ATI RN NURSING CARE OF CHILDREN PROCTORED EXAM

1. A nurse is caring for a child who has absence seizures. Which of the following findings should the nurse expect? (Select all that apply.) A. Loss of consciousness
B. Appearance of daydreaming
C. Dropping held objects
D. Falling to the floor
E. E. Having a piercing cry

55a

1. A. CORRECT: Loss of consciousness for 5 to 10 seconds is a manifestation of an absence seizure.
B. CORRECT: Behavior that resembles daydreaming is a manifestation of an absence seizure.
C. CORRECT: A child who is having absence seizures might drop a held object.
D. Falling to the floor is a manifestation of a tonic-clonicseizure.
E. A piercing cry is a manifestation of a tonic-clonicseizure.

55b

2. A nurse is caring for a child who just experienced a generalized seizure. Which of the following is the priority action for the nurse to take?
A. Maintain the child in a side-lying position.
B. Loosen the child's restrictive clothing.
C. Reorient the child to the environment.
D. Note the time and characteristics of the child's seizure.

56a

2. A. CORRECT: Following a seizure, children often experience vomiting. Using the airway, breathing, circulation priority-setting framework, the first action the nurse should take is to place the child in a side-lying position to maintain a patent airway and prevent aspiration of secretions. B. Loosening the child's restrictive clothing is an appropriate action. However, it is not the priority action.
C. R eorienting the child to the environment following a generalized seizure is an appropriate action. However, it is not the priority action. D. Noting the time and characteristics of the child's seizure is an appropriate action. However, it is not the priority action.

56b

3. A nurse is providing teaching to the parent of a child who is to have an electroencephalogram (EEG). Which of the following responses should the nurse include in the teaching?
A. "Decaffeinated beverages should be offered on the morning of the procedure.

" B. "Do not wash your child's hair the night before the procedure."
C. "Withhold all foods the morning of the procedure."
D. "Give your child an analgesic the night before the procedure."

3. A. CORRECT: Caffeine can alter the results of an EEG and should be avoided prior to the test.
B. The child's hair should be washed to remove oils that permit adherence of the EEG electrodes.
C. Foods are not withheld prior to an EEG.
D. Analgesics can alter the results of an EEG and should be avoided prior to the test.

A nurse is caring for a school-age child who is receiving a blood transfusion. Which of the following manifestations should alert the nurse to a possible hemolytic transfusion reaction?
a. Laryngeal edema
b. Flank pain
c. Distended neck veins
d. Muscular weakness

Answer- b. Flank pain. The nurse should recognize that flank pain is caused by the breakdown of RBCs and is an indication of a **hemolytic reaction** to the blood transfusion.
A- Laryngeal edema is an indication of an allergic reaction to the blood transfusion.
C- Distended neck veins are an indication of circulatory overload, which is a complication of a blood transfusion.
D- Muscle weakness is an indication of an electrolyte disturbance, which is a complication of a blood transfusion.

A community health nurse is assessing an 18-month-old toddler in a community day care. Which of the following findings should the nurse identify as a potential indication of physical neglect?
a. Resists having an axillary temperature taken
b. Exhibits withdrawal behaviors when her parent leaves
c. Has multiple bruises on her knees
d. Poor personal hygiene

Answer- d. Poor personal hygiene. Poor personal hygiene in a toddler is a potential indication of physical **neglect**. Because toddlers are still dependent on their parents for help with hygiene needs, poor personal hygiene indicates a lack of supervision.
A- The toddler has begun to develop a sense of body image and boundaries and can be resistant to intrusive assessments such as assessing the mouth or ears, or taking an axillary temperature. Therefore, this finding is not an indication of physical neglect.

B- Separation anxiety is an expected finding for a **toddler**. The child of this age can become fearful and exhibit regressive behaviors when left alone with strangers and separated from her parents; therefore, this finding is not an indication of physical neglect.
C- The 18-month-old toddler has accomplished the gross motor skills of standing and walking and has begun to try to run but falls easily and can have bruises on her knees. Therefore, this finding is not an indication of physical neglect.

A nurse is caring for a school-age child who is receiving chemotherapy and is severely immunocompromised. Which of the following actions should the nurse take?
a. Use surgical asepsis when providing routine care for the child.
b. Administer the measles, mumps, rubella (MMR) vaccine to the child.
c. Screen the child's visitors for indications of infection.
d. Infuse packed RBCs.

Answer- c. Screen the child's visitors for indications of infection. The child who is severely immunocompromised is unable to adequately respond to infectious organisms resulting in the potential for overwhelming infection; therefore, the nurse should screen the child's visitors for indications of infection.
A- It is not necessary for the nurse to use surgical asepsis when providing direct care. Strict hand washing and medical asepsis are recommended to prevent the spread of infection.
B- It is contraindicated for a child who is severely immunocompromised to receive the MMR vaccine because it is a live virus vaccine and the child may not be able to build adequate antibodies to prevent infection with the organism.

1. What are the main types of consequences for children that are misbehaving?

Answer

Behavior Modification

Reasoning
Scolding
Behavior modification
Consequences
Corporal or physical punishment

Q
2. A nurse is facilitating group therapy and the group is currently in the working phase of group developr
during this phase?

Answer

It is to to promote problem-solving skills in order to facilitate behavioral changes.

Q
3. A nurse is caring for a client with delirium. What is the onset and clinical manifestations of this disorde

Answer

Hypo activity syndrome
hyper active symptoms

Inability to concentrate,

Insomnia,

Loss of appetite,

Restlessness,

Confusion

Late manifestations: agitation, hallucinations, misperception

Q
4. A nurse is caring for a client with attention seeking behaviors. Describe attention-seeking behaviors
diagnosed with histrionic personality disorder.

Answer

The person tend to present provocative behavior, and influenced easily by others or circumstances

Q
5. A nurse is caring for a client with a psychotic disorder who is exhibiting alterations in speech. Define t
Flight of ideas, neologisms, echolalia, clang association, and word salad.

Answer

Flight of ideas is associative looseness sentences do not relate to each other.

Neologisms are made up words that only make sense to patients.

Echolalia is imitating words

Clang association is meaningless rhyming.

Word salad jumbling words together without meaning

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