoacidosis.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering

REF: p. 1270 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

27. An infant has just been diagnosed with Tay-Sachs disease. What action by the nurse is most appropriate?
    a. Refer the family to a support group.
    b. Educate the family on bone marrow transplant.
    c. Teach the family how to promote growth and development.
    d. Obtain informed consent for laser eye surgery.

    ANS: A
    Tay-Sachs is inevitably fatal, usually by early childhood. The family will need much emotional support, which is found in support groups where they will interact with families who are or who have been in a similar situation. Tay-Sachs is not treated with bone marrow transplant or eye surgery. Development regresses with neurologic deterioration, and the infant usually exhibits macrocephaly, seizures, blindness, and deafness.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1247 | Table 51.1 OBJ: Integrated Process: Caring
    MSC: Client Needs: Psychosocial Integrity

28. A nurse is caring for a child undergoing an ACTH stimulation test. After administering the Cortrosyn according to policy, what action by the nurse takes priority?
    a. Obtain a set of vital signs.
    b. Monitor the urine output.
    c. Facilitate a lab draw in 30 minutes.
    d. Keep the child NPO.

    ANS: C
    For the ACTH stimulation test, cortisol levels are drawn before and 30 and 60 minutes after cortisone administration. The nurses' priority is to facilitate the lab being drawn on time. Obtaining vital signs and urine output and keeping the child NPO are not related to this test.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1245 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. Which nursing interventions are appropriate for a child with type 1 diabetes who is experiencing deficient fluid volume related to abnormal fluid losses through diuresis and emesis? (*Select all that apply*.)
    a. Initiate IV access.
    b. Begin IV fluid replacement with normal saline.
    c. Begin IV fluid replacement with D5 1/2NS.
    d. Weigh on arrival to the unit and then every other day.
    e. Maintain strict intake and output monitoring.

    ANS: A, B, E

IV access should always be obtained on a hospitalized child with dehydration and a history of type 1 diabetes. Maintaining circulation is a priority nursing intervention. If the child is vomiting and unable to maintain adequate hydration, fluid volume replacement/rehydration is needed. Normal saline is the initial IV rehydration fluid. Maintaining strict intake and output is essential in calculating rehydration status. D5 1/2NS is not the recommended fluid for rehydration of this patient. Weighing the patient on arrival is important, but following the initial weight, the child needs to be weighed more frequently than every other day. Comparison of admission weight and a weight every 8 hours provides an indication of hydration status.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1271 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

2. Which children admitted to the pediatric unit would the nurse monitor closely for development of SIADH? (*Select all that apply*.)
   a. A newly diagnosed preschooler with type 1 diabetes
   b. A school-age child returning from surgery for removal of a brain tumor
   c. An infant with suspected meningitis
   d. An adolescent with blunt abdominal trauma following a car accident
   e. A school-age child with head trauma

   ANS: B, C, E
   Childhood SIADH usually is caused by disorders affecting the central nervous system, such as infections (meningitis), head trauma, and brain tumors. Diabetes and abdominal trauma do not cause SIADH.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1254 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. A child is diagnosed with hypothyroidism. The nurse should expect to assess which symptoms associated with hypothyroidism? (*Select all that apply*.)
   a. Weight loss
   b. Fatigue
   c. Diarrhea
   d. Dry, thick skin
   e. Cold intolerance

   ANS: B, D, E
   A child with hypothyroidism will display fatigue, dry, thick skin, and cold intolerance. Weight loss and diarrhea are signs of hyperthyroidism.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1251 | Box 51.1 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. What is a sign of increased intracranial pressure (ICP) in a 10-year-old child?
   a. Headache
   b. Bulging fontanel
   c. Tachypnea
   d. Increase in head circumference

   ANS: A
   Headaches are a clinical manifestation of increased ICP in children. A change in the child's normal behavior pattern may be an important early sign of increased ICP. Bulging fontanel or increased head circumference is seen in infants. A change in respiratory pattern is a late sign of increased ICP. Cheyne–Stokes respiration may be evident. This refers to a pattern of increasing rate and depth of respirations followed by a decreasing rate and depth with a pause of variable length.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1279 | Box 52.1 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

2. Which information should the nurse give to a child who is to have magnetic resonance imaging (MRI) of the brain?
   a. "You won't be able to move your head during the procedure."
   b. "You will have to drink a special fluid before the test."
   c. "You will have to lie flat after the test is finished."
   d. "You will have electrodes placed on your head with glue."

   ANS: A
   To reduce fear and enhance cooperation during the MRI, the child should be made aware that head movement will be restricted to obtain accurate information. The child does not need to drink special liquids, lie on the back afterward, or have electrodes placed.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1278 OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

3. Which term is used when a patient remains in a deep sleep, responsive only to vigorous and repeated stimulation?
   a. Coma
   b. Stupor
   c. Obtundation
   d. Persistent vegetative state

   ANS: B

Stupor exists when the child remains in a deep sleep, responsive only to vigorous and repeated stimulation. Coma is the state in which no motor or verbal response occurs to noxious (painful) stimuli. Obtundation describes a level of consciousness in which the child is arousable with stimulation. Persistent vegetative state describes the permanent loss of function of the cerebral cortex.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1282 | Nursing Quality Alert Box
OBJ: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

4. The Glasgow Coma Scale consists of an assessment of
   a. pupil reactivity and motor response.
   b. eye opening and verbal and motor responses.
   c. level of consciousness and verbal response.
   d. ICP and level of consciousness.

ANS: B
The Glasgow Coma Scale assesses eye opening, and verbal and motor responses. Pupil reactivity is not a part of the Glasgow Coma Scale but is included in the pediatric coma scale. Level of consciousness is not a part of the Glasgow Coma Scale. Intracranial pressure and level of consciousness are not part of the Glasgow Coma Scale.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1282 | Table 52.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

5. Nursing care of the infant who has had a myelomeningocele repair should include
   a. securely fastening the diaper.
   b. measurement of pupil size.
   c. measurement of head circumference.
   d. administration of seizure medications.

ANS: C
Head circumference measurement is essential because hydrocephalus can develop in these infants. A diaper should be placed under the infant but not fastened. Keeping the diaper open facilitates frequent cleaning and decreases the risk for skin breakdown. Pupil size measurement is usually not necessary. Seizure medications are not routinely given to infants who do not have seizures.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1286 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

6. The most common problem of children born with a myelomeningocele is
   a. bladder incontinence.
   b. intellectual impairment.
   c. respiratory compromise.
   d. cranioschisis.

ANS: A

Myelomeningocele is one of the most common causes of neuropathic (neurogenic) bladder dysfunction among children, leading to incontinence. Risk of intellectual impairment is minimized through early intervention and management of hydrocephalus. Respiratory compromise is not a common problem in myelomeningocele. Cranioschisis is a skull defect through which various tissues protrude. It is not associated with myelomeningocele.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1286 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

7. A recommendation to prevent neural tube defects is the supplementation of
   a. vitamin A throughout pregnancy.
   b. multivitamin preparations as soon as pregnancy is suspected.
   c. folic acid for all women of childbearing age.
   d. folic acid during the first and second trimesters of pregnancy.

   ANS: C
   The widespread use of folic acid among women of childbearing age is expected to decrease the incidence of spina bifida significantly. Vitamin A, multivitamins, and folic acid only during specific points during the pregnancy have not been shown to prevent neural tube defects.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1285 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

8. How much folic acid does the nurse tell female patients is recommended for women of childbearing age?
   a. 1.0 mg
   b. 0.4 mg
   c. 1.5 mg
   d. 2.0 mg

   ANS: B
   It has been estimated that a daily intake of 0.4 mg of folic acid in women of childbearing age has contributed to a reduction in the number of children with neural tube defects. The other doses are not the recommended dose.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1285 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

9. Latex allergy is suspected in a child with spina bifida. Appropriate nursing interventions include which of the following?
   a. Avoiding using any latex product
   b. Using only non-allergenic latex products
   c. Administering medication for long-term desensitization
   d. Teaching family about long-term management of allergic manifestations

   ANS: A

Care must be taken that individuals who are at high risk for latex allergies do not come in direct or secondary contact with products or equipment containing latex at any time during medical treatment. Latex allergy is estimated to occur in 75% of this patient population. There are no non-allergenic latex products. At this time, desensitization is not an option. There are no treatment options for long-term management of allergic symptoms for latex allergy.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1285 OBJ: Nursing Process: Intervention
MSC: Client Needs: Physiologic Integrity

10. When a 2-week-old infant is seen for irritability, poor appetite, and rapid head growth with observable distended scalp veins, the nurse recognizes these signs as indicative of which disorder?
    a. Hydrocephalus
    b. Syndrome of inappropriate antidiuretic hormone (SIADH)
    c. Cerebral palsy
    d. Reye's syndrome

    ANS: A
    The combination of signs is strongly suggestive of hydrocephalus. SIADH would not manifest in this way. The child would have decreased urination, hypertension, weight gain, fluid retention, hyponatremia, and increased urine specific gravity. The manifestations of cerebral palsy vary but may include persistence of primitive reflexes, delayed gross motor development, and lack of progression through developmental milestones. Reye's syndrome is associated with an antecedent viral infection with symptoms of malaise, nausea, and vomiting. Progressive neurologic deterioration occurs.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1287 | Table 52.2 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

11. What finding should cause the nurse to suspect a diagnosis of spastic cerebral palsy?
    a. Tremulous movements at rest and with activity
    b. Sudden jerking movement caused by stimuli
    c. Writhing, uncontrolled, involuntary movements
    d. Clumsy, uncoordinated movements

    ANS: B
    Spastic cerebral palsy, the most common type of cerebral palsy, will manifest with hypertonicity and increased deep tendon reflexes. The child's muscles are very tight, and any stimuli may cause a sudden jerking movement. Tremulous movements, slow writhing movements, and loss of kinesthetic sense are not manifestations of spastic cerebral palsy.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1289 | Pathophysiology Box OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

12. Which finding in an analysis of cerebrospinal fluid (CSF) is consistent with a diagnosis of bacterial meningitis?
    a. CSF appears cloudy.
    b. CSF pressure is decreased.

c. Few leukocytes are present.
d. Glucose level is increased compared with blood.

ANS: A
In acute bacterial meningitis, the CSF is cloudy to milky or yellowish in color. The CSF pressure is usually increased in acute bacterial meningitis. Many polymorphonuclear cells are present in CSF with acute bacterial meningitis. The CSF glucose level is usually decreased compared with the serum glucose level.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1302 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

13. How should the nurse explain positioning for a lumbar puncture to a 5-year-old child?
a. "You will be on your knees with your head down on the table."
b. "You will be able to sit up with your chin against your chest."
c. "You will be on your side with the head of your bed slightly raised."
d. "You will lie on your side and bend your knees so that they touch your chin."

ANS: D
The child should lie on her side with knees bent and chin tucked in to the knees. This position exposes the area of the back for the lumbar puncture. The other positions are not used for a lumbar puncture.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1279 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

14. A mother reports that her child has episodes where he appears to be staring into space. This behavior is characteristic of which type of seizure?
a. Absence
b. Atonic
c. Tonic–clonic
d. Simple partial

ANS: A
Absence seizures are very brief episodes of altered awareness. The child has a blank expression. Atonic seizures cause an abrupt loss of postural tone, loss of consciousness, confusion, lethargy, and sleep. Tonic–clonic seizures involve sustained generalized muscle contractions followed by alternating contraction and relaxation of major muscle groups. There is no change in level of consciousness with simple partial seizures. Simple partial seizures consist of motor, autonomic, or sensory symptoms.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1296 | Box 52.5 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

15. What is the best response to a father who tells the nurse that his son "daydreams" at home and that his teacher has observed this behavior at school?
a. "Your son must have an active imagination."
b. "Can you tell me exactly how many times this occurs in one day?"
c. "Tell me about your son's activity when you notice the daydreams."

d. “He is probably overtired and needs more rest.”

ANS: C
The daydream episodes are suggestive of absence seizures, and data about activity associated with the daydreams should be obtained. Describing an active imagination or an overtired child does not address the symptoms of the father’s concern. Determining the number of times the behavior occurs is not as helpful as information about the behavior.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1296 | Box 52.5 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

16. The nurse teaches parents to alert their health care provider about which adverse effect when a child receives valproic acid (Depakene) to control generalized seizures?
a. Weight loss
b. Bruising
c. Anorexia
d. Drowsiness

ANS: B
Thrombocytopenia is an adverse effect of valproic acid. Parents should be alert for any unusual bruising or bleeding. Weight gain, not loss, is a side effect of valproic acid. Drowsiness is not a side effect of valproic acid, although it is associated with other anticonvulsant medications. Anorexia is not a side effect of valproic acid.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1298 | Table 52.3 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

17. A child with a head injury sleeps unless aroused, and when aroused responds briefly before falling back to sleep. What should the nurse chart for this child’s level of consciousness?
a. Disoriented
b. Obtunded
c. Lethargic
d. Stuporous

ANS: B
Obtunded describes an individual who sleeps unless aroused and once aroused has limited interaction with the environment. Disoriented refers to lack of ability to recognize place or person. An individual is lethargic when he or she awakens easily but exhibits limited responsiveness. Stupor refers to requiring considerable stimulation to arouse the individual.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1282 | Nursing Quality Alert Box
OBJ: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

18. Which type of fracture describes traumatic separation of cranial sutures?
a. Basilar
b. Linear
c. Comminuted
d. Depressed

ANS: C
Comminuted skull fractures include fragmentation of the bone or a multiple fracture line. A basilar fracture involves the basilar portion of the frontal, ethmoid, sphenoid, temporal, or occipital bone. A linear fracture includes a straight-line fracture without dural involvement. A depressed fracture has the bone pushed inward, causing pressure on the brain.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1291 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

19. Which statement best describes a subdural hematoma?
    a. Bleeding occurs between the dura and the skull.
    b. Bleeding occurs between the dura and the cerebrum.
    c. Bleeding is generally arterial, and brain compression occurs rapidly.
    d. The hematoma commonly occurs in the parietotemporal region.

ANS: B
A subdural hematoma is bleeding that occurs between the dura and the cerebrum as a result of a rupture of cortical veins that bridge the subdural space. An epidural hemorrhage occurs between the dura and the skull, is usually arterial with rapid brain concussion, and occurs most often in the parietotemporal region. An epidural hemorrhage occurs between the dura and the skull, is usually arterial with rapid brain concussion, and occurs most often in the parietotemporal region. An epidural hemorrhage occurs between the dura and the skull, is usually arterial with rapid brain concussion, and occurs most often in the parietotemporal region.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1291 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

20. The nurse is assessing a child who was just admitted to the hospital for observation after a head injury. What is the most essential part of nursing assessment to detect early signs of a worsening condition?
    a. Posturing
    b. Vital signs
    c. Focal neurologic signs
    d. Level of consciousness

ANS: D
The most important nursing observation is assessment of the child's level of consciousness. Alterations in consciousness appear earlier in the progression of head injury than do alterations of vital signs or focal neurologic signs. Neurologic posturing is indicative of neurologic damage. Vital signs and focal neurologic signs are later signs of progression when compared with level-of-consciousness changes. Vital signs and focal neurologic signs are later signs of progression when compared with level-of-consciousness changes.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1292 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

21. A 5-year-old sustained a concussion after falling out of a tree. In preparation for discharge, the nurse is discussing home care with the parents. Which statement made by the parents indicates a correct understanding of the teaching?
    a. “I should expect my child to have a few episodes of vomiting.”
    b. “If I notice sleep disturbances, I should contact the physician immediately.”
    c. “I should expect my child to have some behavioral changes after the accident.”
    d. “If I notice diplopia, I will have my child rest for 1 hour.”

    ANS: C
    The parents are advised of probable posttraumatic symptoms. These include behavioral changes and sleep disturbances. Vomiting and diplopia should be reported immediately. Sleep disturbances may occur with postconcussive syndrome, but difficulty waking the child up should be reported.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1293 | Parents Want to Know Box
    OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

22. Which type of seizure involves both hemispheres of the brain?
    a. Focal
    b. Partial
    c. Generalized
    d. Acquired

    ANS: C
    Clinical observations of generalized seizures indicate that the initial involvement is from both hemispheres. Focal seizures may arise from any area of the cerebral cortex, but the frontal, temporal, and parietal lobes are most commonly affected. Partial seizures are caused by abnormal electric discharges from epileptogenic foci limited to a circumscribed region of the cerebral cortex. A seizure disorder that is acquired is a result of a brain injury from a variety of factors; it does not specify the type of seizure.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1296 | Box 52.5 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

23. What is the most appropriate nursing action when a child is in the tonic phase of a generalized tonic–clonic seizure?
    a. Guide the child to the floor if standing and go for help.
    b. Turn the child’s body on the side.
    c. Place a padded tongue blade between the teeth.
    d. Quickly slip soft restraints on the child’s wrists.

    ANS: B
    Positioning the child on his side will prevent aspiration. It is inappropriate to leave the child during the seizure. Nothing should be inserted into the child’s mouth during a seizure to prevent injury to the mouth, gums, or teeth. Restraints could cause injury. Sharp objects and furniture should be moved out of the way to prevent injury.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1301 | Nursing Quality Alert Box
    OBJ: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

24. After a tonic–clonic seizure, it would not be unusual for a child to display
    a. irritability and hunger.
    b. lethargy and confusion.
    c. nausea and vomiting.
    d. nervousness and excitability.

    ANS: B
    In the period after a tonic–clonic seizure, the child may be confused and lethargic. Some children may sleep for a period of time. The other manifestations are not normally seen after a seizure.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1296 | Box 52.5 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

25. What should the nurse teach parents when the child is taking phenytoin (Dilantin) to control seizures?
    a. The child should use a soft toothbrush and floss the teeth after every meal.
    b. The child will require monitoring of renal function while taking this medication.
    c. Dilantin should be taken with food because it causes gastrointestinal distress.
    d. The medication can be stopped when the child has been seizure free for 1 month.

    ANS: A
    A side effect of Dilantin is gingival hyperplasia. Good oral hygiene will minimize this adverse effect. The child should have liver function studies because this anticonvulsant may cause hepatic dysfunction, not renal dysfunction. Dilantin has not been found to cause gastrointestinal upset. The medication can be taken without food. Anticonvulsants should never be stopped suddenly or without consulting the physician. Such action could result in seizure activity.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1298 | Table 52.3 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

26. The father of a newborn infant with myelomeningocele asks about the cause of this condition. What response by the nurse is most appropriate?
    a. “One of the parents carries a defective gene that causes myelomeningocele.”
    b. “A deficiency in folic acid in the father is the most likely cause.”
    c. “Offspring of parents who have a spinal abnormality are at greater risk for myelomeningocele.”
    d. “There may be no definitive cause identified.”

    ANS: D
    The etiology of most neural tube defects is unknown in most cases. There may be a genetic predisposition or a viral origin, and the disorder has been linked to maternal folic acid deficiency; however, the actual cause has not been determined. There may be a genetic predisposition, but no pattern has been identified. Folic acid deficiency in the mother has been linked to neural tube defect. There is no evidence that children who have parents with spinal problems are at greater risk for neural tube defects.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding

REF: p. 1285 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

27. Which change in status should alert the nurse to increased intracranial pressure (ICP) in a child with a head injury?
    a. Rapid, shallow breathing
    b. Irregular, rapid heart rate
    c. Increased diastolic pressure with narrowing pulse pressure
    d. Confusion and altered mental status

    ANS: D
    The child with a head injury may have confusion and altered mental status, a change in vital signs, retinal hemorrhaging, hemiparesis, and papilledema. Respiratory changes occur with ICP. One pattern that may be evident is Cheyne–Stokes respiration. This pattern of breathing is characterized by increasing rate and depth, then decreasing rate and depth, with a pause of variable length. Temperature elevation may occur in children with ICP. Changes in blood pressure occur, but the diastolic pressure does not increase, nor is there a narrowing of pulse pressure.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1279 | Box 52.1 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

28. The nurse should expect a child who has frequent tension-type headaches to describe headache pain as which of the following?
    a. “There is a rubber-band squeezing my head.”
    b. “It’s a throbbing pain over my left eye.”
    c. “My headaches are worse in the morning and get better later in the day.”
    d. “I have a stomachache and a headache at the same time.”

    ANS: A
    The child who has tension-type headaches may describe the pain as a bandlike tightness or pressure, tight neck muscles, or soreness in the scalp. A common symptom of migraines is throbbing headache pain, typically on one side of the eye. A headache that is worse in the morning and improves throughout the course of the day is typical of ICP. Abdominal pain may accompany headache pain in migraines.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1307 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

29. What is an appropriate nursing intervention for the child with a tension headache?
    a. Assess for an aura.
    b. Maintain complete bed rest.
    c. Administer mild pain medication.
    d. Assess for nausea and vomiting.

    ANS: C
    Mild pain relievers like acetaminophen or ibuprofen are appropriate for the child with a tension headache. The other measures are not warranted.

    PTS: 1 DIF: Cognitive Level: Application/Applying

REF: p. 1307 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

30. Which statement by an adolescent indicates an understanding about factors that can trigger migraine headaches?
    a. "I should avoid loud noises because this is a common migraine trigger."
    b. "Exercise can cause a migraine. I guess I won't have to take gym anymore."
    c. "I think I'll get a migraine if I go to bed at 9 PM on week nights."
    d. "I am learning to relax because I get headaches when I am worried about stuff."

    ANS: D
    Stress can trigger migraines. Relaxation therapy can help the adolescent control stress and headaches. Other precipitating factors in addition to stress include poor diet, food sensitivities, and flashing lights. Visual stimuli, not auditory stimuli, are known to be a common trigger for migraines. Exercise is not a trigger for migraines. The adolescent needs regular physical exercise. Altered sleep patterns and fatigue are common triggers for migraine headaches. Going to bed at 9 PM should allow an adolescent plenty of sleep to prevent fatigue.

    PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
    REF: p. 1308 OBJ: Nursing Process: Evaluation
    MSC: Client Needs: Physiologic Integrity

31. What is the priority nursing intervention for the child with ascending paralysis as a result of Guillain–Barré syndrome (GBS)?
    a. Immunosuppressive medications
    b. Respiratory assessment
    c. Passive range-of-motion exercises
    d. Anticoagulant therapy

    ANS: B
    Special attention to respiratory status is needed because most deaths from GBS are attributed to respiratory failure. Respiratory support is necessary if the respiratory system becomes compromised and muscles weaken and become flaccid. Children with rapidly progressing paralysis are treated with intravenous immunoglobulins for several days. Administering this infusion is not the nursing priority. The child with GBS is at risk for complications of immobility. Performing passive range-of-motion exercises is an appropriate nursing intervention but not the priority intervention. Anticoagulant therapy may be initiated because the risk of pulmonary embolus as a result of deep vein thrombosis is always a threat. This is not the priority nursing intervention.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1304 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

32. A child is brought to the emergency department in status epilepticus. Which medication should the nurse expect to be given initially in this situation?
    a. Clorazepate dipotassium (Tranxene)
    b. Fosphenytoin (Cerebyx)
    c. Phenobarbital
    d. Lorazepam (Ativan)

    ANS: D

Lorazepam (Ativan) or diazepam (Valium) is given intravenously to control generalized tonic–clonic status epilepticus and may also be used for seizures lasting more than 5 minutes. The other drugs are used for seizures but are not the first-line treatment for status.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1301 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

33. What should be the nurse's first action when a child with a head injury complains of double vision and a headache, and then vomits?
    a. Immobilize the child's neck.
    b. Report this information to the physician.
    c. Darken the room and put a cool cloth on the child's forehead.
    d. Restrict the child's oral fluid intake.

    ANS: B
    Any indication of ICP such as double vision, headache, or vomiting should be promptly reported to the physician. Stabilizing the child's neck does not address the child's symptoms. Darkening the room and giving a cool cloth are comfort measures. A fluid restriction is not needed.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1279 | Box 52.1 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

34. A nurse is explaining to parents how the central nervous system of a child differs from that of an adult. Which statement accurately describes these differences?
    a. The infant has 150 mL of CSF compared with 50 mL in the adult.
    b. Papilledema is a common manifestation of ICP in the very young child.
    c. The brain of a term infant weighs less than half of the weight of the adult brain.
    d. Coordination and fine motor skills develop as myelinization of peripheral nerves progresses.

    ANS: D
    Peripheral nerves are not completely myelinated at birth. As myelinization progresses, so does the child's coordination and fine muscle movements. An infant has about 50 mL of CSF compared with 150 mL in an adult. Papilledema rarely occurs in infancy because open fontanels and sutures can expand in the presence of ICP. The brain of the term infant is two thirds the weight of an adult's brain.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1276 | Pediatric Differences Box
    OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Health Promotion and Maintenance

35. The nurse is preparing a school-age child for computed tomography (CT scan) to assess cerebral function. Which statement should the nurse include when preparing the child?
    a. "Pain medication will be given."
    b. "The scan will not hurt."
    c. "You will be able to move once the equipment is in place."
    d. "Unfortunately no one can remain in the room with you during the test."

ANS: B
For CT scans, the child must be immobilized. It is important to emphasize to the child that at no time is the procedure painful. Pain medication is not required; however, sedation is sometimes necessary. The child will not be allowed to move and will be immobilized. Someone is able to remain with the child during the procedure.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1278 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

36. Which neurologic diagnostic test gives a visualized horizontal and vertical cross section of the brain at any axis?
    a. Nuclear brain scan
    b. Echoencephalography
    c. CT scan
    d. MRI

ANS: C
A CT scan provides a visualization of the horizontal and vertical cross sections of the brain at any axis. A nuclear brain scan uses a radioisotope that accumulates where the blood–brain barrier is defective. Echoencephalography identifies shifts in midline structures of the brain as a result of intracranial lesions. MRI permits visualization of morphologic features of target structures and permits tissue discrimination that is unavailable with any other techniques.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1278 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. What nursing actions are indicated when the nurse is administering phenytoin (Dilantin) by the intravenous route to control seizures? (*Select all that apply.*)
    a. It must be given with $D_5$1/2 NS.
    b. Occasional blood levels will be assessed.
    c. Dilantin should be given with food because it causes gastrointestinal distress.
    d. It must be given in normal saline.
    e. It must be filtered.

ANS: B, D, E
The child should have serum levels drawn to monitor for optimal therapeutic levels. In addition, liver function studies should be monitored because this anticonvulsant may cause hepatic dysfunction. The IV dose must be given in normal saline, not $D_5$1/2 NS. The IV dose must be filtered. The IV dose must be given in normal saline, not $D_5$1/2 NS. Dilantin has not been found to cause gastrointestinal upset, and since it is being given by the IV route, this is not a concern. The medication can be taken without food.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1298 | Table 52.3 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

2. A nurse should expect which cerebral spinal fluid (CSF) laboratory results on a child diagnosed with bacterial meningitis? (*Select all that apply.*)
   a. Elevated white blood count (WBC)
   b. Decreased protein
   c. Decreased glucose
   d. Cloudy in color
   e. Increase in red blood cells (RBC)

   ANS: A, C, D
   The CSF laboratory results for bacterial meningitis include elevated WBC counts, cloudy or milky in color, and decreased glucose. The protein is elevated and there should be no RBCs present. RBCs are present when the tap was traumatic.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1302 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. A 14-year-old is in the intensive care unit after a spinal cord injury 2 days ago. Nursing care for this child includes (*Select all that apply.*)
   a. monitoring and maintaining systemic blood pressure.
   b. administering corticosteroids.
   c. minimizing environmental stimuli.
   d. discussing long-term care issues with the family.
   e. monitoring for respiratory complications.

   ANS: A, B, E
   Spinal cord injury patients are physiologically labile, and close monitoring is required. They may be unstable for the first few weeks after the injury. Corticosteroids are administered to minimize the inflammation present with the injury. Spinal cord injury is a catastrophic event. Discussion of long-term care should be delayed until the child is stable.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: pp. 1294-1295 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

COMPLETION

1. A 62-pound child has a spinal cord injury and is to receive steroid therapy. How much medication does the nurse draw up for the bolus dose? Record your answer in a whole number. Administer _____ mg.

   ANS:
   845

   First calculate the child's weight in kilograms: 62/2.2 = 28.181818 kilograms.
   Next multiply the child's weight by the standard bolus dose: 28.181818 × 30 = 845.454545 mg.
   Round to the nearest whole number = 845 mg.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 1294 OBJ: Nursing Process: Implementation

MSC: Client Needs: Physiologic Integrity

2. A 62-pound child has a spinal cord injury and has completed the bolus dose of IV steroids. The nurse is preparing to hang an IV infusion of steroids for the next 23 hours. How much medication should this child get per hour? Record your answer using 1 decimal place.
Administer _____ mg/hour.

ANS:
152.2

First calculate the child's weight in kilograms: 62/2.2 = 28.181818 kilograms.
Next multiply the weight by the standard dose of 5.4 mg/kg/hour × 28.181818 = 152.181818. Last, round to 1 decimal place = 152.2 mg/hour.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1294 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

MULTIPLE CHOICE

1. Which sign or symptom is likely to be manifested by an adolescent with a depressive disorder?
   a. Abuse of alcohol
   b. Impulsivity and distractibility
   c. Carelessness and inattention to details
   d. Refusal to leave the house

   ANS: A
   Depression often manifests in conjunction with substance abuse, so children who abuse substances should be evaluated for depression as well. Impulsivity and distractibility are manifestations of attention-deficit/hyperactivity disorder (ADHD). A diminished ability to think or concentrate, carelessness, and inattention to details is a clinical manifestation of ADHD. A refusal to leave the house, even to play with friends, is characteristic of separation anxiety disorder.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1325 | Table 53.1 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Psychosocial Integrity

2. Which statement about suicide is correct?
   a. Children younger than 10 years of age are least likely to attempt suicide.
   b. Suicide risk decreases with age.
   c. Suicide is usually an isolated event in a school community.
   d. The prevalence of suicide attempts is higher among males.

   ANS: A
   Suicide by children under the age of 10 is uncommon although it is the third leading cause of death in children ages 5 to 10. The risk of suicide increases with age. It is common for suicide to occur in a cluster within a community (e.g., schools). Males have a 4% rate of suicide attempts compared to 8% in females; however, males are more likely to die after a suicide attempt.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1318 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Psychosocial Integrity

3. An adolescent states “I am very sad. I wish I was not alive.” What is the best response by the nurse?
   a. “Everyone feels sad once in a while.”
   b. “You are just trying to escape your problems.”
   c. “Have you told your parents how you feel?”
   d. “Have you thought about hurting yourself?”

   ANS: D

This response acknowledges the adolescent's suicide gesture and further assesses the adolescent's condition. It is judgmental and belittles the teen's feelings to tell the teen that everyone is sad once in a while or to accuse the teen of trying to escape problems. The parents should be made aware of an adolescent's precarious mental state; however, this response does not address the adolescent's statement. It also does not begin to provide safety for the teen.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1319 | Box 53.1 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

4. The long-term treatment plan for an adolescent with an eating disorder focuses on which of the following?
   a. Managing the effects of malnutrition
   b. Establishing sufficient caloric intake
   c. Improving family dynamics
   d. Restructuring perception of body image

ANS: A
The treatment of eating disorders is initially focused on reestablishing physiologic homeostasis. Once body systems are stabilized, the next goal of treatment for eating disorders is maintaining adequate caloric intake. Although family therapy is indicated when dysfunctional family relationships exist, the primary focus of therapy for eating disorders is to help the adolescent cope with complex issues. The focus of treatment in individual therapy for an eating disorder involves restructuring cognitive perceptions about the individual's body image.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1324 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

5. A parent of a child with an anxiety disorder states, "I don't know how my child developed this problem." On what information should the nurse base a response?
   a. Genetic factors, hormonal imbalances, and societal influences all contribute to the development of anxiety disorders in children.
   b. Like many conditions affecting children, the etiology of anxiety disorders is unknown.
   c. The majority of anxiety disorders has a clear pattern of genetic inheritance.
   d. Dysfunctional family patterns are usually identified as the cause of an anxiety disorder.

ANS: A
Anxiety disorders are responses to stress and may be manifested as disturbances in feeling, body functions, behavior, or performance. Children with a history of verbal, physical, or sexual abuse; frequent separation from or loss of loved ones; drug use, incarceration, or lower socioeconomic status; homosexuality; chronic illness; behavioral disorders; and dysfunctional families are more likely than peers with healthy family patterns to have anxiety disorders. The etiology of many anxiety disorders in children can be identified. Some anxiety disorders are inheritable disorders. Others have been identified as having other origins. Research consistently shows that psychosocial disorders are caused by a combination of predisposing or inherent factors and environmental or interactional factors.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1314 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

6. In counseling an adolescent who is abusing alcohol, the nurse explains that alcohol abuse primarily affects which organ of the body?
   a. Heart
   b. Liver
   c. Brain
   d. Lungs

   ANS: C
   The primary effect of substance abuse is on the brain and residually on the rest of the body. Alcohol affects the entire brain by decreasing its responsiveness. Although an excessive amount of a chemical can cause cardiac abnormalities, the brain is the most commonly affected organ. Long-term alcohol use is known to impair the liver; however, brain function is decreased by any amount of alcohol intake. The pulmonary system is not the primary target; however, one commonly abused drug known to cause pulmonary problems is tobacco.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1326 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Psychosocial Integrity

7. A 14-year-old admits to using marijuana every day with friends after attending school. What phase of substance abuse does this behavior exemplify?
   a. Experimentation
   b. Early drug use
   c. True drug addiction
   d. Severe drug addiction

   ANS: C
   True drug addiction is identified as regular use of drugs. Physical dependence may be present. Social functioning has a drug focus. With experimentation, the individual tries the drug to see what it is like or to satisfy peers. Early drug use is identified as using drugs with some degree of regularity for their desirable effects. In severe drug addiction, the physical condition of the individual deteriorates, and all activities are related to drug use.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1326 | Box 53.2 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Psychosocial Integrity

8. The school nurse observes an unkempt child dressed in inappropriate clothing who repeatedly asks for food. About which problem is the nurse concerned?
   a. Physical abuse
   b. Physical neglect
   c. Emotional abuse
   d. Sexual abuse

   ANS: B

   These physical and behavioral indicators suggest that parental attention is not being given to the child’s physical needs. The child is being neglected. There are no indicators of physical, emotional, or sexual abuse in this scenario.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1328 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

9. A child who has symptoms of irritable mood, changes in sleep and appetite patterns, decreased self-esteem, and disengagement from family and friends lasting 3 weeks meets the criteria for which depressive disorder?
   a. Major depressive disorder
   b. Dysthymic disorder
   c. Cyclothymic disorder
   d. Panic disorder

   ANS: A
   A 2-week (or longer) episode of depressed or irritable mood in addition to disturbances in appetite, sleep, energy, or self-esteem meets the criteria for a major depressive disorder. A dysthymic disorder is associated with a depressed or irritable mood for at least a year. A cyclothymic or bipolar mood disorder is characterized by chronic, fluctuating mood disturbances between depressive lows and highs for a year. A panic disorder is a type of anxiety disorder.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1315 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Psychosocial Integrity

10. What is the goal of therapeutic management for a child diagnosed with ADHD?
    a. Administer stimulant medications.
    b. Assess the child for other psychosocial disorders.
    c. Correct nutritional imbalances.
    d. Reduce the frequency and intensity of unsocialized behaviors.

    ANS: D
    The primary goal of therapeutic management for the child with ADHD is to reduce the intensity and frequency of unsocialized behaviors. Although medications are effective in managing behaviors associated with ADHD, all families do not choose to give their child medication. Administering medication is not the primary goal. Children with ADHD may have other psychosocial or learning problems; however, diagnosing these is not the primary goal. Interventions to correct nutritional imbalances are the primary focus of care for eating disorders.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1321 OBJ: Nursing Process: Planning
    MSC: Client Needs: Psychosocial Integrity

11. Which behavior demonstrated by an adolescent should alert the school nurse to a problem of substance abuse?
    a. States feelings of worthlessness
    b. Increased desire for social conformity
    c. Does not feel need for peer approval
    d. Deterioration of relationships with family members

    ANS: D

Deterioration of relationships with family members, irregular school attendance, low grades, rebellious or aggressive behavior, and excessive dependence on peer influence are behaviors that may indicate substance abuse. Feelings of worthlessness are suggestive of a depressive disorder. An adolescent with a substance abuse problem may be depressed, but this behavior is not a manifestation of substance abuse. The clinical manifestations of substance abuse are marked by an increase in antisocial behavior as the desire for social conformity decreases and the need for the substance increases. The adolescent with a substance abuse problem may demonstrate an excessive dependence on peer influence.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1326 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

12. Which behavior verbalized by a school-age child should alert the school nurse to a problem of possible obsessive–compulsive disorder (OCD)?
    a. States feelings of worthlessness and sadness every day
    b. Feels need to ride a bike around the tree in front of the house seven times every day before entering the house
    c. Recurrent episodes of chest pain, heart palpitations, and shortness of breath when entering the computer classroom
    d. Deterioration of relationships with family members

    ANS: B
    Obsessive–compulsive disorder (OCD) manifests repetitive unwanted thoughts (obsessions) or ritualistic actions (compulsions) or both. Feelings of worthlessness and sadness are suggestive of a depressive disorder. Panic disorders often cause recurrent episodes of chest pain, heart palpitations, and shortness of breath. These symptoms may be accompanied by a feeling of impending doom. Deterioration of relationships with family members, irregular school attendance, low grades, rebellious or aggressive behavior, and excessive dependence on peer influence are behaviors that may indicate substance abuse.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1315 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

13. Which finding noted by the nurse on a physical assessment is most suggestive that a child has been sexually abused?
    a. Swelling of the genitalia and pain on urination
    b. Smooth philtrum and thin upper lip
    c. Speech and physical development delays
    d. History of constipation, drowsiness, and constricted pupils

    ANS: A

Physical indicators of sexual abuse may include swelling or itching of the genitalia and pain on urination. Other indicators may include bruises, bleeding, or lacerations of the external genitalia, vagina, or anal area. The infant with fetal alcohol syndrome may have microphthalmia or abnormally small eyes or short palpebral fissures, a thin upper lip, and a poorly developed philtrum. Children who have been emotionally abused may exhibit speech disorders, lags in physical development, failure to thrive, or hyperactive and disruptive behaviors. Although there is a possibility for speech and developmental delays, these are not more suggestive of sexual abuse than swollen genitalia and pain on urination. Opiates can cause detachment and apathy, drowsiness, constricted pupils, constipation, slurred speech, and impaired judgment.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1328 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

14. Which manifestation is atypical of ADHD?
    a. Talking incessantly
    b. Blurting out the answers to questions before the questions have been completed
    c. Acting withdrawn in social situations
    d. Fidgeting with hands or feet

    ANS: C
    The child with ADHD tends to be talkative, often interrupting conversations, rather than withdrawn in social situations. Talking excessively, blurting out the answers to questions, and fidgeting are all characteristics of impulsivity/hyperactivity.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1320 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

15. A home health care nurse is working with a child whose parents seem to be quite rigid in their rules and expectations and seem very distrustful of the nurse. What action by the nurse is most appropriate?
    a. Ask the parents why they don’t trust outsiders.
    b. Interview the parents separately.
    c. Monitor the child for signs of abuse.
    d. Assess the parents for substance abuse.

    ANS: C
    Families that hold very rigid rules and expectations and who are distrustful of outsiders fit some of the characteristics of an abusive family. The nurse should be alert for signs of abuse in the child. Asking “why” questions puts people on the defensive. There is no need to separate the parents to interview them. Substance abuse is not indicated.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1328 | Box 53.3 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Psychosocial Integrity

16. A teen has told the school nurse about recent suicidal thoughts. What action by the nurse is best?
    a. Call the police and the teen’s parents.

b. Ask if the teen has access to firearms.
c. Assess the teen for substance abuse.
d. Report the finding to the principal.

ANS: B
When a child or adolescent (or adult) admits to having suicidal thoughts, the nurse must ensure that person's safety. Along with asking if the person has a definite plan, the nurse must assess for access to weapons. The teen's parents and principal should be notified, but the police do not need to be called. Assessing for substance abuse is not the priority.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1319 | Box 53.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

17. A student nurse is working with a child in foster care. The child was removed from the home due to abuse. The child is crying for the parents and the student is confused. What information does the registered nurse provide?
a. Children will grieve the loss of parents, even if they were abusive.
b. The child needs therapy from a qualified therapist.
c. Play therapy will alleviate this behavior.
d. The parents may not have been the abusers.

ANS: A
Children removed from the home will grieve that loss. Play therapy can be beneficial, but its purpose is not to alleviate displays of grief. The child probably does need therapy, but this does not explain the behavior to the student. Stating that someone else may have abused the child also does not explain the situation.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1331 | Nursing Care Plan OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. The parents of a teen suspect their child is using amphetamines. Manifestations of amphetamine use include (*Select all that apply.*)
a. weight gain.
b. excessive talking and activity.
c. excessive sleeping.
d. insomnia.
e. agitation.

ANS: B, D, E
Euphoria, hyperactivity, agitation, irritability, insomnia, weight loss, tachycardia, and hypertension are expected behaviors and effects of amphetamine abuse. The adolescent using amphetamines is likely to have weight loss, not weight gain. Excessive sleeping may be associated with alcohol abuse or abuse of barbiturates.

PTS: 1 DIF: Cognitive Level: Analysis REF: p. 1325 | Table 53.1
OBJ: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

2. A nurse working on the pediatric unit should be aware that children admitted with which of the following assessment findings are suggestive of physical child abuse? (*Select all that apply.*)
   a. Bruises in various stages of healing
   b. Bruises over the shins or bony prominences
   c. Burns on the palms of the hands
   d. A fracture of the right wrist from a sports accident
   e. Rib fractures in an infant

   ANS: A, C, E
   Bruises in various stages of healing and burns on the palms of the hand may be indicative of physical abuse. Rib fractures in an infant are another indicator of physical abuse. Bruises over the shins or bony prominences are seen in children beginning to walk. A fracture of the right wrist can occur as the child begins to participate in sports activities.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1328 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Psychosocial Integrity

3. The nurse is aware that suicide risk increases if the child displays which characteristics? (*Select all that apply.*)
   a. Previous suicide attempt
   b. No previous exposure to violence in the home
   c. Recent loss
   d. Effective social network
   e. History of physical abuse

   ANS: A, C, E
   The risk of suicide increases if the child has had a previous suicide attempt, a recent loss, or a history of physical abuse. No previous violence in the home or having an effective social network decreases the risk of suicide.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1318 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Psychosocial Integrity

MULTIPLE CHOICE

1. A parent whose child has been diagnosed with a cognitive deficit should be counseled that intellectual impairment
   a. is usually due to a genetic defect.
   b. may be caused by a variety of factors.
   c. is rarely due to first trimester events.
   d. is usually caused by parental intellectual impairment.

   ANS: B
   There are a multitude of causes for intellectual impairment. In most cases, a specific cause has not been identified. Only a small percentage of children with intellectual impairment are affected by a genetic defect. One third of children with intellectual impairment are affected by first trimester events. Intellectual impairment can be transmitted to a child only if the parent has a genetic disorder.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1338 OBJ: Integrated Process: Teaching-Learning
   MSC: Client Needs: Health Promotion and Maintenance

2. A parent asks the nurse why a developmental assessment is being conducted for a child during a routine well-child visit. The nurse answers based on the knowledge that routine developmental assessments during well-child visits are
   a. not necessary unless the parents request them.
   b. the best method for early detection of cognitive disorders.
   c. frightening to parents and children and should be avoided.
   d. valuable in measuring intelligence in children.

   ANS: B
   Early detection of cognitive disorders can be facilitated through assessment of development at each well-child examination. Developmental assessment is a component of all well-child examinations. Developmental assessments are not as frightening when the parent and child are educated about the purpose of the assessment. Developmental assessments are not intended to measure intelligence.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 1340 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Health Promotion and Maintenance

3. The father of a child recently diagnosed with developmental delay is very rude and hostile toward the nurses. This father was cooperative during the child's evaluation a month ago. What is the best explanation for this change in parental behavior?
   a. The father is exhibiting symptoms of a psychiatric illness.
   b. The father may be abusing the child.
   c. The father is resentful of the time he is missing from work for this appointment.
   d. The father is experiencing a symptom of grief.

ANS: D
After a child is diagnosed with a developmental delay, families typically experience a cycle of grieving that is repeated when developmental milestones are not met. One cannot determine that a parent is exhibiting symptoms of a psychiatric illness on the basis of a single situation. The scenario does not give any information to suggest child abuse. Although the father may have difficulty balancing his work schedule with medical appointments for his child, a more likely explanation for his behavior change is that he is grieving the loss of a normal child.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1342 | Nursing Care Plan OBJ: Nursing Process: Assessment
MSC: Client Needs: Psychosocial Integrity

4. The most appropriate nursing diagnosis for a child with a cognitive dysfunction is
   a. impaired social interaction.
   b. deficient knowledge.
   c. risk for injury.
   d. ineffective coping.

   ANS: C
   The nurse needs to know that limited cognitive abilities to anticipate danger lead to risk for injury. Safety is a priority for all children with cognitive dysfunction. Impaired social interaction is indeed a concern for the child with a cognitive disorder but does not address the limited ability to anticipate danger. Because of the child's cognitive deficit, knowledge will not be retained and will not decrease the risk for injury. Ineffective individual coping does not address the limited ability to anticipate danger.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 1341 | Safety Alert Box OBJ: Nursing Process: Diagnosis
   MSC: Client Needs: Health Promotion and Maintenance

5. Anticipatory guidance for the family of a preadolescent with a cognitive dysfunction should include information about
   a. institutional placement.
   b. sexual development.
   c. sterilization.
   d. appropriate clothing.

   ANS: B
   Preadolescents who have a cognitive dysfunction may have normal sexual development without the emotional and cognitive abilities to deal with it. It is important to assist the family and child through this developmental stage. The child may or may not need institutional placement at some point. Sterilization is not an appropriate intervention when a child has a cognitive dysfunction. By the time a child reaches preadolescence, the family should have received counseling on age-appropriate clothing.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 1342 | Nursing Care Plan OBJ: Nursing Process: Planning
   MSC: Client Needs: Health Promotion and Maintenance

6. What should be the major consideration when selecting toys for a child with an intellectual or developmental disability?

a. Safety
b. Age appropriateness
c. Ability to provide exercise
d. Ability to teach useful skills

ANS: A
Safety is the primary concern in selecting recreational and exercise activities for all children. This is especially true for children who are intellectually disabled. Age appropriateness should be considered in the selection of toys, but safety is of paramount importance since their intellectual age will be less than their chronological age. Ability to provide exercise and teach skills is also important but not as vital as safety.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1341 | Safety Alert Box OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

7. Appropriate interventions to facilitate socialization of the cognitively impaired child include
a. providing age-appropriate toys and play activities.
b. providing peer experiences, such as scouting, when older.
c. avoiding exposure to strangers who may not understand cognitive development.
d. emphasizing mastery of physical skills because they are the most delayed.

ANS: B
The acquisition of social skills is a complex task. Children of all ages need peer relationships. Parents should enroll the child in preschool. When older, they should have peer experiences similar to other children such as group outings, Boy and Girl Scouts, and Special Olympics. Providing age-appropriate toys and play activities is important. However, peer interactions will better facilitate social development. Parents should expose the child to strangers so that the child can practice social skills. Verbal skills are delayed more than physical skills.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1343 | Nursing Care Plan OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

8. A newborn assessment shows separated sagittal suture, oblique palpebral fissures, depressed nasal bridge, protruding tongue, and transverse palmar creases. These findings are most suggestive of
a. microcephaly.
b. Down syndrome.
c. cerebral palsy.
d. fragile X syndrome.

ANS: B
These are characteristics associated with Down syndrome. The infant with microcephaly has a small head. Cerebral palsy is a diagnosis not usually made at birth. No characteristic physical signs are present. The infant with fragile X syndrome has increased head circumference; long, wide, and/or protruding ears; long, narrow face with prominent jaw; hypotonia; and high arched palate.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1345 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

9. The infant with Down syndrome is closely monitored during the first year of life for what serious condition?
   a. Thyroid complications
   b. Orthopedic malformations
   c. Dental malformation
   d. Cardiac abnormalities

   ANS: D
   The high incidence of cardiac defects in children with Down syndrome makes assessment for signs and symptoms of these defects important during the first year. Clinicians recommend the child be monitored frequently throughout the first 12 months of life, including a full cardiac workup. Infants with Down syndrome are not known to have thyroid complications although they can manifest later. Orthopedic malformations may be present, but special attention is given to assessment for cardiac and gastrointestinal abnormalities. Dental malformations are not a major concern compared with the life-threatening complications of cardiac defects.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1344 | Box 54.4 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

10. Many of the physical characteristics of Down syndrome present feeding problems. Care of the infant should include
    a. delaying feeding solid foods until the tongue thrust has stopped.
    b. modifying diet as necessary to minimize the diarrhea that often occurs.
    c. providing calories appropriate to child's age.
    d. using special bottles that may assist the infant with feeding.

    ANS: D
    Breastfeeding may not be possible if the infant's muscle tone or sucking reflex is immature. Mothers should be encouraged to pump breast milk and use special bottles for assistance with feeding. Some children with Down syndrome can breastfeed adequately. The child has a protruding tongue, which makes feeding difficult. The parents must persist with feeding while the child continues the physiologic response of the tongue thrust. The child is predisposed to constipation. Calories should be appropriate to the child's weight and growth needs, not age.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1346 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Physiologic Integrity

11. What action is contraindicated when a child with Down syndrome is hospitalized?
    a. Determine the child's vocabulary for specific body functions.
    b. Assess the child's hearing and visual capabilities.
    c. Encourage parents to leave the child alone to encourage adaptation.
    d. Have meals served at the child's usual meal times.

    ANS: C

The child with Down syndrome needs routine schedules and consistency. Having familiar people present, especially parents, helps to decrease the child's anxiety. To communicate effectively with the child, it is important to know the child's particular vocabulary for specific body functions. Children with Down syndrome have a high incidence of hearing loss and vision problems and should have hearing and vision assessed whenever they are in a health care facility. Routine schedules and consistency are important to children.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1345 OBJ: Nursing Process: Planning
MSC: Client Needs: Psychosocial Integrity

12. The child with Down syndrome should be evaluated for which condition before participating in some sports?
    a. Hyperflexibility
    b. Cutis marmorata
    c. Atlantoaxial instability
    d. Speckling of iris (Brushfield spots)

ANS: C
Children with Down syndrome are at risk for atlantoaxial instability. Before participating in sports that put stress on the head and neck, a radiologic examination should be done. Although hyperflexibility is characteristic of Down syndrome, it does not affect the child's ability to participate in sports. Although cutis marmorata is characteristic of Down syndrome, it does not affect the child's ability to participate in sports. Although Brushfield spots are characteristic of Down syndrome, they do not affect the child's ability to participate in sports.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1345 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

13. A nurse is giving a parent information about autism. Which statement made by the parent indicates understanding of the teaching?
    a. Autism is characterized by periods of remission and exacerbation.
    b. The onset of autism usually occurs before 3 years of age.
    c. Children with autism have imitation and gesturing skills.
    d. Autism can be treated effectively with medication.

ANS: B
The onset of autism usually occurs before 3 years of age. Autism does not have periods of remission and exacerbation. Autistic children lack imitative skills. Medications are of limited use in children with autism.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 1350 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Health Promotion and Maintenance

14. What should the nurse keep in mind when planning to communicate with a child who has autism?
    a. The child has normal verbal communication.
    b. Expect the child to use sign language.
    c. The child may exhibit monotone speech and echolalia.

d. The child is not listening if she is not looking at the nurse.

ANS: C
Children with autism have abnormalities in the production of speech such as a monotone voice or echolalia or inappropriate volume, pitch, rate, rhythm, or intonation. The child has impaired verbal communication and abnormalities in the production of speech. Some autistic children may use sign language, but it is not assumed. Children with autism often are reluctant to initiate direct eye contact.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1352 OBJ: Nursing Process: Planning
MSC: Client Needs: Psychosocial Integrity

15. Developmental delays, self-injury, fecal smearing, and severe temper tantrums in a preschool child are symptoms of
a. Down syndrome.
b. intellectual disability.
c. psychosocial deprivation.
d. separation anxiety.

ANS: B
These are symptoms of intellectual disability. Down syndrome is often identified at birth by characteristic facial and head features, such as brachycephaly (disproportionate shortness of the head); flat profile; inner epicanthal folds; wide, flat nasal bridge; narrow, high-arched palate; protruding tongue; and small, short ears, which may be low set. Although intellectual impairment may be present, the symptoms listed are not the primary ones expected in the diagnosis of Down syndrome. Psychosocial deprivation may be a cause of mild intellectual disability. The symptoms listed are characteristic of severe intellectual disability. Symptoms of separation anxiety include protest, despair, and detachment.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1340 | Box 54.2 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

16. Throughout their life span, cognitively impaired children are less capable of managing environmental challenges and are at risk for
a. nutritional deficits.
b. visual impairments.
c. physical injuries.
d. psychiatric problems.

ANS: C
Safety is a challenge for cognitively impaired children. Decreased capability to manage environmental challenges may lead to physical injuries. Nutritional deficits are related more to dietary habits and the caregivers' understanding of nutrition. Visual impairments are unrelated to cognitive impairment. Psychiatric problems may coexist with cognitive impairment; however, they are not environmental challenges.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1341 | Safety Alert Box OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

17. Which statement best describes fragile X syndrome?
    a. Chromosomal defect affecting only females.
    b. Chromosomal defect that follows the pattern of X-linked recessive disorders.
    c. It is a common genetic cause of cognitive impairment.
    d. Most common cause of noninherited cognitive impairment.

    ANS: C
    Fragile X syndrome is the most common inherited cause of cognitive impairment and the second most common cause of cognitive impairment after Down syndrome. Fragile X primarily affects males. Fragile X follows the pattern of X-linked dominant with reduced manifestation of the syndrome in female and moderate to severe dysfunction in males. Fragile X is inherited.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1346 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

18. The nurse is providing counseling to the mother of a child diagnosed with fragile X syndrome. She explains to the mother that fragile X syndrome is
    a. most commonly seen in girls.
    b. acquired after birth.
    c. usually transmitted by the male carrier.
    d. usually transmitted by the female carrier.

    ANS: D
    The gene causing fragile X syndrome is transmitted by the mother. Fragile X syndrome is most common in males. Fragile X syndrome is congenital. Fragile X syndrome is not transmitted by a male carrier.

    PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
    REF: p. 1347 OBJ: Integrated Process: Teaching-Learning
    MSC: Client Needs: Physiologic Integrity

19. Which is the best setting for daytime care for a 5-year-old autistic child whose mother works?
    a. Private day care
    b. Public school
    c. His own home with a sitter
    d. A specialized program that uses behavioral methods

    ANS: D
    Autistic children can benefit from specialized educational programs that address their special needs. Day care programs generally do not have resources to meet the needs of severely impaired children. To best meet the needs of an autistic child, the public school may refer the child to a specialized program. A sitter might not have the skills to interact with an autistic child.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1352 OBJ: Nursing Process: Planning
    MSC: Client Needs: Health Promotion and Maintenance

20. Parents have learned that their 6-year-old child has autism. The nurse may help the parents to cope by explaining that the child may

a. have an extremely developed skill in a particular area.
b. outgrow the condition by early adulthood.
c. have average social skills.
d. have age-appropriate language skills.

ANS: A
Some children with autism have an extremely developed skill in a particular area such as mathematics or music. This information may be comforting, although the nurse should avoid giving false hope. No evidence supports that autism is outgrown. Autistic children have abnormal ways of relating to people (social skills). Speech and language skills are usually delayed in autistic children.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1352 OBJ: Nursing Process: Implementation
MSC: Client Needs: Psychosocial Integrity

21. A child with autism is hospitalized with asthma. The nurse should plan care so that the
a. parents' expectations are met.
b. child's routine habits and preferences are maintained.
c. child is supported through the autistic crisis.
d. parents need not be at the hospital.

ANS: B
Children with autism are often unable to tolerate even slight changes in routine. The child's routine habits and preferences are important to maintain. Focus of care is on the child's needs rather than on the parent's desires. Autism is a life -long condition. The presence of the parents is almost always required when an autistic child is hospitalized.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1352 OBJ: Nursing Process: Planning
MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. The nurse is assessing a 3-year-old child who has characteristics of autism. Which observed behaviors are associated with autism? (*Select all that apply.*)
a. The child flicks the light in the examination room on and off repetitiously.
b. The child has a flat affect.
c. The child demonstrates imitation and gesturing skills.
d. The mother reports the child has no interest in playing with other children.
e. The child is able to make eye contact.

ANS: A, B, D
Self-stimulation is common and usually involves repetition of a sensory stimulus. Autistic children show a fixed, unchanging response to a particular stimulus. Autistic children play alone or involve others only as mere objects. Autistic children lack imitative skills. These children lack social ability and make poor eye contact.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: pp. 1351-1352 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

2. A nurse is assessing a newborn for facial feature characteristics associated with fetal alcohol syndrome. Which characteristics should the nurse expect to assess? (*Select all that apply.*)
   a. Short palpebral fissures
   b. Smooth philtrum
   c. Low-set ears
   d. Inner epicanthal folds
   e. Thin upper lip

   ANS: A, B, C, E
   Infants with fetal alcohol syndrome may have characteristic facial features, including short palpebral fissures, a smooth philtrum (the vertical groove in the median portion of the upper lip), low-set ears, and a thin upper lip. Low-set ears and inner epicanthal folds are associated with Down syndrome.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1348 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. A nurse should plan to implement which interventions for a child admitted with inorganic failure to thrive? (*Select all that apply.*)
   a. Observation of parent–child interactions
   b. Assignment of different nurses to care for the child from day to day
   c. Use of 28-calorie-per-ounce concentrated formulas
   d. Administration of daily multivitamin supplements
   e. Role-modeling appropriate adult–child interactions

   ANS: A, D, E
   The nurse should plan to assess parent–child interactions when a child is admitted for nonorganic failure to thrive. The observations should include how the child is held and fed, how eye contact is initiated and maintained, and the facial expressions of both the child and the caregiver during interactions. Role-modeling and teaching appropriate adult–child interactions (including holding, touching, and feeding the child) will facilitate appropriate parent–child relationships, enhance parents' confidence in caring for their child, and facilitate expression by the parents of realistic expectations based on the child's developmental needs. Daily multivitamin supplements with minerals are often prescribed to ensure that specific nutritional deficiencies do not occur in the course of rapid growth. The nursing staff assigned to care for the child should be consistent. Providing a consistent caregiver from the nursing staff increases trust and provides the child with an adult who anticipates his or her needs and who is able to role-model child care to the parent. Caloric enrichment of food is essential, and formula may be concentrated in titrated amounts up to 24 calories per ounce. Greater concentrations can lead to diarrhea and dehydration.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 1351 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

4. A nurse is providing anticipatory guidance to parents of a child with an intellectual disability. Which safety information is correct based on the child's age? (*Select all that apply.*)
   a. Elementary age: safe use of grooming products
   b. High school age: safety while cooking

c. Preschool age: keep hands inside car
d. High school age: stranger danger
e. Elementary age: water safety

ANS: B, C, E
Many factors related to anticipatory guidance and safety will be similar for the cognitively impaired child as for the other children, based on the child's intellectual age. Teaching high school–age children about safety in the kitchen, preschool-age children to keep their hands inside the car, and elementary-age children water safety are appropriate areas to start with, tailored to intellectual age. Elementary-age children are too young for grooming product safety, and high school–age children are too old for stranger danger.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1341 | Table 54.1 OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE CHOICE

1. An adolescent goes to the primary care provider complaining of difficulty with vision. When the nurse asks the adolescent to explain the visual deficits, the adolescent states, "I am having difficulty seeing distant objects; they are less clear than things that are close." What disorder does the nurse suspect the adolescent has?
   a. Hyphema
   b. Astigmatism
   c. Amblyopia
   d. Myopia

   ANS: D
   Myopic patients have the ability to see near objects more clearly than those at a distance; it is caused by the image focusing beyond the retina. Hyphema includes hemorrhage in the anterior chamber and is not a refractive disorder. Astigmatism is caused by an abnormal curvature of the cornea or lens. Amblyopia is a problem of reduced visual acuity not correctable by refraction.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1358 | Table 55.1 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

2. A 10-year-old patient is talking to the nurse about wanting to try contact lenses instead of wearing glasses. The child states that the other children at school call her "four-eyes." Contact lenses should be prescribed for a child who is
   a. at least 12 years of age.
   b. able to read all the written information and instructions.
   c. able to independently care for the lenses in a responsible manner.
   d. confident that she really wants contact lenses.

   ANS: C
   The child must be able to care for the lenses independently. Serious eye damage can occur with irresponsible use of contact lenses. Chronologic age is not the major determinant. A responsible 10-year-old child might be permitted to wear contact lenses. The ability to read does not indicate understanding of the instructions. Confidence and "wanting" do not equal responsibility.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1358 OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

3. Which statement best describes how a cataract affects a child's vision?
   a. It increases intraocular pressure.
   b. It alters the ability to distinguish among colors.
   c. It causes double vision.
   d. It prevents a clear image from forming on the retina.

.

ANS: D
A cataract is an opacity of the lens or loss of transparency of the lens. Coughing, straining, or vomiting can increase intraocular pressure postoperatively. Nystagmus and strabismus are clinical signs of a cataract. Color deficiency is not a sign. A cataract usually does not cause double vision.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1361 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

4. Which statement by a parent about conjunctivitis indicates that further teaching is needed?
   a. "I'll have separate towels and washcloths for each family member."
   b. "I'll notify my doctor if the eye gets redder or the drainage increases."
   c. "When the eye drainage improves, we'll stop giving the antibiotic ointment."
   d. "After taking the antibiotic for 24 hours, my child can return to school."

   ANS: C
   The antibiotic should be continued for the full prescription. Maintaining separate towels and washcloths will prevent the other family members from acquiring the infection. If the infection proliferates, the physician should be contacted. The child should be kept home from school or day care until the child receives the antibiotic for 24 hours.

   PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
   REF: p. 1363 OBJ: Nursing Process: Evaluation
   MSC: Client Needs: Physiologic Integrity

5. Which teaching guideline helps prevent eye injuries during sports and play activities?
   a. Restrict helmet use to those who wear eye glasses or contact lenses.
   b. Discourage the use of goggles with helmets so the child can see better.
   c. Wear eye protection when participating in high-risk sports such as paintball.
   d. Wear a face mask when playing any sport or playing roughly.

   ANS: C
   High- risk sports such as paintball can cause penetrating eye injuries. Eye protection should be worn. All children who play games should be protected by the appropriate headgear. Goggles and helmets can and should be used concurrently. A face mask does not prevent damage to the child's head.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: pp. 1364-1365 | Parents Want to Know Box
   OBJ: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

6. Initial care of the child with a chemical burn to the eye(s) is focused on which of the following?
   a. Irrigation of the affected eye(s)
   b. Application of topical steroids
   c. Administration of an analgesic
   d. Administration of medication to constrict the pupils

   ANS: A

.

Chemical eye burns are an ocular emergency and best managed by immediate irrigation of the eye(s) with water or normal saline solution. The other actions are not part of initial care.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1365 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

7. The nurse is caring for a 2-year-old child who has a history of meningitis as an infant. The child is not speaking and does not turn the head to the sound of a rattle. Which type of hearing loss in a child may have resulted from a previous infection with meningitis?
   a. Conductive
   b. Sensorineural
   c. Central
   d. Mixed

   ANS: B
   When hearing loss is caused by malformations, auditory nerve damage, or infection, the loss is usually permanent. Damage caused by inflammation or obstruction usually causes a temporary and reversible hearing loss. A central type of hearing loss usually causes difficulties in differentiating sounds and problems with auditory memory, and it is reversible. A combination of conductive and sensorineural loss. Conductive loss is often reversible, whereas sensorineural is permanent.

   PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
   REF: p. 1365 | Box 55.3 OBJ: Nursing Process: Planning
   MSC: Client Needs: Physiologic Integrity

8. On the second postoperative day of an eye surgery, the child has puffy eyes, increased tearing, and fever. What is the most applicable nursing diagnosis?
   a. Risk for Infection related to surgical procedure
   b. Infection related to surgical procedure
   c. Disturbed Sensory Perception (Visual) related to surgical procedure
   d. Acute Pain related to recent surgical intervention

   ANS: B
   Any surgical procedure leaves the patient vulnerable to infection and with a nursing diagnosis of Risk for Infection. However, this child is manifesting signs of infection, which changes the diagnosis to an actual, not risk for, diagnosis. There is no data to support disturbed sensory perception or acute pain.

   PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
   REF: p. 1362 OBJ: Nursing Process: Diagnosis
   MSC: Client Needs: Physiologic Integrity

9. Parents of a 4-year-old child are concerned because the child continues to stutter. What nursing intervention is correct?
   a. Remind the parents that stuttering is normal in children younger than 10 years.
   b. Facilitate a speech evaluation performed if the stuttering continues beyond age 5 years.
   c. Reinforce the fact that this common speech defect requires no treatment.
   d. Tell the parents that speech problems are most treatable during the child's teen

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years.

ANS: B
If stuttering persists after 5 years of age, the child should be seen by the physician and referred to a speech therapist. Stuttering is not normal after age 5 years. Early diagnosis and intervention are important to correct speech disorders.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1368 OBJ: Nursing Process: Implementation
MSC: Client Needs: Health Promotion and Maintenance

10. A 13-year-old adolescent is suspected to have a visual deficit and is scheduled for further evaluation. The teen asks the nurse to tell "the truth" about the tests. What is the nurse's best response?
    a. "Don't worry about anything. We're here to take good care of you."
    b. "Ask your parents. They have talked with the physicians."
    c. "Most of the vision tests are painless and noninvasive."
    d. "Trust the doctors. They know what is best for you."

ANS: C
The nurse should be knowledgeable and honest in answering questions about procedures. The nurse should not belittle the teen's concerns by giving false reassurance, having the teen ask the parents for information, or telling the teen to trust the doctors.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1357 | Nursing Quality Alert Box
OBJ: Integrated Process: Communication and Documentation
MSC: Client Needs: Psychosocial Integrity

11. Teaching parents about the use and application of an eye patch to treat strabismus should include which instruction?
    a. Check under the patch four times a day.
    b. Apply the patch directly to the face.
    c. Sometimes patching alone will straighten the eye.
    d. Negotiate the number of hours per day that the patch is to be worn.

ANS: B
The patch should be securely applied to the face and should remain in place for the prescribed number of hours. There is no need to check under the patch. Patching alone will not straighten the eye. The amount of time the child wears the eye patch is not negotiable. Parents should learn strategies for dealing with resistant behaviors.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1359 | Patient-Centered Teaching Box
OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Physiologic Integrity

12. The correct position for the postoperative child who has had a cataract removed from the right eye is the _____ position.
    a. supine
    b. prone

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c. knee–chest
d. right lateral Sims

ANS: A
To prevent edema and pressure on the operative site, the nurse should elevate the head of the bed slightly and avoid placing the child in a dependent position. The prone position is a dependent position, which is contraindicated after cataract surgery. The knee–chest position is contraindicated after cataract surgery. The right lateral Sims position increases pressure on the operative site.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1361 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

13. What manifestation in a 5-month-old child could indicate visual problems?
a. Lack of binocularity
b. Visual acuity of 20/50
c. Strabismus
d. Hyperopia

ANS: C
Strabismus is normal in the young infant but should not be present after 3 months of age. Binocularity, the ability to fixate on one visual field with both eyes, is not present at birth but is established by 6 months of age. Visual acuity by 4 months of age is between 20/50 and 20/80. Hyperopia, or farsightedness, is normal until about 7 years of age.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1357 | Box 55.1 OBJ: Nursing Process: Assessment
MSC: Client Needs: Health Promotion and Maintenance

14. The nurse should know that the results of untreated amblyopia (“lazy eye”) in the child may include which of the following?
a. Impaired depth perception
b. Strabismus
c. Color deficiency
d. Ptosis

ANS: A
Untreated amblyopia causes the child to lose binocular vision, which may impair depth perception. Amblyopia, or decreased vision in the deviated eye, can result from strabismus. Color deficiency is not a result of amblyopia. Ptosis, or drooping of the eyelid, is not a result of untreated amblyopia.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1359 | Patient-Centered Teaching Box
OBJ: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

15. The teaching plan for the parents of a 3-year-old child with amblyopia (“lazy eye”) should include what instruction?
a. Apply a patch to the child’s eyeglass lenses.
b. Apply a patch only during waking hours.

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c. Apply a patch over the “bad” eye to strengthen it.
d. Cover the “good” eye completely with a patch.

ANS: D
The “good” eye is patched to force the child to use the “bad” eye, thus strengthening the muscles. The patch should always be applied directly to the child’s face, not to eyeglasses. The patch should be left in place even when the child is sleeping. Covering the “bad” eye will not contribute to strengthening it. The “good” eye should be patched.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1359 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

16. The teaching plan for a 7-year-old boy with color deficiency should include what instruction?
a. Buy only one color of clothing to ensure the child’s ability to match items himself.
b. Patching the weaker eye will improve his color vision.
c. Teach him an alternate way to distinguish between the colors of traffic signals.
d. Botulism toxin drops must be administered every 2 months to improve color vision.

ANS: C
Distinguishing colors of warning signals must be taught an alternative way to identify them. Clothes may be labeled or organized so the child can identify them. They do not have to be purchased only in one color. There is no cure for color blindness. Because the eye is not weak, patching will not correct the color deficiency. Color deficiency cannot be treated or corrected. The child can be taught adaptive measures to compensate for the condition.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1359 OBJ: Nursing Process: Planning
MSC: Client Needs: Physiologic Integrity

17. A 2-year-old has excessive tearing and corneal haziness. The nurse knows that these symptoms may indicate which of the following?
a. Viral conjunctivitis
b. Paralytic strabismus
c. Congenital cataract
d. Infantile glaucoma

ANS: D
Excessive tearing and corneal haziness are indicative of glaucoma. Because the child is younger than 3 years of age, it would be classified as “infantile.” Discharge is noted with conjunctivitis. Corneal haziness is not a symptom of conjunctivitis. Neither tearing nor corneal haziness is a symptom of paralytic strabismus. A congenital cataract will cause an opacity but not excessive tearing.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1360 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

18. A child just returned from cataract eye surgery. What is the most significant nursing intervention to prevent increasing intraocular pressure in this child?

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a. Monitor for hypertension.
b. Prevent coughing and vomiting.
c. Lower the head of the bed slightly.
d. Avoid use of steroids after the surgery.

ANS: B
Preventing coughing, straining, vomiting, and touching the operative site are all measures directed toward avoiding increased intraocular pressure. Hypertension is not a symptom of increased intraocular pressure. The head of the bed should be raised slightly. Steroids, antibiotics, and mydriatics may be used after the surgery.

PTS: 1 DIF: Cognitive Level: Application/Application
REF: p. 1361 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

19. A 5-year-old diagnosed with chlamydial conjunctivitis should be carefully assessed for which of the following?
a. Sexual abuse
b. Immune deficiency
c. Congenital cataract
d. Secondary glaucoma

ANS: A
A diagnosis of chlamydial conjunctivitis in a nonsexually active child should signal the health care provider to assess the child for sexual abuse. Chlamydial infection is not related to immune deficiencies, cataracts, or glaucoma.

PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
REF: p. 1363 OBJ: Nursing Process: Assessment
MSC: Client Needs: Physiologic Integrity

20. Which statement by a parent indicates understanding of instructions on the care of a child with conjunctivitis?
a. “I should treat my other children with these eye drops to prevent spread of the disease.”
b. “My child must remain home from school until she has received 72 hours of antibiotic drops.”
c. “I should avoid touching the tip of the ointment tube to my child’s eye.”
d. “My child may go back to wearing her contact lenses 24 hours after treatment has started.”

ANS: C
Care should be taken to avoid touching the tip of the ointment tube or dropper to the eye to avoid contamination of the medication. The other statements indicate a need for further instruction.

PTS: 1 DIF: Cognitive Level: Evaluation/Evaluating
REF: p. 1363 OBJ: Nursing Process: Evaluation
MSC: Client Needs: Physiologic Integrity

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21. Discharge planning for an 8-year-old child with a patched eye after a large corneal abrasion should include which instruction?
    a. Removing the patch after 8 hours for instillation of antibiotic ointment
    b. Gently massaging the affected eye to prevent edema
    c. Keeping the patch in place for 24 hours
    d. Returning after 7 days of patching for reassessment

    ANS: C
    With severe abrasions, the eye should be patched and left undisturbed for 24 hours. After 24 hours, treatment with antibiotic ointment is started. Massaging the affected eye will increase the size of the abrasion and should be avoided. The child should also be taught not to rub the affected eye. The child should return in 24 hours for reassessment if the eye is patched.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1364 OBJ: Nursing Process: Planning
    MSC: Client Needs: Physiologic Integrity

22. A patient who has a hyphema is at risk for developing which condition?
    a. Glaucoma
    b. Strabismus
    c. Diplopia
    d. Astigmatism

    ANS: A
    After hyphema, there is a risk for the development of glaucoma. There is no connection between the other conditions and hyphema.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1364 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

23. A parent brings an 18-month-old to the pediatrician for a routine well-child visit and reports the child has been babbling and cooing since 6 months of age but is not yet saying any words. Which response by the nurse is the most appropriate?
    a. “Don’t worry, your child should catch up soon.”
    b. “The doctor will want to refer your child to an audiologist and speech pathologist.”
    c. “This is normal speech development for an 18-month-old child.”
    d. “Your child has an expressive language disorder and needs further evaluation.”

    ANS: B
    This is an appropriate response. By 18 months children should be speaking in simple sentences. Adequate hearing is essential for the development of speech. Hearing and language should be tested, and a referral to an audiologist and speech pathologist is indicated. The nurse should not give false reassurance and needs to address the parent’s concerns. The nurse cannot diagnose an expressive language disorder.

    PTS: 1 DIF: Cognitive Level: Application/Applying
    REF: p. 1367 OBJ: Nursing Process: Implementation
    MSC: Client Needs: Health Promotion and Maintenance

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24. The most common type of hearing loss, which results from interference of transmission of sound to the middle ear, is called
    a. conductive.
    b. sensorineural.
    c. mixed conductive-sensorineural.
    d. central auditory imperceptive.

    ANS: A
    Conductive or middle ear hearing loss is the most common type. It results from interference of transmission of sound to the middle ear, most often from recurrent otitis media. The other types occur much less often.

    PTS: 1 DIF: Cognitive Level: Knowledge REF: p. 1365 | Box 55.3
    OBJ: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

25. The nurse should suspect a hearing impairment in an infant who demonstrates which of the following?
    a. Absence of intelligible speech by 12 months
    b. Cessation of babbling at age 7 months
    c. Lack of eye contact when being spoken to
    d. Lack of gesturing to indicate wants after age 15 months

    ANS: B
    Infants who are deaf babble like hearing infants until approximately 5 to 6 months of age, at which time babbling is noted to cease. Failure to develop intelligible speech is not considered a problem by 12 months. This would be considered a problem at 24 months. The lack of a startle reflex indicates a problem with hearing. The child with hearing impairment uses gestures rather than vocalizations to express desires at this age.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1367 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

26. A nurse suspects possible visual impairment in a child who displays which problem?
    a. Excessive tearing of the eyes
    b. Rapid lateral movement of the eyes
    c. Delay in speech development
    d. Lack of interest in casual conversation with peers

    ANS: A
    Excessive tearing of the eyes, especially one accompanied by pain and itching, is a clinical manifestation of potential vision problems. The other problems are not associated with visual impairment.

    PTS: 1 DIF: Cognitive Level: Knowledge/Remembering
    REF: p. 1357| Box 55.1 OBJ: Nursing Process: Assessment
    MSC: Client Needs: Physiologic Integrity

27. The school nurse is caring for a child with a penetrating eye injury. Emergency treatment includes which of the following?
    a. Taping the eye shut

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b. Patching the affected eye with any reasonable item
c. Applying ice until the physician is seen
d. Irrigating the eye copiously with a sterile saline solution

ANS: B
The role of the nurse in a penetrating eye injury is to protect the eye from further injury. The injured eye should be patched with any reasonable material that serves the purpose. For instance, a Styrofoam cup can be used. The nurse would not tape the eye shut, apply ice, or irrigate the eye.

PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1364 OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

28. A nurse is providing anticipatory guidance to parents of a 2 1/2-year-old. What instruction is best to help the child's language development?
a. Have the child's hearing tested at 3 years.
b. Use clear speech and avoid baby talk.
c. Speak with different voice inflections.
d. Insist the child listen when you are talking.

ANS: B
Between the ages of 2 and 4 the parents need to speak clearly with good grammar and avoid baby talk to encourage language development. Testing the child's hearing does not promote language. Speaking with different voice inflections is appropriate for children up to 2 years of age. Insisting the child listen when you are speaking is a good technique for children aged 4 to 6.

PTS: 1 DIF: Cognitive Level: Comprehension/Understanding
REF: p. 1368 | Patient-Centered Teaching Box
OBJ: Integrated Process: Teaching-Learning
MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. Which interventions should the nurse plan when caring for a child with a visual impairment? (*Select all that apply.*)
a. Touch the child upon entering the room before speaking.
b. Keep items in the room in the same location.
c. Describe the placement of the eating utensils on the meal tray.
d. Face the child when speaking.
e. Identify noises for the child.

ANS: B, C, E
Keep all items in the room in the same location and order. Describing how many steps away something is and the placement of eating utensils on a tray are both useful tactics. Identify noises for the child because children who are visually impaired or blind often have difficulty establishing the source of a noise. Never touch the child without identifying yourself and explaining what you plan to do. Facing the child when speaking would help a child with a hearing impairment.

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PTS: 1 DIF: Cognitive Level: Application/Applying
REF: p. 1365 | Safety Alert Box OBJ: Nursing Process: Implementation
MSC: Client Needs: Physiologic Integrity

2. Which interventions should the nurse plan when caring for a child with a hearing loss? (*Select all that apply.*)
   a. Speak loudly.
   b. Speak slowly.
   c. Have the child's full attention.
   d. Use visual aids.
   e. Eliminate background noise.

   ANS: B, C, D, E
   Speak clearly and at a slightly slower speed than normal. Eliminate background noise so the child can focus on what is being said. Use visual aids to assist communication. Look directly at the child, and have the child's full attention before speaking. Do not speak loudly.

   PTS: 1 DIF: Cognitive Level: Application/Applying
   REF: p. 1367 OBJ: Nursing Process: Implementation
   MSC: Client Needs: Physiologic Integrity

COMPLETION

1. Adequate hearing depends on intact auditory structures and quality of sound. Failure to hear at 40 to 69 dB would be categorized as a _____ hearing loss.

   ANS:
   moderate

   Normal hearing ranges from −10 to +15 dB at a variety of frequencies. Hearing loss is categorized as follows:
   Moderate: failure to hear at 40 to 69 dB
   Severe: failure to hear at 70 to 89 dB
   Profound: failure to hear at more than 90 dB

   PTS: 1 DIF: Cognitive Level: Knowledge
   REF: p. 1366 | Pathophysiology Box OBJ: Nursing Process: Assessment
   MSC: Client Needs: Physiologic Integrity

TRUE/FALSE

1. The nurse is preparing new parents for discharge home with their well newborn. The nurse explains that the newborn cannot be discharged until the mandatory hearing screening is performed. Is this statement true or false?

   ANS: T
   At the recommendation of The Joint Commission on Infant Screening, most U.S. states and Canada have implemented mandatory infant hearing screening programs. As part of this program all newborns are screened before hospital discharge.

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PTS: 1 DIF: Cognitive Level: Application REF: p. 1366
OBJ: Nursing Process: Implementation
MSC: Client Needs: Safe and Effective Care Environment

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