2020 HESI RN PEDIATRICS EXAM 55 ANSWERS

1. The nurse is caring for a 3-year old child who is 2 hours postop from a cardiac catheterization via the right femoral artery. Which assessment finding is an indication of arterial obstruction?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Measure the infant's head-to-toe length.
B. **Palpate the anterior fontanel for tension and bulging.**
C. Observe the infant for sunken eyes.
D. Plot the measurement on the infant's growth chart.

9. The nurse is preparing a 10-year-old with a lacerated forehead for suturing. Both parents and 12-year-old sibling are at the child's bedside. Which instruction best supports family?

A. While waiting for the healthcare provider, only one visitor may stay with the child.
B. All of you should leave while the healthcare provider sutures the child's forehead.
C. It is best if the sibling goes to the waiting room until the suturing is completed.
D. **Please decide who will stay when the healthcare provider begins suturing.**

10. The nurse is planning for a 5-month old with gastroesophageal reflux disease whose weight has decreased by 3 ounces since the last clinic visit one month ago. To increase caloric intake and decrease vomiting, what instructions should the nurse provide this mother?

A. Give small amounts of baby food with each feeding.
B. **Thicken formula with cereal for each feeding.**
C. Dilute the child's formula with equal parts of water.
D. Offer 10 % dextrose in water between most feedings.

11. While teaching a parenting class to new parents the nurse describes the needs of infants and toddlers regarding discipline and limit setting. What is the most important reason for implementing such parenting behaviors?

A. Children need help in developing social skills.This age child fears loss of self-control.
B. **They provide the child with a sense of security.**
C. Children must to learn to deal with authority.

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

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

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

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

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

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

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

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

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

A. **Obtain specimen for blood cultures.**
B. Assess the CBC.

C. Monitor the oral temperature every hour.
D. Administer acetaminophen as prescribed.

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

1875mg

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

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

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

A. At diaper change generously powder the baby's diaper area with talcum powder to promote dryness.
B. Wash the diaper area every 2 hours with soap and water to help prevent skin breakdown.
C. **Use a barrier cream, such as zinc oxide, which does not have to be completely removed with each diaper change.**
D. Place a cloth diaper inside the disposable diaper for overnight periods when increased wearing time is likely.

20. Which statement by a school aged client going to summer camp indicates the best understanding of the mode of transmission of Lyme disease?

A. I'll cover my mouth with a wet cloth if there's too much dust blowing.
B. Cuts and scrapes need to be washed out and covered right away.
C. I'm not going to swim where the water is standing still or feels too hot.
D. **I have to wear long sleeves and pants when we're hiking around the pond.**

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

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

22. The HR for a 3-year-old with a congenital heart defect has steadily decreased over the last few hours, now it's 76 bpm, the previous reading 4 hours ago was 110 bpm. Which additional finding should be reported immediately to a healthcare provider?

A. Oxygen saturation 94%.
B. RR of 25 breaths/minute.
C. Urine output 20 mL/hr.
D. **BP 70/40.**

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

A. **Describe the side-lying, knees to chest position that must be assumed during the procedure.**

B. Tell the child to expect loud clicking noises during the procedure that may be slightly annoying.
C. Reassure the child that there will be no restrictions on activity after the procedure is completed.
D. Explain that fluids cannot be taken for 8 hours before the procedure and for 4 hours after the procedure.

24. the parents of a 3 y/o boy who has Duchenne muscular dystrophy (DMD) ask "how can our son have this disease? We are wondering if we should have any more children" What information should the nurse provide these parents?
A. **This is an inherited X-linked recessive disorder, which primarily affects male children in the family**
B. The male infant had a viral infection that went unnoticed and untreated, so muscle damage was incurred
C. The XXXX muscle groups of males can be impacted by a lack of the protein dystrophin in the mother
D. Birth trauma with a breech vaginal birth causes damage to the spinal cord, thus weakening the muscles

25. The nurse finds a 6-month-old infant unresponsive and calls for help. After opening the airway and finding the XXXX the infant is still no breathing. Which action should the nurse take?
A. Palpate femoral pulse and check for regularity
B. Deliver cycles of 30 chest compressions and 2 breaths
C. **Give two breath that makes the chest rise**
D. Feel the carotid pulse and check for adequate breathing

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

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

27.. A 16 y/o female student with a history of asthma controlled with both an oral antihistamine and an albuterol (Provenfil) metered-dose inhaler (MDI) comes to the school nurse. The student complains that she cannot sleep at night, feels shaky and her heart feels like it is "beating a mile per minute" Which information is most important for the nurse to obtain?
a. When she last took the antihistamine
b. When her last Asthma attack occurred
c. Duration of most asthmas' attacks
d. **How often the MDI is used daily**

28. The nurse is assessing a child for neurological soft signs, which finding is most likely demonstrated in the child's behavior?
a. Inability to move tongue in a direction
b. Presence of vertigo
c. **Poor coordination and sense of position**
d. Loss of visual acuity

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

a. **Metabolic alkalosis**
b. Respiratory acidosis
c. Metabolic acidosis
d. Respiratory Alkalosis

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

a. Bilateral bronchial breath sounds
b. Diaphragmatic respiration
c. A resting respiratory rate of 35 breathe per minute
d. **flaring of the nares**

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

a. **Let me read this book to you**
b. Two years old usually stop crying the minute the parent leaves
c. Now be a big boy. Mommy will be back soon
d. Let's wave bye-bye to mommy

32. A two-year-old child with a heart failure (HF) is admitted for replacement of a graft for coarctation of the aorta. Prior to administering the next dose of digoxin (Lanoxin) the nurse obtains an apical heart rate of 128 bpm. What action should the nurse implement?

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

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

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

34. a 6-year-old who has asthma is demonstrating a prolonged expiratory phase and wheezing and has a35% of personal best peak expiratory flow rate (PEFR) based on these finding, actions should the nurse take first?

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

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

5 ml

36. the nurse observes a mother giving her 11-month-old ferrous sulfate, followed by two ounces of orange juice. What should the nurse do next?
a. suggest placing the iron drops in the orange juice and feed the infant
b. Tell the mother to follow the iron drops with formula instead of orange juice
c. instruct the mother to feed the infant nothing in the next 30 minutes after the iron
d. **Give positive feedback about the way she administered the sulfate**

37. Which nursing intervention is most important to include in the plan of care for a child with acute glomerulonephritis
A. encourage fluid intake
b. promote complete bed rest
c. **weight the child daily**
d. administer vitamin supplements

38. During a well-baby visit the parents explain that a soft bulge appears in the groin of their 4-month-old son when he cries or strain stooling. The infant is schedule for surgical repair of the inguinal; hernia in two weeks. The parent should be instructed to take which measure if the hernia becomes incarcerated prior to the surgery?
a. Use rectal thermometer for straining on stool
b. **Gently manipulate the hernia for reduction**
c. Offer oral electrolyte fluids for comfort
d. Give acetaminophen or aspirin for crying

39. A 16-year-old male client who has been treated in the past for a seizure disorder is admitted to the hospital. Immediately after admission he begins to have a grand mal seizure. Which action should the nurse take?
a. Obtain assistance in holding him to prevent injury
b. **Observe him carefully**
c. Call a CODE
d. Place a padded tongue blade between the teeth

40. The mother of a 9-month-old who was diagnosed with respiratory syncytial virus yesterday calls the clinic to inquire if it will be all right to take her infant to the first b-day party of a friend's child the following day. What response should the nurse provide this mother?
a. The child will no longer be contagious, no need to take any further precaution
b. Make sure there are not children under the age of 6 months around the infected child
c. The child can be around other children but should wear mask at all times
d. **Do not expose other children to RSV. It is very contagious even without direct contact**

41. When screening a 5-year-old for strabism, what action should the nurse take
A. Have the child identify colored patterns on polychromatic cards
B. **Direct the child through the six cardinal position of glaze**
C. Inspect the child for the setting sun sign
D. Observe the child for blank, sunken eyes

42. The nurse is assessing a 6-month-old infant. Which response requires further evaluation by the nurse?
A. Has doubled birth weight
B. Turn head to locate sound
C. Plays pick a boo
D. **Demonstrate startle reflex**

43. A child is brought to the clinic complaining of fever and joins pain, and is DX with rheumatic fever. When planning care for this child what is the goal of nursing care?
A. Reduce fever
B. Maintain fluid and electrolytes
C. **Prevent cardiac damage**
D. Maintain join mobility and function

44. The nurse working on the pediatric unit takes two 8-year old girls to the playroom. Which activity is best for the nurse to plan for these girls?
A. **Selecting a board game**

B. Playing Doctor and nurse
C. Watching cartoon on TV
D. Coloring, cutting and pasting

45. The nurse is developing the plan of care for a hospitalized child with von Willebrand disease. What priority nursing intervention should be included in this child plan of care
A. Reduce exposure to infection
B. Eliminate contact with cold grafts *(crafts? Is not legible)*
C. **Guard against bleeding injuries**
D. Reduce contact with other children

46. How should the nurse instruct the parents of a 4-month-old with seborrheic dermatitis (cradle cap) to shampoo the child's hair?
A. **Use a soft brush and gently scrub the area**
B. B. Avoid scrubbing the scalp until the scales disappear
C. Avoid washing the child's hair more than once a week
D. Use soap and water and avoid shampoos

47. Prior to discharge, the parents of a child with cystic fibrosis are demonstrating chest physiotherapy (CPT) that they will perform for their child at home. Which action requires intervention by the nurse?
A. Plan to perform CPT when the child awakens in the morning
B. A Copped hand is used when percussing the lung field
C. A bronchodilator is administered before starting CPT
D. **The child is placed in a supine position to begin percussion**

48. When assessing the breath sounds of an 18-month-old child who is crying, what action should the nurse take?
A. Document that the assessment is not available because the child is crying
B. Ask the parents to quiet the child so breath sounds can be auscultated
C. **Allow the child to initially play with stethoscope, and distract during auscultation**
D. Auscultate and document breath sounds, noting that the child was crying at the time

49. The mother of a one month old calls the clinic to report that the back of her infant is flat. How should the nurse respond?
A. Turn the infant on the left side braced against the crib when sleeping
B. Prop the infant in a sitting position with a cushion when no sleeping
C. Place a small pillow under the infant's head while lying on the back
D. **Position the infant on the stomach occasionally when awake and active**

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

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

51. A 7-year-old child is admitted to the hospital with acute glomerulonephritis (AGN). When obtaining the nursing history which finding should the nurse expect to obtain?
A. High blood cholesterol level on routine screening

B. Increased thirst and urination
C. **A recent strep throat infection**
D. A recent DPT immunization

52. The nurse plans to screen only the highest risk children for scoliosis. Which group of children should the nurse screen first?
A. **Girls between ages 10 and 14**
B. Boys between ages 10 and 14
C. Boys and girls between 12 and 14
D. Boys and girls between 8 and 12

53. In assessing a 10-year-old newly diagnosed with osteomyelitis, which information is most for the nurse to obtain
A. **Recent recurrence of infections**
B. Cultural heritage and belief
C. Family history of bone disorder
D. Occurrence of increased fluid intake

54. A 3-year-old boy in a daycare facility scratches his head frequently and the nurse confirms the presence if head lice. The nurse washes the child's hair with permethrin (Nix) shampoo and call his parents. What instructions should the nurse provide to the parents about treatment of head lice?
A. **Wash the child's bed linens and clothing In hot soapy water**
B. Dispose of the child's brushes, comb's and other hair accessories
C. Rewash the child's hair following a 24-hour isolation period
D. Take the child to a hair salon for a shampoo and shorter haircut

55. The nurse on a pediatric unit observes a distraught mother in the hallway scolding her 3-year-old son for wetting his pants. What initial action should the nurse take?
A. Suggest that the mother consult a pediatric nephrologist
B. Provide disposable training pants while calming the mother
C. Refer the mother to a community parent education program
D. **Inform the mother that toilet training is slower for boys**