ATI PEDIATRICS PROCTORED 2019 B EXAM COMPLETE QUESTIONS AND ANSWERS WITH RATIONALES.LATEST UPDATE 2023

- **A nurse is assessing the pain level of a 3 year old toddler. Which of thefollowing assessment scales should the nurse use?**

- **FACES**
- **Numeric**
- **CRIES**
- **Visual analog✓✓✓** A. The nurse should use the FACES pain rating scale for pediatric clients who are 3 years old and older. This scale allows the toddler to pointto the face that depicts their current level of pain. The nurse can then determine the need for pain management.

- **A nurse is planning an educational program to teach parents about pro-tecting their children from sunburns. Which of the following instructions should the nurse plan to include?**

- **"allow your child to play outside during the hours between 10:00am and2:00pm."**
- **"choose a waterproof sunscreen with a minimum SPF of 15."**
- **"dress you child in loose weave polyester fabric prior to sun exposure."**
- **"reapply sunscreen every 4 hours."**✓✓✓ B. The nurse should instruct parents to apply a waterproof sunscreen with a minimum SPF of 15 for children. The parents should apply the sunscreen prior to sun exposure to reduce the risk of sunburn.

- **A nurse is performing hearing screenings for children at a communityhealth fair. Which of the following children should the nurse refer to a provider for a more extensive hearing evaluation?**

- **an 18 month old toddler who has unintelligible speech**
- **a 3 month old infant who has exaggerated startle response**
- **a 4 year old preschooler who prefers playing with others rather than alone**
- **an 8 month old infant who is not yet making babbling sounds**✓✓✓ D. The nurse should refer an infant who is not

making babbling sounds by the age of 7 months to a provider for a more extensive evaluation of hearing.

- **A nurse in an emergency department is assessing a 3 month old infant who has rotavirus and is experiencing acute vomiting and diarrhea. Which ofthe following manifestations should the nurse identify as an indication thatthe infant has moderate to severe dehydration?**

- **HR 124**
- **increased tear production**
- **sunken anterior fontanel**
- **capillary refill 2 seconds**✓✓✓ C. The nurse should recognize that a sunken anteriorfontanel is an indication of moderate to severe dehydration due to the acute loss of fluid.

- **A nurse is providing teaching to the family of a school-age child who hasjuvenile idiopathic arthrisis. Which of the following instructions should thenurse include in the teaching?**

- **"limit movement of the child's large joints"**
- **"encourage the child to perform independent self-care."**

- **"provide the child with a soft mattress for sleeping."**
- **"schedule a 2 hour daily nap for the child in the afternoon."**✓✓✓ B. The nurse should teach the family the importance of encouraging the child to performindependent self-care. This will minimize the child's pain while maximizing mobility.Encouraging and praising the child's efforts for independence will also increase their self-esteem.

- **A nurse is planning care for a school age child who has a tunneled central venous access device. Which of the following interventions should the nurseinclude in the plan?**

- **use sterile scissors to remove the dressing from the site**
- **irrigate each lumen weekly with 10 ml of 0.9% sodium chloride solutionwhen not in use**
- **access the site suing a noncoring angle needle**
- **use a semipermeable transparent depressing to cover the site**✓✓✓ D. The nurse should cover the site with a semipermeable transparent dressing to reduce the risk of infection.

- **A nurse is providing anticipatory guidance to the parent of a toddler.Whichof the following expected behavior characteristics of toddlers should the nurse include?**

- **controls impulsive feelings**
- **understands right from wrong**
- **easily separates from parents for long periods of time**
- **expresses likes and dislikes✓✓✓** D. The nurse should include that expressing likesand dislikes is an expected behavior of toddlers. This is the time in life when a toddler is developing autonomy and self-concept. They will try to assert themselvesand frequently refuse to comply. The parent should allow the child to have some

control, but also set limits for them so they learn from their behavior and learn tocontrol their actions.

- **A nurse is providing discharge teaching to the parent of a school age childwho has moderate persistent asthma. Which of the following instructions should the nurse include?**

- **"you should give your child their salmeterol inhaler every 4 hours whenthey are having an acute episode of wheezing."**
- **"you should monitor your child's weight weekly while they are receivinginhaled corticosteroids therapy."**
- **"pulmonary function tests will be performed every 12-24 months to evalu-ate how your child is responding to therapy."**
- **"when using the peak expiratory flow meter, record your child's average of three readings."**✓✓✓ C. The nurse should inform the parent that their child will need pulmonary function tests every 12 to 24 months to evaluate the presence oflung disease and how the child is responding to the current treatment regimen. As children grow, sometimes their manifestations can improve or decline, and treatment needs to change accordingly.

- **A nurse is assessing an adolescent who received a sodium polystyrene sulfonate enema. Which of the following findings indicates effectiveness ofthe medication?**

- **reports an absence of nausea and vomiting**

- **reports experiencing an onset of loose stools within 15 minutes of admin-istration**
- **serum potassium level 4.1 mEq/L**
- **blood pressure 86/52 mm Hg**✓✓✓ C. The nurse should monitor the adolescent's serum potassium level following the administration of sodium polystyrene sul- fonate. This medication is used to treat hyperkalemia by exchanging sodium ionsfor potassium ions in the intestine. Therefore, a potassium level within the expectedreference range of 3.4 to 4.7 mEq/L indicates the effectiveness of the medication.

- **A nurse is assessing an infant who has pneumonia. Which of the follow-ing findings is the priority for the nurse to report the provider?**

- **nasal flaring**
- **WBC count 11,300/mm^3**
- **diarrhea**
- **abdominal distension**✓✓✓ A. When using the airway, breathing, and circulation

approach to client care, the nurse should determine that the priority finding to reportto the provider is nasal flaring. Nasal flaring indicates the infant is experiencing acute respiratory distress.

- **A nurse is providing discharge teaching to the guardian of a school age child who has undergone a tonsillectomy. Which of the following statements by the guardian indicates an understanding the teaching?**
- **"my child can resume usual activities since this year just an outpatientsurgery."**
- **"my child will be able to drink the chocolate milkshake I promised to getfor them tonight."**
- **"I will notify the doctor if I notice that my child is swallowing frequently."**
- **"I will have my child gargle with warm salt water to relieve their sore throat."**✓✓✓ C. The nurse should instruct the parent that frequent swallowing is anindication of bleeding and, if it is observed, to notify the provider immediately.

- **A nurse is discussing organ donation with the parents of a school agechild who has sustained brain death due to a bicycle crash. Which of the following actions should the nurse take first?**

- **inform the parents that written consent is required prior to organ donation**
- **provide written information to the parents about organ donation**
- **ask the provider to explain misconceptions of organ donation to theparents.**
- **explore the parents feelings and wishes regarding organ donation**✓✓✓ D. Thefirst action the nurse should take when using the nursing process is assessment.The nurse should first explore the parents' feelings and wishes regarding organ donation to assist in determining if organ donation is the right choice for the family.

- **A nurse is caring for a newly admitted school age child who has hypopi-tuitarism. Which of the following medications should the nurse expect the provider to prescribe?**

- **Desmopressin**
- **Luteinizing hormone-releasing hormone**
- **Recombinant growth hormone**
- **Levothyroxine**✓✓✓ C. Recombinant growth hormone injections are used to treat hypopituitarism, which inhibits cell

growth and results in growth failure. The nurseshould expect the provider to prescribe this treatment.

- **A nurse is providing discharge teaching to he parents of a 3 month oldinfant following a cheiloplasty. Which of the following instructions should the nurse include?**

- **"clean your baby's sutures daily with a mixture of chlorhexidine andwater."**
- **"expect your baby to swallow more than usual over the next few days."**
- **"inspect your baby's tongue for white patches using a tongue depressorevery 8 hours."**
- **"apply a thin layer of antibiotic ointment on your baby's suture line daily for the next 3 days."**✓✓✓ D. The nurse should instruct the parents to apply a thin layerof antibiotic ointment on the infant's suture line daily for 3 days and then continueto apply petroleum jelly to the area for several weeks to promote healing.

- **A nurse is caring for a school age child who has peripheral edema. Thenurse should identify that which of the following assessments should be performed to confirm peripheral edema?**