Pediatric Primary Care 4th Edition Richardson Testbank/StudyGuide

Chapter 1 Obtaining an Initial History

MULTIPLE CHOICE
1. The nurse is seeing an adolescent and the parents in the clinic for the first time. Which should the nurse do first?

a. Introduce him- or herself.
b. Make the family comfortable.
c. Give assurance of privacy.
d. Explain the purpose of the interview.

ANS: A
The first thing that nurses must do is to introduce themselves to the patient and family. Parents and other adults should be addressed with appropriate titles unless they specify a preferred name. Clarification of the purpose of the interview and the nurses role is the second thing that should be done. During the initial part of the interview, the nurse should include general conversation to help make the family feel at ease. The interview also should take place in an environment as free of distraction as possible. In addition, the nurse should clarify which information will be shared with other members of the health care team and any limits to the confidentiality.
2. Which is considered a block to effective communication?

a. Using silence
b. Using clichs
c. Directing the focus
d. Defining the problem

ANS: B
Using stereotyped comments or clichs can block effective communication. After the nurse uses such trite phrases, parents often do not respond. Silence can be an effective interviewing tool. Silence permits the interviewee to sort out thoughts and feelings and search for responses to questions. To be effective, the nurse must be able to direct the focus of the interview while allowing maximum freedom of expression. By using open-ended questions and guiding questions, the nurse can obtain the necessary information and maintain a relationship with the family. The nurse and parent must collaborate and define the problem that will be the focus of the nursing intervention.
3. Which is the single most important factor to consider when communicating with children?

a. Presence of the childs parent
b. Childs physical condition
c. Childs developmental level

d. Childs nonverbal behaviors

ANS: C

The nurse must be aware of the childs developmental stage to engage in effective communication. The use of both verbal and nonverbal communication should be appropriate to the developmental level. Nonverbal behaviors vary in importance based on the childs developmental level and physical condition. Although the childs physical condition is a consideration, developmental level is much more important. The presence of parents is important when communicating with young children but may be detrimental when speaking with adolescents.

4. Because children younger than 5 years are egocentric, the nurse should do which when communicating with them?

a. Focus communication on the child.

b. Use easy analogies when possible.

c. Explain experiences of others to the child.

d. Assure the child that communication is private.

ANS: A

Because children of this age are able to see things only in terms of themselves, the best approach is to focus communication directly on them. Children should be provided with information about what they can do and how they will feel. With children who are egocentric, analogies, experiences, and assurances that communication is private will not be effective because the child is not capable of understanding.

5. The nurses approach when introducing hospital equipment to a preschooler who seems afraid should be based on which principle?

a. The child may think the equipment is alive.

b. Explaining the equipment will only increase the childs fear.

c. One brief explanation will be enough to reduce the childs fear.

d. The child is too young to understand what the equipment does.

ANS: A

Young children attribute human characteristics to inanimate objects. They often fear that the objects may jump, bite, cut, or pinch all by themselves without human direction. Equipment should be kept out of sight until needed. Simple, concrete explanations about what the equipment does and how it will feel will help alleviate the childs fear. Preschoolers need repeated explanations as reassurance.

6. When the nurse interviews an adolescent, which is especially important?

a. Focus the discussion on the peer group.

b. Allow an opportunity to express feelings.

c. Use the same type of language as the adolescent.

d. Emphasize that confidentiality will always be maintained.

ANS: B

Adolescents, like all children, need opportunities to express their feelings. Often they interject feelings into their words. The nurse must be alert to the words and feelings expressed. The nurse

should maintain a professional relationship with adolescents. To avoid misunderstanding or misinterpretation of words and phrases used, the nurse should clarify the terms used, what information will be shared with other members of the health care team, and any limits to confidentiality. Although the peer group is important to this age group, the interview should focus on the adolescent.

7. The nurse is preparing to assess a 10-month-old infant. He is sitting on his fathers lap and appears to be afraid of the nurse and of what might happen next. Which initial actions by the nurse should be most appropriate?

a. Initiate a game of peek-a-boo.

b. Ask the infants father to place the infant on the examination table.

c. Talk softly to the infant while taking him from his father.

d. Undress the infant while he is still sitting on his fathers lap.

ANS: A

Peek-a-boo is an excellent means of initiating communication with infants while maintaining a safe, nonthreatening distance. The child will most likely become upset if separated from his father. As much of the assessment as possible should be done with the child on the fathers lap. The nurse should have the father undress the child as needed during the examination.

8. An 8-year-old girl asks the nurse how the blood pressure apparatus works. The most appropriate nursing action is which?

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 so that the child can then observe during the procedure. 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 in asking how the blood pressure apparatus works, just requesting clarification of what will occur.

9. The nurse is having difficulty communicating with a hospitalized 6-year-old child. Which technique should be most helpful?

a. Recommend that the child keep a diary.

b. Provide supplies for the child to draw a picture.

c. Suggest that the parent read fairy tales to the child.

d. Ask the parent if the child is always uncommunicative.

ANS: B

Drawing is one of the most valuable forms of communication. Childrens drawings tell a great deal about them because they are projections of the childrens inner self. A diary should be difficult for a 6-year-old child, who is most likely learning to read. The parent reading fairy tales to the child is a passive activity involving the parent and child; it should not facilitate

communication with the nurse. The child is in a stressful situation and is probably uncomfortable with strangers, not always uncommunicative.

10. Which data should be included in a health history?

a. Review of systems

b. Physical assessment

c. Growth measurements

d. Record of vital signs

ANS: A

A review of systems is done to elicit information concerning any potential health problems. This further guides the interview process. Physical assessment, growth measurements, and a record of vital signs are components of the physical examination.

11. The nurse is taking a health history of an adolescent. Which best describes how the chief complaint should be determined?

a. Request a detailed listing of symptoms.

b. Ask the adolescent, Why did you come here today?

c. Interview the parent away from the adolescent to determine the chief complaint.

d. Use what the adolescent says to determine, in correct medical terminology, what the problem is.

ANS: B

The chief complaint is the specific reason for the childs visit to the clinic, office, or hospital. Because the adolescent is the focus of the history, this is an appropriate way to determine the chief complaint. Requesting a detailed list of symptoms makes it difficult to determine the chief complaint. The parent and adolescent may be interviewed separately, but the nurse should determine the reason the adolescent is seeking attention at this time. The chief complaint is usually written in the words that the parent or adolescent uses to describe the reason for seeking help.

12. The nurse is interviewing the mother of an infant. The mother reports, I had a difficult delivery, and my baby was born prematurely. This information should be recorded under which heading?

a. History

b. Present illness

c. Chief complaint

d. Review of systems

ANS: A

The history refers to information that relates to previous aspects of the childs health, not to the current problem. The difficult delivery and prematurity are important parts of the infants history. The history of the present illness is a narrative of the chief complaint from its earliest onset through its progression to the present. Unless the chief complaint is directly related to the prematurity, this information is not included in the history of the present illness. The chief complaint is the specific reason for the childs visit to the clinic, office, or hospital. It should not include the birth information. The review of systems is a specific review of each body system. It does not include the premature birth but might include sequelae such as pulmonary dysfunction.

13. Where in the health history does a record of immunizations belong?

a. History

b. Present illness

c. Review of systems

d. Physical assessment

ANS: A

The history contains information relating to all previous aspects of the childs health status. The immunizations are appropriately included in the history. The present illness, review of systems, and physical assessment are not appropriate places to record the immunization status.

14. The nurse is taking a sexual history on an adolescent girl. Which is the best way to determine whether she is sexually active?

a. Ask her, Are you sexually active?

b. Ask her, Are you having sex with anyone?

c. Ask her, Are you having sex with a boyfriend?

d. Ask both the girl and her parent if she is sexually active.

ANS: B

Asking the adolescent girl if she is having sex with anyone is a direct question that is well understood. The phrase sexually active is broadly defined and may not provide specific information for the nurse to provide necessary care. The word anyone is preferred to using gender-specific terms such as boyfriend or girlfriend. Using gender-neutral terms is inclusive and conveys acceptance to the adolescent. Questioning about sexual activity should occur when the adolescent is alone.

15. When doing a nutritional assessment on a Hispanic family, the nurse learns that their diet consists mainly of vegetables, legumes, and starches. The nurse should recognize that this diet is which?

a. Lacking in protein

b. Indicating they live in poverty

c. Providing sufficient amino acids

d. Needing enrichment with meat and milk

ANS: C

A diet that contains vegetables, legumes, and starches may provide sufficient essential amino acids even though the actual amount of meat or dairy protein is low. Combinations of foods contain the essential amino acids necessary for growth. Many cultures use diets that contain this combination of foods. It is not indicative of poverty. A dietary assessment should be done, but many vegetarian diets are sufficient for growth.

16. Which parameter correlates best with measurements of total muscle mass?

a. Height

b. Weight

c. Skinfold thickness

d. Upper arm circumference

ANS: D

Upper arm circumference is correlated with measurements of total muscle mass. Muscle serves as the bodys major protein reserve and is considered an index of the bodys protein stores. Height is reflective of past nutritional status. Weight is indicative of current nutritional status. Skinfold thickness is a measurement of the bodys fat content.

17. The nurse is preparing to perform a physical assessment on a 10-year-old girl. The nurse gives her the option of her mother staying in the room or leaving. This action should be considered which?

a. Appropriate because of childs age

b. Appropriate, but the mother may be uncomfortable

c. Inappropriate because of childs age

d. Inappropriate because child is same sex as mother

ANS: A

It is appropriate to give older school-age children the option of having the parent present or not. During the examination, the nurse should respect the childs need for privacy. Children who are 10 years old are minors, and parents are responsible for health care decisions. The mother of a 10-year-old child would not be uncomfortable. The child should help determine who is present during the examination.

18. With the National Center for Health Statistics criteria, which body mass index (BMI)for-age percentiles should indicate the patient is at risk for being overweight?

a. 10th percentile

b. 75th percentile

c. 85th percentile

d. 95th percentile

ANS: C

Children who have BMI-for-age greater than or equal to the 85th percentile and less than the 95th percentile are at risk for being overweight. Children who are greater than or equal to the 95th percentile are considered overweight. Children whose BMI is between the 10th and 75th percentiles are within normal limits.

19. Rectal temperatures are indicated in which situation?

a. In the newborn period

b. Whenever accuracy is essential

c. Rectal temperatures are never indicated

d. When rapid temperature changes are occurring

ANS: B

Rectal temperatures are recommended when definitive measurements are necessary in infants older than age 1 month. Rectal temperatures are not done in the newborn period to avoid trauma to the rectal mucosa. Rectal temperature is an intrusive procedure that should be avoided whenever possible.

20. What is the earliest age at which a satisfactory radial pulse can be taken in children?

a. 1 year

b. 2 years

c. 3 years

d. 6 years

ANS: B

Satisfactory radial pulses can be taken in children older than 2 years. In infants and young children, the apical pulse is more reliable.

21. The nurse needs to take the blood pressure of a small child. Of the cuffs available, one is too large and one is too small. The best nursing action is which?

a. Use the small cuff.

b. Use the large cuff.

c. Use either cuff using the palpation method.

d. Wait to take the blood pressure until a proper cuff can be located.

ANS: B

If blood pressure measurement is indicated and the appropriate size cuff is not available, the next larger size is used. The nurse recognizes that this may be a falsely low blood pressure. Using the small cuff will give an incorrectly high reading. The palpation method will not improve the inaccuracy inherent in the cuff.

22. Where is the best place to observe for the presence of petechiae in dark-skinned individuals?

a. Face

b. Buttocks

c. Oral mucosa

d. Palms and soles

ANS: C

Petechiae, small distinct pinpoint hemorrhages, are difficult to see in dark-skinned individuals unless they are in the mouth or conjunctiva.

23. During a routine health assessment, the nurse notes that an 8-month-old infant has a significant head lag. Which is the most appropriate action?

a. Recheck head control at next visit.

b. Teach the parents appropriate exercises.

c. Schedule the child for further evaluation.

d. Refer the child for further evaluation if the anterior fontanel is still open.

ANS: C

Significant head lag after age 6 months strongly indicates cerebral injury and is referred for further evaluation. Head control is part of normal development. Exercises will not be effective. The lack of achievement of this developmental milestone must be evaluated.

24. The nurse has just started assessing a young child who is febrile and appears ill. There is hyperextension of the childs head (opisthotonos) with pain on flexion. Which is the most appropriate action?

a. Ask the parent when the neck was injured.

b. Refer for immediate medical evaluation.

c. Continue assessment to determine the cause of the neck pain.

d. Record head lag on the assessment record and continue the assessment of the child.

ANS: B

Hyperextension of the childs head with pain on flexion is indicative of meningeal irritation and needs immediate evaluation. No indication of injury is present. This situation is not descriptive of head lag.

25. During a funduscopic examination of a school-age child, the nurse notes a brilliant, uniform red reflex in both eyes. The nurse should recognize that this is which?

a. A normal finding

b. A sign of a possible visual defect and a need for vision screening

c. An abnormal finding requiring referral to an ophthalmologist

d. A sign of small hemorrhages, which usually resolve spontaneously

ANS: A

A brilliant, uniform red reflex is an important normal finding. It rules out many serious defects of the cornea, aqueous chamber, lens, and vitreous chamber.

26. Which explains the importance of detecting strabismus in young children?

a. Color vision deficit may result.

b. Amblyopia, a type of blindness, may result.

c. Epicanthal folds may develop in the affected eye.

d. Corneal light reflexes may fall symmetrically within each pupil.

ANS: B

By the age of 3 to 4 months, infants are able to fixate on one visual field with both eyes simultaneously. In strabismus, or cross-eye, one eye deviates from the point of fixation. If misalignment is constant, the weak eye becomes lazy, and the brain eventually suppresses the image produced from that eye. If strabismus is not detected and corrected by age 4 to 6 years, blindness from disuse, known as amblyopia, may occur. Color vision is not the only concern. Epicanthal folds are not related to amblyopia. In children with strabismus, the corneal light reflex will not be symmetric for each eye.

27. Which is the most frequently used test for measuring visual acuity?

a. Snellen letter chart

b. Ishihara vision test

c. Allen picture card test

d. Denver eye screening test

ANS: A

The Snellen letter chart, which consists of lines of letters of decreasing size, is the most frequently used test for visual acuity. The Ishihara Vision Test is used for color vision. The Allen picture card test and Denver eye screening test involve single cards for children ages 2 years and older who are unable to use the Snellen letter chart.

28. The nurse is testing an infants visual acuity. By which age should the infant be able to fix on and follow a target?

a. 1 month

b. 1 to 2 months

c. 3 to 4 months

d. 6 months

ANS: C

Visual fixation and ability to follow a target should be present by ages 3 to 4 months. One to 2 months is too young for this developmental milestone. If an infant is not able to fix and follow by 6 months, further ophthalmologic evaluation is needed.

29. During an otoscopic examination on an infant, in which direction is the pinna pulled?

a. Up and back

b. Up and forward

c. Down and back

d. Down and forward

ANS: C

In infants and toddlers, the ear canal is curved upward. To visualize the ear canal, it is necessary to pull the pinna down and back to the 6 to 9 oclock range to straighten the canal. In children older than age 3 years and adults, the canal curves downward and forward. The pinna is pulled up and back to the 10 oclock position. Up and forward and down and forward are positions that do not facilitate visualization of the ear canal.

Chapter 2 Obtaining an Interval History

1. What is an appropriate screening test for hearing that the nurse can administer to a 5-year-old child?

a. Rinne test

b. Weber test

c. Pure tone audiometry

d. Eliciting the startle reflex

ANS: C

Pure tone audiometry uses an audiometer that produces sounds at different volumes and pitches in the childs ears. The child is asked to respond in some way when the tone is heard in the earphone. The Rinne and Weber tests measure bone conduction of sound. Eliciting the startle reflex may be useful in infants.

2. What is the appropriate placement of a tongue blade for assessment of the mouth and throat?

a. On the lower jaw

b. Side of the tongue

c. Against the soft palate

d. Center back area of the tongue

ANS: B

The side of the tongue is the correct position. It avoids the gag reflex yet allows visualization. On the lower jaw and against the soft palate are not appropriate places for the tongue blade. Placement in the center back area of the tongue elicits the gag reflex.

3. When assessing a preschoolers chest, what should the nurse expect?

a. Respiratory movements to be chiefly thoracic

b. Anteroposterior diameter to be equal to the transverse diameter

c. Retraction of the muscles between the ribs on respiratory movement

d. Movement of the chest wall to be symmetric bilaterally and coordinated with breathing

ANS: D

Movement of the chest wall should be symmetric bilaterally and coordinated with breathing. In children younger than 6 or 7 years, respiratory movement is principally abdominal or diaphragmatic. The anteroposterior diameter is equal to the transverse diameter during infancy. As the child grows, the chest increases in the transverse direction, so that the anteroposterior diameter is less than the lateral diameter. Retractions of the muscles between the ribs on respiratory movement are indicative of respiratory distress.

4. When auscultating an infants lungs, the nurse detects diminished breath sounds. What should the nurse interpret this as?

a. Suggestive of chronic pulmonary disease

b. Suggestive of impending respiratory failure

c. An abnormal finding warranting investigation

d. A normal finding in infants younger than 1 year of age

ANS: C

Absent or diminished breath sounds are always an abnormal finding. Fluid, air, or solid masses in the pleural space all interfere with the conduction of breath sounds. Further data are necessary for diagnosis of chronic pulmonary disease or impending respiratory failure. Diminished breath

sounds in certain segments of the lungs can alert the nurse to pulmonary areas that may benefit from chest physiotherapy. Further evaluation is needed in all age groups.

5. Which type of breath sound is normally heard over the entire surface of the lungs except for the upper intrascapular area and the area beneath the manubrium?

a. Vesicular

b. Bronchial

c. Adventitious

d. Bronchovesicular

ANS: A

This is the definition of vesicular breath sounds. They are heard over the entire surface of the lungs, with the exception of the upper intrascapular area and the area beneath the manubrium. Bronchial breath sounds are heard only over the trachea near the suprasternal notch. Adventitious breath sounds are not usually heard over the chest. These sounds occur in addition to normal or abnormal breath sounds. Bronchovesicular breath sounds are heard over the manubrium and in the upper intrascapular regions, where the trachea and bronchi bifurcate.

6. The nurse is assessing a childs capillary refill time. This can be accomplished by doing what?

a. Inspect the chest.

b. Auscultate the heart.

c. Palpate the apical pulse.

d. Palpate the nail bed with pressure to produce a slight blanching.

ANS: D

Capillary refill time is assessed by pressing lightly on the skin to produce blanching and then noting the amount of time it takes for the blanched area to refill. Inspecting the chest, auscultating the heart, and palpating the apical pulse will not provide an assessment of capillary refill time.

7. Which heart sound is produced by vibrations within the heart chambers or in the major arteries from the back-and-forth flow of blood?

a. S1 and S2

b. S3 and S4

c. Murmur

d. Physiologic splitting

ANS: C

Murmurs are the sounds that are produced in the heart chambers or major arteries from the back-and-forth flow of blood. S1 and S2 are normal heart sounds. S1 is the closure of the tricuspid and mitral valves, and S2 is the closure of the pulmonic and aortic valves. S3 is a normal heart sound sometimes heard in children. S4 is rarely heard as a normal heart sound. If it is heard, medical evaluation is required. Physiologic splitting is the distinction of the two sounds in S2, which widens on inspiration. It is a significant normal finding.

8. Examination of the abdomen is performed correctly by the nurse in which order?

a. Inspection, palpation, percussion, and auscultation

b. Inspection, percussion, auscultation, and palpation

c. Palpation, percussion, auscultation, and inspection

d. Inspection, auscultation, percussion, and palpation

ANS: D

The correct order of abdominal examination is inspection, auscultation, percussion, and palpation. Palpation is always performed last because it may distort the normal abdominal sounds. Auscultation is performed before percussion. The act of percussion can influence the findings on auscultation.

9. Superficial palpation of the abdomen is often perceived by the child as tickling. Which measure by the nurse is most likely to minimize this sensation and promote relaxation?

a. Palpate another area simultaneously.

b. Ask the child not to laugh or move if it tickles.

c. Begin with deeper palpation and gradually progress to superficial palpation.

d. Have the child help with palpation by placing his or her hand over the palpating hand.

ANS: D

Having the child help with palpation by placing his or her hand over the palpating hand will help minimize the feeling of tickling and enlist the childs cooperation. Palpating another area simultaneously will create the sensation of tickling in the other area also. Asking the child not to laugh or move will bring attention to the tickling and make it more difficult for the child. Superficial palpation is done before deep palpation.

10. During examination of a toddlers extremities, the nurse notes that the child is bowlegged. The nurse should recognize that this finding is which?

a. Abnormal and requires 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

Lateral bowing of the tibia (bowlegged) is an expected finding in toddlers when they begin to walk. It usually persists until all of their lower back and leg muscles are well developed. Further evaluation is needed if it persists beyond ages 2 to 3 years, especially in African American children.

11. The nurse is caring for a nonEnglish-speaking child and family. Which should the nurse consider when using an interpreter?

a. Pose several questions at a time.

b. Use medical jargon when possible.

c. Communicate directly with family members when asking questions.

d. Carry on some communication in English with the interpreter about the familys needs.

ANS: C

When using an interpreter, the nurse should communicate directly with family members when asking questions to reinforce interest in them and to observe nonverbal expressions. Questions should be posed one at a time to elicit only one answer at a time. Medical jargon should be avoided whenever possible. The nurse should avoid discussing the familys needs with the interpreter in English because some family members may understand some English.

12. Which action should the nurse implement when taking an axillary temperature?

a. Take the temperature through one layer of clothing.

b. Add a degree to the result when recording the temperature.

c. Place the tip of the thermometer under the arm in the center of the axilla.

d. Hold the childs arm away from the body while taking the temperature.

ANS: C

The thermometer tip should be placed under the arm in the center of the axilla and kept close to the skin, not clothing. The temperature should not be taken through any clothing. The childs arm should be pressed firmly against the side, not held away from the body. The temperature should be recorded without a degree added and designated as being taken by the axillary method.

13. The nurse is aware that skin turgor best estimates what?

a. Perfusion

b. Adequate hydration

c. Amount of body fat

d. Amount of anemia

ANS: B

Skin turgor is one of the best estimates of adequate hydration and nutrition. It does not indicate amount of body fat and is not a test for anemia.

14. The Asian parent of a child being seen in the clinic avoids eye contact with the nurse. What is the best explanation for this considering cultural differences?

a. The parent feels inferior to the nurse.

b. The parent is showing respect for the nurse.

c. The parent is embarrassed to seek health care.

d. The parent feels responsible for her childs illness.

ANS: B

In some ethnic groups, eye contact is avoided. In the Vietnamese culture, an individual may not look directly into the nurses eyes as a sign of respect. The nurse providing culturally competent care would recognize that the other answers listed are not why the parent avoids eye contact with the nurse.

15. The nurse is performing an otoscopic examination on a child. Which are normal findings the nurse should expect?*(Select all that apply.)*

a. Ashen gray areas

b. A well-defined light reflex

c. A small, round, concave spot near the center of the drum

d. The tympanic membrane is a nontransparent grayish color

e. A whitish line extending from the umbo upward to the margin of the membrane

ANS: B, C, E

Normal findings include the light reflex and bony landmarks. The light reflex is a fairly well-defined, cone-shaped reflection that normally points away from the face. The bony landmarks of the eardrum are formed by the umbo, or tip of the malleus. It appears as a small, round, opaque, concave spot near the center of the eardrum. The manubrium (long process or handle) of the malleus appears to be a whitish line extending from the umbo upward to the margin of the membrane. The tympanic membrane should be light pearly pink or gray and translucent, not nontransparent. Ashen gray areas indicate signs of scarring from a previous perforation.

16. The nurse is assessing breath sounds on a child. Which are expected auscultated breath sounds? *(Select all that apply.)*

a. Wheezes

b. Crackles

c. Vesicular

d. Bronchial

e. Bronchovesicular

ANS: C, D, E

Normal breath sounds are classified as vesicular, bronchovesicular, or bronchial. Wheezes or crackles are abnormal or adventitious sounds.

17. The nurse is performing an oral examination on a preschool child. Which strategies should the nurse use to encourage the child to open the mouth for the examination? *(Select all that apply.)*

a. Lightly brush the palate with a cotton swab.

b. Perform the examination in front of a mirror.

c. Let the child examine someone elses mouth first.

d. Have the child breathe deeply and hold his or her breath.

e. Use a tongue blade to help the child open his or her mouth.

ANS: A, B, C, D

To encourage a child to open the mouth for examination, the nurse can lightly brush the palate with a cotton swab, perform the examination in front of a mirror, let the child examine someone elses mouth first, and have the child breathe deeply and hold his or her breath. A tongue blade may elicit the gag reflex and should not be used.

18. Which are effective auscultation techniques? *(Select all that apply.)*

a. Ask the child to breathe shallowly.

b. Apply light pressure on the chest piece.

c. Use a symmetric and orderly approach.

d. Place the stethoscope over one layer of clothing.

e. Warm the stethoscope before placing it on the skin.

ANS: C, E

Effective auscultation techniques include using a symmetric approach and warming the stethoscope before placing it on the skin. Breath sounds are best heard if the child inspires deeply, not shallowly. Firm, not light, pressure should be used on the chest piece. The stethoscope should be placed on the skin, not over clothing.

19. The nurse is assessing heart sounds on a school-age child. Which should the nurse document as abnormal findings if found on the assessment? *(Select all that apply.)*

a. S4 heart sound
b. S3 heart sound
c. Grade II murmur
d. S1 louder at the apex of the heart
e. S2 louder than S1 in the aortic area

ANS: A, C, E

S4 is rarely heard as a normal heart sound; it usually indicates the need for further cardiac evaluation. A grade II murmur is not normal; it is slightly louder than grade I and is audible in all positions. S3 is normally heard in some children. Normally, S1 is louder at the apex of the heart in the mitral and tricuspid area, and S2 is louder near the base of the heart in the pulmonic and aortic area.

20. The nurse understands that blocks to therapeutic communication include what? *(Select all that apply.)*

a. Socializing
b. Use of silence
c. Using clichs
d. Defending a situation
e. Using open-ended questions

ANS: A, C, D

Blocks to communication include socializing, using clichs, and defending a situation. Use of silence and using open-ended questions are therapeutic communication techniques.

Chapter 3 Performing a Physical Examination

Question 1
Type: MCSA

The nurse is taking a health history from a family of a 3-year-old child. Which statement by the nurse would most likely establish rapport and elicit an accurate response from the family?

1. Does any member of your family have a history of asthma, heart disease, or diabetes?
2. Hello, I would like to talk with you and get some information on you and your child.
3. Tell me about the concerns that brought you to the clinic today.
4. You will need to fill out these forms; make sure that the information is as complete as possible.

Correct Answer: 3

Global Rationale: Asking the parents to talk about their concerns is an open-ended question and one which is more likely to establish rapport and an understanding of the parents perceptions. Giving the family a list of items to answer at once may be confusing to the parents. Giving an introduction before asking the parents for information is likely to establish rapport, but giving an explanation of why the information would be needed would be even more effective at establishing rapport and also for getting more accurate, pertinent information. Simply asking the parents to fill out forms is very impersonal, and more information is likely to be obtained and clarified if the nurse is directing the interview.

Question 2
Type: MCSA

When assessing the cognitive development, which technique would be appropriate to test the remote memory of a 5-year-old?

1. Say the name of an object and after 5 minutes ask the child to tell you what you said the object was.
2. Ask the child to repeat his address.
3. Ask the child to say a poem and listen to the childs speech articulation.
4. Have the child point to various parts of the body as you name them.

Correct Answer: 2

Global Rationale: Repeating the name of an object after 510 minutes is assessing recent memory. Asking the child to repeat his address is assessing remote memory. Listening to speech articulation and pointing to body parts both assess communication skills.

Question 3
Type: SEQ

Place the nursing assessments of a toddler in the best order.

Standard Text: Click and drag the options below to move them up or down.
Choice 1. Examination of eyes, ears, and throat
Choice 2. Auscultation of chest
Choice 3. Palpation of abdomen
Choice 4. Developmental assessment

Correct Answer: 4,2,3,1

Global Rationale: In examining a toddler, it is usually best to go from least invasive to most invasive examination in order to build her trust and cooperation. Developmental assessment involves visual inspection and activities that the toddler may view as games and will likely cooperate with. Auscultation is usually less threatening to the toddler than palpation, especially if

the nurse were to use the stethoscope on a parent or a toy. The most uncomfortable, invasive exam for the toddler is most likely to be the examination of the eyes, ears, and throat, so that should be performed last.
Question 4
Type: MCSA

While assessing a 10-month-old African American infant, the nurse notices that the sclerae have a yellowish tint. Which organ system should the nurse further evaluate to determine an ongoing disease process?

1. Cardiac
2. Respiratory
3. Gastrointestinal
4. Genitourinary
Correct Answer: 3
Global Rationale: This infants sclerae are showing signs of jaundice, which most likely is secondary to a failure or malfunction of the liver in the gastrointestinal system. Cyanosis of the skin and mucous membranes is generally a sign of problems with the cardiac and/or respiratory system. Tenting of the skin and dry mucous membranes could be a sign of dehydration, and edema could be a sign of fluid overload. Both of these conditions could be secondary to problems with functioning of the genitourinary system.
Question 5
Type: MCSA

A nurse caring for a school-age client notices some swelling in the childs ankles. The nurse presses against the ankle bone for five seconds, then releases the pressure and notices a markedly slow disappearance of the indentation. Which priority nursing assessment is appropriate?

1. Skin integrity, especially in the lower extremities
2. Urine output
3. Level of consciousness
4. Range of motion and ankle mobility
Correct Answer: 2
Global Rationale: Dependent, pitting edema, especially in the lower extremities, can be a symptom of both kidney and cardiac disorders. Decreases in urine output can also indicate compromise in both the renal and cardiac systems. Changes in level of consciousness, if present, would more than likely be a later effect in this situation. While ankle edema could lead to both decreased ankle mobility and compromise in skin integrity, diagnosing and treating the underlying cause of the edema is most important.
Question 6
Type: MCSA

A new mother is worried about a soft spot on the top of her newborn infants head. The nurse informs her that this is a normal physical finding called the anterior fontanel. At what age will the nurse educate the mother that the soft spot will close?

1. 2 to 3 months of age
2. 6 to 9 months of age
3. 12 to 18 months of age

4. Approximately 2 years of age
Correct Answer: 3
Global Rationale: The anterior fontanel is located at the top of the head and is the opening at the intersection of the suture lines. As the infant grows, the suture lines begin to fuse, and the anterior fontanel closes at 12 to 18 months of age.
Question 7
Type: MCSA

While inspecting a 5-year-old childs ears, the nurse notes that the right pinna protrudes outward and that there is a mass behind the right ear. In light of these findings, which vital-sign parameter would the nurse assess on priority?

1. Temperature
2. Heart rate
3. Respirations
4. Blood pressure
Correct Answer: 1
Global Rationale: Swelling behind an ear could indicate mastoiditis, and the presence of a fever would indicate a higher index of suspicion for this. There could also be changes in other vital-sign parameters, but they would not be specific for the presence of infection.
Question 8
Type: MCMA

A 7-year-old child presents to the clinic with an exacerbation of asthma symptoms. On physical examination, the nurse would expect which assessment findings?

Standard Text: Select all that apply.
1. Wheezing
2. Increased tactile fremitus
3. Decreased vocal resonance
4. Decreased tactile fremitus
5. Bronchophony
Correct Answer: 1,3,4
Global Rationale: Wheezing is caused by air passing through mucus or fluids in a narrowed lower airway, which is a condition present in asthma exacerbations. The air trapping in the lungs that occurs in asthma causes a decrease in the sensation of vibrations felt, not an increase in tactile fremitus, which is indicative of pneumonia. Bronchophony is an increase in the intensity and clarity of transmitted sounds. This is also indicative of pneumonia but not asthma, which causes a decrease in vocal resonance.
Question 9
Type: MCSA

The nurse is caring for a newly-admitted infant diagnosed with failure to thrive. The nurse begins to implement the healthcare provider prescribed orders by taking blood pressures in all four extremities. Which congenital cardiac defect does the nurse anticipate based on the prescribed order?

1. Tetralogy of Fallot
2. Pulmonary atresia

3. Coarctation of the aorta
4. Ventricular septal defect
Correct Answer: 3
Rationale 1: Normally, blood pressures in the lower extremities are the same as or higher
Global Rationale: Normally, blood pressures in the lower extremities are the same as or higher than upper-extremity blood pressures. But in coarctation of the aorta, the narrowing of the aorta causes decreased blood flow to the lower extremities and thus lower-extremity blood-pressure readings are significantly lower than upper-extremity readings. There are minimal differences between upper and lower blood-pressure readings in tetralogy of Fallot, pulmonary atresia, and ventricular septal defect.
Question 10
Type: MCSA

During an examination, a nurse asks a 5-year-old child to repeat his address. What is the nurse evaluating with this action?

1. Recent memory
2. Language development
3. Remote memory
4. Social-skill development
Correct Answer: 3
Global Rationale: Asking children to remember addresses, phone numbers, and dates assesses remote-memory development. To evaluate recent memory the nurse would have the child name something and then ask him to name it again in 10 to 15 minutes. Listening to how the child talks and his sentence structure evaluates the childs language development, and assessing how he interacts with others evaluates social-skill development.
Question 11
Type: MCSA

During the newborn examination, the nurse assesses the infant for signs of developmental dysplasia of the hip. A finding that would strongly indicate this disorder would be:

1. soles are flat with prominent fat pads.
2. positive Babinski reflex.
3. metatarsus varus.
4. asymmetric thigh and gluteal folds.
Correct Answer: 4
Rationale 1: A positive Babinski reflex and flat soles are normal newborn findings. Metatarsus varus is an in-toeing of the feet that usually occurs secondary to intra-uterine positioning and frequently resolves on its own, but approximately 10 percent of infants with metatarsus varus also have developmental dysplasia of the hip. Asymmetric thigh and gluteal folds are a positive finding for developmental dysplasia of the hip requiring follow-up with ultrasound.
Rationale 2: A positive Babinski reflex and flat soles are normal newborn findings. Metatarsus varus is an in-toeing of the feet that usually occurs secondary to intra-uterine positioning and frequently resolves on its own, but approximately 10 percent of infants with metatarsus varus also have developmental dysplasia of the hip. Asymmetric thigh and gluteal folds are a positive finding for developmental dysplasia of the hip requiring follow-up with ultrasound.

Rationale 3: A positive Babinski reflex and flat soles are normal newborn findings. Metatarsus varus is an in-toeing of the feet that usually occurs secondary to intra-uterine positioning and frequently resolves on its own, but approximately 10 percent of infants with metatarsus varus also have developmental dysplasia of the hip. Asymmetric thigh and gluteal folds are a positive finding for developmental dysplasia of the hip requiring follow-up with ultrasound.
Rationale 4: A positive Babinski reflex and flat soles are normal newborn findings. Metatarsus varus is an in-toeing of the feet that usually occurs secondary to intra-uterine positioning and frequently resolves on its own, but approximately 10 percent of infants with metatarsus varus also have developmental dysplasia of the hip. Asymmetric thigh and gluteal folds are a positive finding for developmental dysplasia of the hip requiring follow-up with ultrasound.
Question 12
Type: MCSA

The nurse must assess each of the 2-year-olds listed below. Which one should be evaluated first?

1. A child with a temperature of 101 degrees F
2. A child who has stridor
3. A child who has absent Babinski sign
4. A child who has a pot belly appearance
Correct Answer: 2
Global Rationale: A child with stridor is at risk for airway compromise; a child with a temperature of 101 degrees F, while sick, is not as ill as the child with stridor; and the child with an absent Babinski sign and the pot-bellied child are normal.
Question 13
Type: MCSA

The nurse notes a history of a grade III heart murmur in a small infant. When assessing the heart, the nurse would expect to:

1. hear a quiet but easily heard murmur.
2. hear a moderately loud murmur without a palpable thrill.
3. hear a very loud murmur with easily palpable thrill.
4. listen without a stethoscope and hear a murmur at chest wall.
Correct Answer: 2
Global Rationale: A quiet but easily heard murmur is a grade II. A moderately loud murmur without palpable thrill is a grade III. A very loud murmur with easily palpable thrill is a grade V. A murmur heard at the chest wall without the aid of a stethoscope is a grade VI.
Question 14
Type: MCSA

The nurse is measuring an abdominal girth on a child with abdominal distension. Identify the area on the childs abdomen where the tape measure should be placed for an accurate abdominal girth.

1. Just above the umbilicus, around the largest circumference of the abdomen
2. Below the umbilicus
3. Just below the sternum
4. Just above the pubic bone
Correct Answer: 1

Global Rationale: An abdominal girth should be taken around the largest circumference of the abdomen, in this case, just above the umbilicus. The circumference below the umbilicus or just below the sternum would not be an accurate abdominal girth.
Question 15
Type: MCMA

The nurse is preparing to assessment a toddler client. Which activities would gain cooperation from the toddler?

Standard Text: Select all that apply.
1. Asking the parents to wait outside
2. Allowing the client to sit in the parents lap
3. Administering vaccinations prior to the assessment
4. Handing the client a stethoscope while taking the health history
5. Making a game out of the assessment process
Correct Answer: 2,4

Global Rationale: Allowing the client to stay on the parents lap and allowing the client to play with instruments that will be used in the assessment process are activities the nurse can implement to gain the toddlers cooperation during the assessment process. Asking the parents to wait outside may cause the toddler to become fearful. Vaccinations should be administered at the end of the visit. While making a game out of the assessment process may be appropriate for older children, this is not an appropriate strategy for a toddler client.
Question 16
Type: MCMA

The nurse is assessing an infant client during a health supervision visit. Which assessment findings are considered normal variations for this client?

Standard Text: Select all that apply.
1. Sucking pads in the mouth
2. A rounded chest
3. Hearing breath sounds over the entire chest
4. Pubertal development
5. Knock-knees
Correct Answer: 1,2,3
Global Rationale: Normal variations for the infant client include sucking pads in the mouth, a rounded chest, and hearing breath sounds over the entire chest. Pubertal development and knock-knees are not normal variations for the infant client.

Question 17
Type: MCMA

The nurse is conducting a health surveillance visit with a 6-month-old infant. Which methods are appropriate to monitor the infants growth pattern since birth?

Standard Text: Select all that apply.
1. Weight the infant twice and average together
2. Measure the infants height

3. Measure the infants head circumference
4. Determine the infants body mass index
5. Plot the infants growth on appropriate chart
Correct Answer: 1,3,5
Global Rationale: In order to determine the infants growth pattern the nurse will obtain two weights and average them together, measure the infants head circumference, and obtain the infants length, not height. After the measurements have been obtained the nurse will plot the measurements on the appropriate growth chart and monitor the infants growth pattern. Body mass index is not determined during infancy.

18. A 5-year-old child is in the clinic for a checkup. The nurse would expect him to:

a. Need to be held on his mothers lap.

b. Be able to sit on the examination table.

c. Be able to stand on the floor for the examination.

d. Be able to remain alone in the examination room.

ANS: B
At 4 or 5 years old, a child usually feels comfortable on the examination table. Older infants and young children aged 6 months to 2 or 3 years should be positioned in the parents lap.
19. Which statement is *true* regarding the recording of data from the history and physical examination?

a. Use long, descriptive sentences to document findings.

b. Record the data as soon as possible after the interview and physical examination.

c. If the information is not documented, then it can be assumed that it was done as a standard of care.

d. The examiner should avoid taking any notes during the history and examination because of the possibility of decreasing the rapport with the patient.

ANS: B
The data from the history and physical examination should be recorded as soon after the event as possible. From a legal perspective, if it is not documented, then it was not done. Brief notes should be taken during the examination. When documenting, the nurse should use short, clear phrases and avoid redundant phrases and descriptions.
20. When assessing the neonate, the nurse should test for hip stability with which method?

a. Eliciting the Moro reflex

b. Performing the Romberg test

c. Checking for the Ortolani sign

d. Assessing the stepping reflex

ANS: C
The nurse should test for hip stability in the neonate by testing for the Ortolani sign. The other tests are not appropriate for testing hip stability.
21. A female patient tells the nurse that she has four children and has had three pregnancies. How should the nurse document this?

a. Gravida 3, para 4

b. Gravida 4, para 3

c. This information cannot be documented using the terms *gravida* and *para*.

d. The patient seems to be confused about how many times she has been pregnant.

ANS: A

Gravida refers to the number of pregnancies, and *para* refers to the number of children. One pregnancy was with twins.

22. The nurse is documenting the assessment of an infant. During the abdominal assessment, the nurse noticed a very loud splash auscultated over the upper abdomen when the nurse rocked her from side to side. This finding would indicate:

a. Epigastric hernia.

b. Pyloric obstruction.

c. Hypoactive bowel sounds.

d. Hyperactive bowel sounds.

ANS: D

A succussion splash, which is unrelated to peristalsis, is a very loud splash auscultated over the upper abdomen when the infant is rocked side to side. It indicates increased air and fluid in the stomach as observed with pyloric obstruction or large hiatus hernia

23. Which of these actions is most appropriate to perform on a 9-month-old infant at a well-child checkup?

a. Testing for Ortolani sign

b. Assessment for stereognosis

c. Blood pressure measurement

d. Assessment for the presence of the startle reflex

ANS: A

Until the age of 12 months, the infant should be assessed for Ortolani sign. If Ortolani sign is present, then it could indicate the presence of a dislocated hip. The other tests are not appropriate for a 9-month-old child.

Chapter 4 Making Newborn Rounds

MULTIPLE CHOICE

1. What is a function of brown adipose tissue (BAT) in newborns?

a. Generates heat for distribution to other parts of body

b. Provides ready source of calories in the newborn period

c. Protects newborns from injury during the birth process

d. Insulates the body against lowered environmental temperature

ANS: A
Brown fat is a unique source of heat for newborns. It has a larger content of mitochondrial cytochromes and a greater capacity for heat production through intensified metabolic activity than does ordinary adipose tissue. Heat generated in brown fat is distributed to other parts of the body by the blood. It is effective only in heat production. Brown fat is located in superficial areas such as between the scapulae, around the neck, in the axillae, and behind the sternum. These areas should not protect the newborn from injury during the birth process. The newborn has a thin layer of subcutaneous fat, which does not provide for conservation of heat.

2. Which characteristic is representative of a full-term newborns gastrointestinal tract?

a. Transit time is diminished.

b. Peristaltic waves are relatively slow.

c. Pancreatic amylase is overproduced.

d. Stomach capacity is very limited.

ANS: D
Newborns require frequent small feedings because their stomach capacity is very limited. A newborns colon has a relatively small volume and resulting increased bowel movements. Peristaltic waves are rapid. A deficiency of pancreatic lipase limits the absorption of fats.

3. Which term is used to describe a newborns first stool?

a. Milia

b. Milk stool

c. Meconium

d. Transitional

ANS: C
Meconium is composed of amniotic fluid and its constituents, intestinal secretions, shed mucosal cells, and possibly blood. It is a newborns first stool. Milia involves distended sweat glands that appear as minute vesicles, primarily on the face. Milk stool usually occurs by the fourth day. The appearance varies depending on whether the newborn is breast or formula fed. Transitional stools usually appear by the third day after the beginning of feeding. They are usually greenish brown to yellowish brown, thin, and less sticky than meconium.

4. In term newborns, the first meconium stool should occur no later than within how many hours after birth?

a. 6

b. 8

c. 12

d. 24

ANS: D
The first meconium stool should occur within the first 24 hours. It may be delayed up to 7 days in very lowbirth-weight newborns.

5. Which is true regarding an infants kidney function?

a. Conservation of fluid and electrolytes occurs.

b. Urine has color and odor similar to the urine of adults.

c. The ability to concentrate urine is less than that of adults.

d. Normally, urination does not occur until 24 hours after delivery.

ANS: C

At birth, all structural components are present in the renal system, but there is a functional deficiency in the kidneys ability to concentrate urine and to cope with conditions of fluid and electrolyte stress such as dehydration or a concentrated solute load. Infants urine is colorless and odorless. The first voiding usually occurs within 24 hours of delivery. Newborns void when the bladder is stretched to 15 ml, resulting in about 20 voidings per day.

6. The Apgar score of an infant 5 minutes after birth is 8. Which is the nurses best interpretation of this?

a. Resuscitation is likely to be needed.

b. Adjustment to extrauterine life is adequate.

c. Additional scoring in 5 more minutes is needed.

d. Maternal sedation or analgesia contributed to the low score.

ANS: B

The Apgar reflects an infants status in five areas: heart rate, respiratory effort, muscle tone, reflex irritability, and color. A score of 8 to 10 indicates an absence of difficulty adjusting to extrauterine life. Scores of 0 to 3 indicate severe distress, and scores of 4 to 7 indicate moderate difficulty. All infants are rescored at 5 minutes of life, and a score of 8 is not indicative of distress; the newborn does not have a low score. The Apgar score is not used to determine the infants need for resuscitation at birth.

7. Which statement best represents the first stage or the first period of reactivity in the infant?

a. Begins when the newborn awakes from a deep sleep

b. Is an excellent time to acquaint the parents with the newborn

c. Ends when the amounts of respiratory mucus have decreased

d. Provides time for the mother to recover from the childbirth process

ANS: B

During the first period of reactivity, the infant is alert, cries vigorously, may suck his or her fist greedily, and appears interested in the environment. The infants eyes are usually wide open, suggesting that this is an excellent opportunity for mother, father, and infant to see each other. The second period of reactivity begins when the infant awakes from a deep sleep and ends when the amounts of respiratory mucus have decreased. The mother should sleep and recover during the second stage, when the infant is sleeping.

8. Which statement reflects accurate information about patterns of sleep and wakefulness in the newborn?

a. States of sleep are independent of environmental stimuli.

b. The quiet alert stage is the best stage for newborn stimulation.

c. Cycles of sleep states are uniform in newborns of the same age.

d. Muscle twitches and irregular breathing are common during deep sleep.

ANS: B

During the quiet alert stage, the newborns eyes are wide open and bright. The newborn responds to the environment by active body movement and staring at close-range objects. Newborns ability to control their own cycles depend on their neurobehavioral development. Each newborn has an individual cycle. Muscle twitches and irregular breathing are common during light sleep.

9. The nurse observes that a new mother avoids making eye contact with her infant. What should the nurse do?

a. Ask the mother why she wont look at the infant.

b. Examine the infants eyes for the ability to focus.

c. Assess the mother for other attachment behaviors.

d. Recognize this as a common reaction in new mothers.

ANS: C

Attachment behaviors are thought to indicate the formation of emotional bonds between the newborn and mother. A mothers failure to make eye contact with her infant may indicate difficulties with the formation of emotional bonds. The nurse should perform a more thorough assessment. Asking the mother why she will not look at the infant is a confrontational response that might put the mother in a defensive position. Infants do not have binocularity and cannot focus. Avoiding eye contact is an uncommon reaction in new mothers.

10. Which should the nurse use when assessing the physical maturity of a newborn?

a. Length

b. Apgar score

c. Posture at rest

d. Chest circumference

ANS: C

With the newborn quiet and in a supine position, the degree of flexion in the arms and legs can be used for determination of gestational age. Length and chest circumference reflect the newborns size and weight, which vary according to race and gender. Birth weight alone is a poor indicator of gestational age and fetal maturity. The Apgar score is an indication of the newborns adjustment to extrauterine life.

11. What is the grayish white, cheeselike substance that covers the newborns skin?

a. Milia

b. Meconium

c. Amniotic fluid

d. Vernix caseosa

ANS: D

The vernix caseosa is the grayish white, cheeselike substance that covers a newborns skin.

12. What is most descriptive of the shape of the anterior fontanel in a newborn?

a. Circle

b. Square

c. Triangle

d. Diamond

ANS: D
The anterior fontanel is diamond shaped and measures from barely palpable to 4 to 5 cm. The shape of the posterior fontanel is a triangle. Neither of the fontanels is a circle or a square.
13. Which term describes irregular areas of deep blue pigmentation seen predominantly in infants of African, Asian, Native American, or Hispanic descent?

a. Acrocyanosis

b. Mongolian spots

c. Erythema toxicum

d. Harlequin color change

ANS: B
Mongolian spots are irregular areas of deep blue pigmentation, which are common variations found in newborns of African, Asian, Native American, or Hispanic descent. Acrocyanosis is cyanosis of the hands and feet; this is a usual finding in infants. Erythema toxicum is a pink papular rash with vesicles that may appear in 24 to 48 hours and resolve after several days. Harlequin color changes are clearly outlined areas of color change. As the infant lies on a side, the lower half of the body becomes pink, and the upper half is pale.
14. The nurse should expect the apical heart rate of a stabilized newborn to be in which range?

a. 60 to 80 beats/min

b. 80 to 100 beats/min

c. 120 to 140 beats/min

d. 160 to 180 beats/min

ANS: C
The pulse rate of the newborn varies with periods of reactivity. Usually the pulse rate is between 120 and 140 beats/min. Sixty to 100 beats/min is too slow for a newborn, and 160 to 180 beats/min is too fast for a newborn.
15. Which finding in the newborn is considered abnormal?

a. Nystagmus

b. Profuse drooling

c. Dark green or black stools

d. Slight vaginal reddish discharge

ANS: B
Profuse drooling and salivation are potential signs of a major abnormality. Newborns with esophageal atresia cannot swallow their oral secretions, resulting in excessive drooling. Nystagmus is an involuntary movement of the eyes. This is a common variation in newborns. Meconium, the first stool of newborns, is dark green or black. A pseudomenstruation may be present in normal newborns. This is a blood-tinged or mucoid vaginal discharge.
16. When doing the first assessment of a male newborn, the nurse notes that the scrotum is large, edematous, and pendulous. What should this be interpreted as?

a. A hydrocele

b. An inguinal hernia

c. A normal finding

d. An absence of testes

ANS: C

A large, edematous, and pendulous scrotum in a term newborn, especially in those born in a breech position, is a normal finding. A hydrocele is fluid in the scrotum, usually unilateral, which usually resolves within a few months. An inguinal hernia may or may not be present at birth. It is more easily detected when the child is crying. The presence or absence of testes should be determined on palpation of the scrotum and inguinal canal. Absence of testes may be an indication of ambiguous genitalia.

17. Why are rectal temperatures not recommended in newborns?

a. They are inaccurate.

b. They do not reflect core body temperature.

c. They can cause perforation of rectal mucosa.

d. They take too long to obtain an accurate reading.

ANS: C

Rectal temperatures are avoided in newborns. If done incorrectly, the insertion of a thermometer into the rectum can cause perforation of the mucosa. The time it takes to determine body temperature is related to the equipment used, not only the route.

18. Which is the name of the suture separating the parietal bones at the top of a newborns head?

a. Frontal

b. Sagittal

c. Coronal

d. Occipital

ANS: B

The sagittal suture separates the parietal bones at the top of the newborns head. The frontal suture separates the frontal bones. The coronal suture is said to crown the head. The lambdoid suture is at the margin of the parietal and occipital.

19. The nurse observes flaring of nares in a newborn. What should this be interpreted as?

a. Nasal occlusion

b. Sign of respiratory distress

c. Snuffles of congenital syphilis

d. Appropriate newborn breathing

ANS: B

Nasal flaring is an indication of respiratory distress. A nasal occlusion should prevent the child from breathing through the nose. Because newborns are obligatory nose breathers, this should require immediate referral. Snuffles are indicated by a thick, bloody nasal discharge without sneezing. Sneezing and thin, white mucus drainage are common in newborns and are not related to nasal flaring.

20. The nurse is assessing the reflexes of a newborn. Stroking the outer sole of the foot assesses which reflex?

a. Grasp

b. Perez

c. Babinski

d. Dance or step

ANS: C

This is a description of the Babinski reflex. Stroking the outer sole of the foot upward from the heel across the ball of the foot causes the big toes to dorsiflex and the other toes to hyperextend. This reflex persists until approximately age 1 year or when the newborn begins to walk. The grasp reflex is elicited by touching the palms or soles at the base of the digits. The digits will flex or grasp. The Perez reflex involves stroking the newborns back when prone; the child flexes the extremities, elevating the head and pelvis. This disappears at ages 4 to 6 months. When the newborn is held so that the sole of the foot touches a hard surface, there is a reciprocal flexion and extension of the leg, simulating walking. This reflex disappears by ages 3 to 4 weeks.

21. Which is most important in the immediate care of the newborn?

a. Maintain a patent airway.

b. Administer prophylactic eye care.

c. Maintain a stable body temperature.

d. Establish identification of the mother and baby.

ANS: A

Maintaining a patent airway is the primary objective in the care of the newborn. First, the pharynx is cleared with a bulb syringe followed by the nasal passages. Administering prophylactic eye care and establishing identification of the mother and baby are important functions, but physiologic stability is the first priority in the immediate care of the newborn. Conserving the newborns body heat and maintaining a stable body temperature are important, but a patent airway must be established first.

22. What should nursing interventions to maintain a patent airway in a newborn include?

a. Positioning the newborn supine after feedings.

b. Wrapping the newborn as snugly as possible.

c. Placing the newborn to sleep in the prone (on abdomen) position.

d. Using a bulb syringe to suction as needed, suctioning the nose first and then the pharynx.

ANS: A

Positioning the newborn supine after feedings is recommended by the American Academy of Pediatrics to prevent sudden newborn death syndrome. The child can be wrapped snugly but should be placed on the side or back. Placing a newborn to sleep in the prone (on abdomen) position is not advised because of the possible link between sleeping in the prone position and sudden newborn death syndrome. A bulb syringe should be kept by the bedside if necessary, but the pharynx should be suctioned before the nose.

23. The nurse quickly dries the newborn after delivery. This is to conserve the newborns body heat by preventing heat loss through which method?

a. Radiation

b. Conduction

c. Convection

d. Evaporation

ANS: D

Evaporation is the loss of heat through moisture. The newborn should be quickly dried of the amniotic fluid. Radiation is the loss of heat to a cooler solid object. The cold air from either the window or the air conditioner will cool the walls of the incubator and subsequently the body of the newborn. Conduction involves the loss of heat from the body because of direct contact of the skin with a cooler object. Convection is similar to conduction but is the loss of heat aided by air currents.

24. An infant is being discharged at 48 hours of age. The parents ask how the infant should be bathed this first week home. Which is the best recommendation by the nurse?

a. Bathe the infant daily with mild soap.

b. Bathe the infant daily with an alkaline soap.

c. Bathe the infant two or three times this week with mild soap.

d. Bathe the infant two or three times this week with plain water.

ANS: D

A newborn infants skin has a pH of approximately 5. This acidic pH has a bacteriostatic effect. The parents should be taught to use only plain warm water for the bath and to bathe the infant no more than two or three times the first 2 weeks. Soaps are alkaline. They will alter the acid mantle of the infants skin, providing a medium for bacterial growth.

25. The stump of the umbilical cord usually drops off in how many days?

a. 3 to 6

b. 10 to 14

c. 16 to 21

d. 24 to 28

ANS: B

The average umbilical cord separates in 10 to 14 days. Three to 6 days is too soon, and 16 to 28 days is too late.

26. The parents of an infant plan to have him circumcised. They ask the nurse about pain associated with this procedure. The nurses response should be based on which?

a. That infants experience pain with circumcision

b. That infants are too young for anesthesia or analgesia

c. That infants do not experience pain with circumcision

d. That infants quickly forget about the pain of circumcision

ANS: A

Circumcision is a surgical procedure. The American Academy of Pediatrics has recommended that procedural analgesia be provided when circumcision is performed. The pain infants experience with surgical procedures can be alleviated with analgesia. Infants who undergo circumcision without anesthetic agents react more intensely to immunization injections at 4 to 6 months of age compared with infants who had an anesthetic.