Price: Pediatric Nursing, 11th Edition

Chapter 02: Care of the Child with Medical/Surgical Needs

Testbank

MULTIPLE CHOICE

1. A nurse who may have a private practice in the office of a pediatrician or a family practice physician is:
   a. A school nurse
   b. A home health nurse
   c. A pediatric nurse practitioner
   d. Any licensed LVN or RN

   ANS: C
   A pediatric nurse practitioner may conduct a private practice in the office of a pediatrician or family practice physician performing physical examinations and general well-child services such as school-based clinics or health clinics.

   DIF: Cognitive Level: Application REF: p. 8 OBJ: 2
   TOP: The Pediatric Nurse Practitioner KEY: Nursing Process Step: N/A
   MSC: NCLEX: N/A

2. A newly admitted 5-year-old asks if he can wear his cowboy shirt. The nurse's response will be based on the understanding that wearing his own clothes will
   a. Make child feel more comfortable
   b. Present an infection control problem
   c. Make caring for the child more difficult
   d. Not be permitted

   ANS: A
   Allowing the child to wear his own clothes helps to bridge the gap between home and hospital. Wearing clothes from home should not pose an infection control problem. The nurse can assess the clothing and determine if this is a risk.

   DIF: Cognitive Level: Application REF: p. 10 OBJ: 4
   TOP: The Hospital Setting KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

3. A 4-year-old is going to have a dressing change that may be painful and frightening, therefore the nurse will perform this procedure in:
   a. The patient room, because the surroundings are familiar
   b. The treatment room, so the child will not associate negative feelings with the patient room
   c. The playroom, so the child will be distracted by other children

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d. A screened-off area in the hall to reduce visual stimulation

ANS: B
Painful and frightening procedures are accomplished in the treatment room. The child needs to feel safe and secure in the patient room. Performing the procedure in front of other children is inappropriate.

DIF: Cognitive Level: Application REF: pp. 11-12 OBJ: 4
TOP: The Hospital Setting KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

4. The nurse clarifies that the purpose of the pediatric unit playroom is to provide:
   a. A safe place for children to go when the nurses take a break
   b. An incentive for patients to choose this hospital
   c. An activity area to alleviate the stress of hospitalization
   d. An environment to determine if the child is well enough for discharge

ANS: C
Playrooms provide a place for children to play and interact with other children. Many units include a play therapist or a child life specialist in attendance.

DIF: Cognitive Level: Knowledge REF: p. 10 OBJ: 3
TOP: Playrooms KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

5. The nurse assesses that a 2-year-old who cries continuously after his mother leaves, watches the door for her return, and then finally exhausts himself and goes to sleep is in the separation anxiety phase of:
   a. Despair
   b. Denial
   c. Protest
   d. Depression

ANS: C
The child is in the protest stage. Depression is not a stage of separation.

DIF: Cognitive Level: Application REF: p. 11 OBJ: 3
TOP: The Child's Reaction to Hospitalization
KEY: Nursing Process Step: Assessment
MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

6. The parents of a 3-year-old who is scheduled to have surgery the following week ask the home health nurse if a tour of the pediatric unit prior to the procedure is wise. The nurse responds:
   a. "Yes, because it allows the parents to meet the people that will be taking care of their child."
   b. "No, because it will overwhelm and frighten your child."

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c. "No, because it will be an infection control risk."
d. "Yes, because parents will not be allowed to stay with the child in the hospital."

ANS: A
A prehospitalization tour or class will help to alleviate the anxiety of the parent and child. The child will be with his parents during the tour. It is not an infection control risk. The parents will be encouraged to stay with the child.

DIF: Cognitive Level: Analysis REF: p. 15 OBJ: 5
TOP: The Family's Reaction to Hospitalization
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

7. When greeting a newly admitted pediatric patient and family, the nurse should:
   a. Stand erect in a confident manner
   b. Show warmth and friendliness to the child and family
   c. Be polite and formal to show respect
   d. Hurry through the interview to lessen the stress on the child

ANS: B
The nurse will greet the child at eye level. Towering over the child is frightening. The nurse should be warm and friendly. The nurse should be calm and unhurried when talking with the child and family.

DIF: Cognitive Level: Application REF: p. 16 OBJ: 4
TOP: Therapeutic Relationships KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

8. The school nurse would consider a recommendation for referral to Shriner's Hospital to the parents of a child with:
   a. A developmental retardation
   b. A cleft lip
   c. An orthopedic deformity
   d. A behavioral problem

ANS: C
Shriner's Hospitals is a network of pediatric specialty hospitals in which children younger than 18 years of age with orthopedic conditions or burns are treated without cost.

DIF: Cognitive Level: Comprehension REF: p. 9 OBJ: 2
TOP: Shriner's Hospitals KEY: Nursing Process Step: Assessment
MSC: NCLEX: Safe, Effective Care Environment: Coordinated Care

9. The nurse performing a review of systems on an 8-month-old infant who is awake and calm should make the initial assessment:
   a. Examination of the ears with an otoscope
   b. Auscultation of the heart, lungs, and bowel sounds

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c. Obtaining a rectal temperature
d. Palpation of the abdomen

ANS: B
Auscultation of the heart, lungs, and abdomen should be the initial assessment as it is the least stressful, especially if the child has had an opportunity to handle the stethoscope.

DIF: Cognitive Level: Application REF: p. 17 OBJ: 7
TOP: Systems Review KEY: Nursing Process Step: Assessment
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

10. When auscultating the heart of a 3-year-old girl, an irregular heartbeat is assessed. The nurse recognizes that:
a. This is normal for a child younger than 4 years of age
b. The arrhythmia should be documented and reported to the charge nurse
c. This may be caused by anxiety and should be rechecked in 1 hour
d. This is an emergency, and help should be called

ANS: B
A child of 3 years of age should have a regular rhythm. An irregular heart rhythm should be documented and reported to the nurse in charge immediately. Arrhythmias do not pose an immediate threat.

DIF: Cognitive Level: Analysis REF: p. 18 OBJ: 7
TOP: Systems Review KEY: Nursing Process Step: Assessment
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

11. When referring a child and family to a hospice service, the nurse considers that to qualify for hospice, the child must:
a. Have adequate insurance coverage
b. Be in an active therapeutic protocol
c. Have a terminal diagnosis
d. Have less than 6 months to live

ANS: D
To qualify for hospice, a patient must have less than 6 months to live. These services are supplied either in the hospital or at home.

DIF: Cognitive Level: Comprehension REF: p. 9 OBJ: 2
TOP: Vital Signs KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

12. The parents of a hospitalized 2-year-old are distressed that the child no longer is toilet trained and now requires a diaper. The nurse's best response to this would be:
a. "Don't worry. Your child will regain toilet training in a few days."
b. "We can start a bladder training program that will restore toilet training."
c. "Toddlers often regress when stressed. Using a diaper now is appropriate."
d. "You need to strongly enforce toilet training practices now."

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ANS: C
With the stress of hospitalization, toddlers may abandon recently acquired skills. When the stress is manageable, the skills will return.

DIF: Cognitive Level: Application REF: p. 11 OBJ: 5
TOP: Regression KEY: Nursing Process Step: Assessment
MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

13. The parents of a 3-year-old who is hospitalized with mumps and is in isolation ask if their child may be allowed out of bed. The nurse's most helpful response would be:
a. "No. A child with an infectious disease needs to stay in bed."
b. "Yes. Your child may go anywhere in the unit."
c. "No. Your child will spread the mumps if allowed out of bed."
d. "Yes. Your child can walk around here in the room, but not out in the hall."

ANS: D
A toddler who feels like getting out of bed and walking should do so; however, keep in mind that a child with an infectious disease should stay within the confines of the room.

DIF: Cognitive Level: Application REF: p. 12 OBJ: 10
TOP: Toddler Activity KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

14. When a 4-year-old asks the nurse if an injection will hurt, the most therapeutic response would be:
a. "No. It is over so quickly you will not feel a thing."
b. "Yes. You can see how sharp the needle is, so it will hurt when it goes in."
c. "No. A big 4-year-old like you won't be bothered by a little needle stick."
d. "Yes. There will be a little sting, but hugging this bear will help."

ANS: D
The nurse should be truthful about procedures. Honesty helps the child not to feel betrayed. Preparation for a painful procedure should be done immediately before the procedure so as not to draw out the anticipation.

DIF: Cognitive Level: Application REF: p. 12 OBJ: 4
TOP: Preparation for a Painful Procedure
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

15. The pediatric nurse takes into consideration that the most stressful procedure for a preschooler would be:
a. Casting a broken arm
b. Circumcision
c. Suturing a laceration on the hand
d. Removing sutures from the face

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ANS: B
Preschoolers fear mutilation during hospitalization, particularly invasive procedures that involve the genital area.

DIF: Cognitive Level: Comprehension REF: p. 12 OBJ: 5
TOP: Preschoolers' Fear of Mutilation KEY: Nursing Process Step: Planning
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

16. After the nurse has lowered the crib rail on the bed of a 6-month-old, in order to prevent the child from rolling out of bed, the nurse should:
    a. Restrain the child with a sheet
    b. Stand touching the side of the bed
    c. Place the child perpendicular to the side rail
    d. Ask assistance from the parent or coworker to hold the child

ANS: C
Placing the child perpendicular to the side rails prevents the child from rolling off the bed.

DIF: Cognitive Level: Application REF: p. 22 OBJ: 9
TOP: Safety KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

17. A 6-year-old newly diagnosed with Type I diabetes is going home today. Her parents have been taught how to manage her disease, but the nurse is concerned that they may not remember everything that was taught. The nurse can best help the parents by:
    a. Instructing the parents that they can bring their child back to the unit for additional help as needed
    b. Beginning discharge planning as soon as the order for discharge has been written by the attending physician
    c. Providing the family with written instructions regarding diet, medications, activity, and procedures needed by the child
    d. Delaying informing the parents of the impending discharge to prevent stress and anxiety for the parents and child

ANS: C
Providing written instructions about all aspects of care will reinforce teaching and provide an important resource for the parents. The parents need to be informed of discharge as soon as possible so that they can begin making arrangements and can prepare for departure.

DIF: Cognitive Level: Synthesis REF: p. 22 OBJ: 8
TOP: Discharge Planning KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

18. A child is admitted with an infectious disease and is placed in an isolation room. In order to assess this child, the nurse should:
    a. Use his or her own stethoscope, and wipe it thoroughly with antiseptic after each use

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b. Use a stethoscope reserved for this patient in the room
c. Use a sterile stethoscope each time the patient is assessed
d. Remove the used equipment each day for disinfection

ANS: B
A patient in isolation will have equipment for daily care placed in the isolation room. A sterile stethoscope is not needed. Equipment is kept in the room until the patient is discharged. Removing the equipment daily will increase exposure risk to others.

DIF: Cognitive Level: Application REF: p. 25 OBJ: 10
TOP: Preventing the Transmission of Infection
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

19. Because the child in isolation is not permitted to go to the playroom, the nurse explains that toys that are:
a. Brought from the playroom will have to be thrown away
b. Washable can be brought from the playroom and later disinfected
c. From the playroom must be sealed in a plastic bag
d. For the child's use must be brought from home

ANS: B
The child can have toys when in isolation, but they must be washable. Children do not have to bring their own toys to play.

DIF: Cognitive Level: Application REF: p. 25 OBJ: 10
TOP: Preventing the Transmission of Infection
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

20. The best restraint for an 8-month-old with sutures after the repair of a cleft lip would be:
a. Elbow restraint
b. Mummy restraint
c. Jacket restraint
d. No restraint at all

ANS: A
The elbow restraint is the best choice as it is useful in the prevention of the child touching the face. Mummy or jacket restraints are excessive and not particularly helpful with a facial injury.

DIF: Cognitive Level: Application REF: p. 24 OBJ: 11
TOP: Restraints KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

21. The nurse is caring for a 5-year-old who had surgery yesterday. In order to evaluate the degree of pain the child is experiencing, the nurse will:
a. Expect the child to complain if she is in pain

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b. Observe for verbal and nonverbal cues that the child is in pain
c. Give pain medication if the child is crying
d. Ask the child to rate her pain on a scale of 1 to 10

ANS: B
Children do not always complain if they are in pain. They are frightened by the events and their surroundings. The nurse should evaluate for both verbal and nonverbal cues of pain. Children may not always cry if they are in pain. Conversely, they may be crying for another reason. Children at this age cannot rate their pain in this way. The nurse would use a pictorial pain scale.

DIF: Cognitive Level: Analysis REF: p. 28 OBJ: 12
TOP: The Child in Pain KEY: Nursing Process Step: Assessment
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

22. The nurse assesses an 8-month-old who had abdominal surgery yesterday as showing an occasional grimace, is kicking legs constantly, is squirming and tense, moans and whimpers occasionally, and is difficult to console. Using the FLACC scale, the nurse would document a score of:
a. 4
b. 5
c. 6
d. 7

ANS: D
RAT: Occasional grimacing = 1, kicking = 2, squirming and tense = 1, occasional moaning = 1, difficult to console = 2. This is a total score of 7.

DIF: Cognitive Level: Application REF: p. 29 OBJ: 11
TOP: Pain Assessment (FLACC) KEY: Nursing Process Step: Assessment
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

23. The nurse who is admitting a child with severe asthma is alarmed when the parents confess that they have been giving the child Echinacea because this herbal remedy may cause:
a. Severe headache
b. Increased asthma
c. Increased blood pressure
d. Liver inflammation

ANS: B
The herbal remedy Echinacea may cause increased asthma or anaphylaxis.

DIF: Cognitive Level: Application REF: p. 17 OBJ: 6
TOP: Alternative Remedies KEY: Nursing Process Step: Assessment
MSC: NCLEX: Physiological Integrity: Pharmacological Therapies

COMPLETION

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1. The nurse recommends a method for children to act out situations that are part of their hospital experience through __________.

   ANS:
   Dramatic play
   Dramatic play allows small children to work through emotions and stressors that they may not be able to verbalize.

   DIF: Cognitive Level: Knowledge REF: p. 13 OBJ: 4
   TOP: The Child's Reaction to Hospitalization
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

2. The nurse takes into consideration that a Mexican-American family may seek the advice of a __________ , a folk healer, for treatment or herbal remedies.

   ANS:
   Curandero
   The curandero is used by the Hispanic community as a folk healer or spiritual healer.

   DIF: Cognitive Level: Comprehension REF: p. 19 OBJ: 5
   TOP: Curandero KEY: Nursing Process Step: Planning
   MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

MULTIPLE RESPONSE

1. The role of the school nurse has been expanded to include such services as: *(Select all that apply.)*
   a. Provision of health counseling
   b. Student advocate
   c. Administration of selected immunizations
   d. Health screenings
   e. Complete physical examinations (system review)

   ANS: A, B, C, D
   School nurses may provide health counseling and education and health screenings, and act as student advocate.

   DIF: Cognitive Level: Comprehension REF: p. 9 OBJ: 2
   TOP: Duties of the School Nurse KEY: Nursing Process Step: N/A
   MSC: NCLEX: N/A

2. The school nurse recommends to a family that they consider the use of an outpatient clinic for the upcoming tonsillectomy of their child because the advantages of this service are: *(Select all that apply.)*

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a. Reduction of risk of infection
b. Less stress to the child
c. Reduced cost
d. Requires no insurance coverage
e. No prolonged separation of the child from the family

ANS: A, B, C, E
Outpatient surgery, although it may require insurance coverage, has the advantages of reduced risk of infection and reduced cost. The child is less stressed as there is no familial separation.

DIF: Cognitive Level: Comprehension REF: p. 9 OBJ: 3
TOP: Outpatient Surgery KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe, Effective Care Environment: Coordinated Care

3. The nurse who is in the role of case manager has the responsibilities of: *(Select all that apply.)*
a. Making home care arrangements
b. Performing hands-on care of the patient in the home
c. Monitoring the continuum of care
d. Managing medical care
e. Assessing the needs of the patient and family

ANS: A, C, D, E
The case manager arranges for home care by organizing medical care, assessing the needs of the patient and family, and organizing the availability of necessary equipment. The case manager does not do hands-on care.

DIF: Cognitive Level: Comprehension REF: p. 9 OBJ: 2
TOP: The Case Manager KEY: Nursing Process Step: N/A
MSC: NCLEX: Safe, Effective Care Environment: Coordinated Care

4. The family of a hospitalized 12-year-old who has been burned confides to the nurse that the patient's 6-year-old sister is distressed about where her brother has gone. They ask what might allay her fears. The nurse suggests: *(Select all that apply.)*
a. Allow the sister to visit in the hospital
b. Explain in detail about the painful surgery and necessary care
c. Encourage the sibling to send cards
d. Request that the patient call his sister on the telephone
e. Report the daily progress to the sibling

ANS: A, C, D, E
Keeping siblings informed and in touch helps to allay concerns. Telephone calls and sending of cards is helpful. Explaining in detail about the treatment may increase anxiety in a sibling.

DIF: Cognitive Level: Comprehension REF: p. 15 OBJ: 5

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TOP: Sibling Concerns KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

5. A patient in an isolation room is experiencing projectile vomiting. In order to assist this patient, the personal protective equipment that the nurse should don would be: *(Select all that apply.)*
   a. Gloves
   b. Mask
   c. Gown
   d. Protective eyewear
   e. Head cover

   ANS: A, C, D
   Standard precautions call for the use of gloves and gowns; because there is a problem with projectile vomiting, protective eyewear should be included. Head cover is not necessary.

   DIF: Cognitive Level: Comprehension REF: pp. 25-26 OBJ: 12
   TOP: Preventing the Spread of Infection KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

6. The nurse reviews nursing implementations that can help relieve the stressors of hospitalization for a child to include: *(Select all that apply.)*
   a. Providing a consistent caregiver
   b. Keeping explanations to a minimum
   c. Encouraging parents to stay with the child
   d. Discouraging play in order to keep the child calm
   e. Allowing the child to make as many choices as possible

   ANS: A, C, E
   Consistent caregivers, presence of the parent(s), and allowing as many choices as possible will relieve the stress of hospitalization. Explanations should be frequent and age-appropriate, and play should be encouraged.

   DIF: Cognitive Level: Comprehension REF: p. 15 OBJ: 4
   TOP: The Child's Reaction to Hospitalization
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Psychological Integrity: Coping and Adaptation

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