ATI Pediatric

Proctored Exam

Version-1

1. A nurse in the emergency department is caring for a 2-year-old child who was found by his parents crying and holding a container of toilet bowl cleaner. The child's lips are edematous and inflamed, and he is drooling. Which of the following is the priority action by the nurse?

a. Remove the child's contaminated clothing.

b. Check the child's respiratory status.

c. Administer an antidote to the child.

d. Establish IV access for the child.

Rationale: The nurse should apply the ABC priority-setting framework when answering this item. This framework emphasizes the basic core of human functioning: having an open airway, being able to breathe in adequate amounts of oxygen, and circulating oxygen to the body's organs via the blood. An alteration in any of these can indicate a threat to life, and is therefore the nurse's priority concern. When applying the ABC priority setting framework, airway is always the highest priority because the airway must be clear and open for oxygen exchange to occur. Breathing is the second highest priority in the ABC priority setting framework because adequate ventilatory effort is essential in order for oxygen exchange to occur. Circulation is the third highest priority in the ABC priority setting framework because delivery of oxygen to critical organs only occurs if the heart and blood vessels are capable of efficiently carrying oxygen to them. The nurse observes that the child's lips are edematous and inflamed and that he is drooling. These findings indicate that the child might have swelling of the oral cavity and pharynx, which can result in a compromised airway.

2. A nurse is teaching a parent of a 12-month old child about development during the toddler years. Which of the following statements should the nurse include?

a. "Your child should be referring to himself using the appropriate pronoun by 18 months of age."

b. "A toddler's interest in looking at pictures occurs at 20 months of age."

c. "A toddler should have daytime control of his bowel and bladder by 24 months of age."

d. "Your child should be able to scribble spontaneously using a crayon at the age of 15 months."

Rationale: The nurse should teach the parent that at the age of 15 months, the toddler should be able to scribble spontaneously, and at the age of 18 months, the toddler should be able to make strokes imitatively.

3. A nurse is caring for a toddler and is preparing to administer 0.9% sodium chloride 100 mL IV to infuse over 4 hr. The drop factor of the manual IV tubing is 60 gtt/mL. The nurse should set the manual IV infusion to deliver how many gtt/min? (Round the answer to the nearest whole number. Use a leading zero if it applies. Do not use a trailing zero.)

25 gtt

Rationale: 100ml/4 hr x 60gtt/1mlx 1 hr/60min= 6000/240= 25 gtt

Ratio and Proportion

STEP 1: What is the unit of measurement to calculate? gtt/min

STEP 2: What is the volume needed? 100 mL

STEP 3: What is the total infusion time? 4 hr

STEP 4: Should the nurse convert the units of measurement? Yes (min does not equal hr)

1 hr/60 min = 4 hr/X min

X = 240 min

STEP 5: Set up an equation and solve for X.

Volume (mL)/Time (min) = drop factor (gtt/mL) = X

100 mL/240 min x 60 gtt/mL = X gtt/min

X = 25

STEP 6: Round if necessary.

STEP 7: Reassess to determine whether the amount to administer makes sense. If the prescription reads 100 ml of 0.9% sodium chloride IV to infuse over 4 hr, it makes sense to administer 25 gtt/min. The nurse should set the manual IV infusion to deliver0.9% sodium chloride IV at 25 gtt/min.

Dimensional Analysis

STEP 1: What is the unit of measurement to calculate? gtt/min

STEP 2: What is the volume needed? 100 mL

STEP 3: What is the total infusion time? 4 hr

STEP 4: Should the nurse convert the units of measurement? Yes (min does not equal hr)

STEP 5: Set up an equation and solve for X.

X = Quantity / 1 mL x Conversion (hr) / Conversion (min) x Volume (mL) / Time (hr)

X gtt/min = 60 gtt/1 mL x 1 hr/ 60 min x 100 mL/4 hr

X = 25

STEP 6: Round if necessary.

STEP 7: Reassess to determine whether the amount to administer makes sense. If the prescription reads 100 ml of 0.9% sodium chloride IV to infuse over 4 hr, it makes sense to administer 25 gtt/min. The nurse should set the manual IV infusion to deliver 0.9% sodium chloride IV at 25 gtt/min.

4. A nurse in a pediatric clinic is assessing a toddler at a well-child visit. Which of the following actions should the nurse take?

a. Perform the assessment in a head to toe sequence.

b. Minimize physical contact with the child initially.

c. Explain procedures using medical terminology.

d. Stop the assessment if the child becomes uncooperative.

Rationale: The nurse should initially minimize physical contact with the toddler, and then progress from the least traumatic to the most traumatic procedures.

5. A nurse is caring for an 18-year-old adolescent who is up-to-date on immunizations and is planning to attend college. The nurse should inform the client that he should receive which of the following immunizations prior to moving into a campus dormitory?

a. Pneumococcal polysaccharide

b. Meningococcal polysaccharide

c. Rotavirus

d. Herpes zoster

Rationale: The meningococcal polysaccharide immunization is used to prevent infection by certain groups of meningococcal bacteria. Meningococcal infection can cause life-threatening illnesses, such as meningococcal meningitis, which affects the brain, and meningococcemia, which affects the blood. Both of these conditions can be fatal. College freshmen, particularly those who live in dormitories, are at an increased risk for meningococcal disease relative to other

persons their age. Therefore, the Centers for Disease Control and Prevention has issued a recommendation that all incoming college students receive the meningococcal immunization.

6. A nurse is teaching the parent of an infant about food allergens. Which of the following foods should the nurse include as being the most common food allergy in children?

a. Cow's milk

b. Wheat bread

c. Corn syrup

d. Eggs

Rationale: According to evidence-based practice, the nurse should instruct the parent that cow's milk is the most common food allergy in children. Some children are sensitive to the protein, called casein, found in cow's milk. They have difficulty metabolizing the casein and are, therefore, allergic to cow's milk.

7. A nurse is teaching the parent of a toddler about home safety. Which of the following statements by the parent indicates an understanding of the teaching?

a. "I lock my medications in the medicine cabinet."

b. "I keep my child's crib mattress at the highest level."

c. "I turn pot handles to the side of my stove while cooking."

d. "I will give my child syrup of ipecac if she swallows something poisonous."

Rationale: Locking up medications and other potential poisons prevents access. Toddlers have improved gross and fine motor skills that allow for further exploration of the environment and possible access to hazardous substances.

8. A nurse is performing a physical assessment on a 6-month-old infant. Which of the following reflexes should the nurse expect to find?

a. Stepping

b. Babinski

c. Extrusion

d. Moro

Rationale: The Babinski reflex, which is elicited by stroking the bottom of the foot and causing the toes to fan and the big toe to dorsiflex, should be present until the age of 1 year. Persistence of neonatal reflexes might indicate neurological deficits.

9. A nurse is preparing to administer recommended immunizations to a 2-month-old infant. Which of the following immunizations should the nurse plan to administer?

a. Human papillomavirus (HPV) and hepatitis A

b. Measles, mumps, rubella (MMR) and tetanus, diphtheria, and acellular pertussis (TDaP)

c. Haemophilus influenzae type B (Hib) and inactivated polio virus (IPV)

d. Varicella (VAR) and live attenuated influenza vaccine (LAIV)

Rationale: The recommended immunizations for a 2-month-old infant include Hib and IPV. The Hib immunization series consists of 3 to 4 doses, depending on the immunization used, and at a minimum is administered at the ages of 2 months, 4 months, and 12 to 15 months. The IPV immunization series consists of 4 doses and is administered at the ages of 2 months, 4 months, 6 to 18 months, and 4 to 6 years.

10. A nurse is developing a plan of care for a school-age child who underwent a surgical procedure that resulted in temporary loss of vision. Which of the following interventions should the nurse include in the plan of care?

a. Assign an assistive personnel to feed the child.

b. Explain sounds the child is hearing.

c. Have the child use a cane when ambulating.

d. Rotate nurses caring for the child.

Rationale: The noises in a facility can be frightening to a child who is experiencing a sensory loss. It is important to explain these noises to allay the child's fears.

11. A nurse is assessing a 3-year-old child who is 1 day postoperative following a tonsillectomy. Which of the following methods should the nurse use to determine if the child is experiencing pain?

a. Ask the parents.

b. Use the FACES scale.

c. Use the numeric rating scale.

d. Check the child's temperature.

Rationale: Pain is a subjective experience even for a 3-year-old child. The FACES scale can be used to accurately determine the presence of pain in children as young as 3 years of age.

12. A nurse is assessing a 6-month-old infant at a well-child visit. Which of the following findings indicates the need for further assessment?

a. Grabs feet and pulls them to her mouth

b. Posterior fontanel is closed

c. Legs remain crossed and extended when supine

d. Birth weight has doubled

Rationale: Legs crossed and extended when supine is an unexpected finding and requires further assessment. At 6 months of age, the legs flex at the knees when the infant is supine. Crossed and extended legs when supine is a finding associated with cerebral palsy.

13. A nurse is observing a mother who is playing peek-a-boo with her 8-month-old child. The mother asks if this game has any developmental significance. The nurse should inform the mother that peek-a-boo helps develop which of the following concepts in the child?

a. Hand-eye coordination

b. Sense of trust

c. Object permanence

d. Egocentrism

Rationale: Object permanence refers to the cognitive skill of knowing an object still exists even when it is out of sight. In discovering a hidden object while playing peek-a-boo, the infant experiences validation of this concept.

14. A nurse is caring for a 15-month-old toddler who requires droplet precautions. Which of the following actions should the nurse take?

a. Have the toddler wear a disposable gown when in the unit's playroom.

b. Wear sterile gloves when changing the toddler's diapers.

c. Wear a mask when assisting the toddler with meals.

d. Ask visitors to wear an N-95 mask when entering the room.

Rationale: The nurse should wear a mask when within 3 to 6 feet of the toddler to prevent the transmission of infections that are spread via large droplet particles expelled in the air.

15. A nurse at a pediatric clinic is assessing a 5-month-old infant during a well-child visit. Which of the following findings should the nurse report to the provider?

a. Head lags when pulled from a lying to a sitting position

b. Absence of startle and crawl reflexes

c. Inability to pick up a rattle after dropping it

d. Rolls from back to side

Rationale: At the age of 5 months, the infant should have no head lag when pulled to a sitting position; therefore, the nurse should report this finding to the provider.

16. A nurse is planning to collect a specimen from a male infant using a urine collection bag. Which of the following actions should the nurse take?

a. Wash and dry the infant's genitalia and perineum thoroughly.

b. Apply a small coating of water-soluble lubricant to the skin of the infant's perineal area.

c. Avoid placing the scrotum inside the collection bag.

d. Wait several hours after positioning the device before checking it.

Rationale: This is the method used to obtain a routine urine specimen of any sort in a child who is not toilet trained. The skin should be washed and dried to promote application of the adhesive of the collection device.

17. A nurse in a pediatric clinic is caring for a 3-year-old child who has a blood lead level of 3 mcg/dL. When teaching the toddler's parents about the correlation of nutrition with lead poisoning, which of the following information is appropriate for the nurse to include in the teaching?

a. Decrease the child's vitamin C intake until the blood lead level decreases to zero.

b. Administer a folic acid supplement to the child each day.

c. Give pancreatic enzymes to the child with meals and snacks.

d. Ensure the child's dietary intake of calcium and iron is adequate.

Rationale: A child who has an elevated blood lead level should have an adequate intake of calcium and iron to reduce the absorption and effects of the lead. Dietary recommendations should include milk as a good source of calcium.

18. A nurse is planning care for a 10-month-old infant who has suspected failure to thrive (FTT). Which of the following interventions should the nurse include in the plan of care? (Select all that apply.)

a. Observe the parents' actions when feeding the child.

b. Maintain a detailed record of food and fluid intake.

c. Follow the child's cues as to when food and fluids are provided.

d. Sit beside the child's high chair when feeding the child.

e. Play music videos during scheduled meal times.

Rationale: Observing the parents' actions when feeding the child is correct. Inappropriate feeding techniques and meal patterns provided by parents can contribute to a child's growth failure. Maintaining a detailed record of food and fluid intake is correct. A nutritional goal for

the child who has suspected FTT is to correct nutritional deficiencies, which can be identified by recording all food and fluid intake. Following the child's cues as to when food and fluids are provided is not correct. A consistent structured routine of feeding the child at the same time and place is used to promote weight gain. A child who has failure to thrive might not offer feeding cues. Sitting beside the child's high chair when feeding the child is not correct. Caregivers should sit directly in front of the child to maintain a face-to-face position during feeding and promote eye contact. The emphasis is on encouraging feeding. Playing music videos during scheduled meal times is not correct. A quiet, stimulation-free environment should be provided at meal times to avoid distractions and focus attention on food intake.

19. A nurse is assessing a 7-year-old child's psychosocial development. Which of the following findings should the nurse recognize as requiring further evaluation?

a. The child prefers playmates of the same sex.

b. The child is competitive when playing board games.

c. The child complains daily about going to school.

d. The child enjoys spending time alone.

Rationale: Complaining every day about going to school is an unexpected finding for a 7-year-old child. The child is in Erikson's psychosocial development stage of industry vs. inferiority. Children in this stage want to learn and master new concepts. If the child complains daily about going to school, it warrants further evaluation.

20. A nurse is providing education to the parent of a toddler who is about to receive her first dose of the MMR (measles, mumps and rubella) immunization. Which of the following statements by the parent indicates an understanding of the teaching?

a. "I am not going to let my child play with other children for 2 days."

b. "I will need to return in 2 weeks for my child to receive the varicella immunization."

c. "I can give my child acetaminophen for discomfort associated with the immunization."

d. "My child might have some discharge from the injection site."