ATI PROCTORED NURSING CARE OF CHILDREN 2019 EXAM A

A nurse is creating a plan of care for a school-age child who has heart disease and has developed heart failure. Which of the following interventions should the nurse include in the plan?
Provide small, frequent meals for the child.

The metabolic rate of a child who has heart failure is high because of poor cardiac function. Therefore, the nurse should provide small, frequent meals for the child because it helps to conserve energy.
A nurse is teaching the parent of an infant who has a Pavlik harness for the treatment of developmental dysplasia of the hip. The nurse should identify that which of the following statements by the parent indicates an understanding of the teaching?
"I will place my infant's diapers under the harness straps."

To prevent soiling of the harness, the parent should apply the infant's diaper under the straps.
A nurse is planning care for a school-age child who is in the oliguric phase of acute kidney injury (AKI) and has a sodium level of 129 mEq/L. Which of the following interventions should the nurse include in the plan?
Initiate seizure precautions for the child.

A sodium level of 129 mEq/L indicates hyponatremia and places the child at increased risk for neurological deficits and seizure activity. The nurse should complete a neurologic assessment and implement seizure precautions to maintain the child's safety.
A nurse is assessing a school-age child immediately following a perforated appendix repair. Which of the following findings should the nurse expect?
Absence of peristalsis

The nurse should expect absence of peristalsis immediately following a perforated appendix repair, until the bowel resumes functioning.
A nurse is preparing an adolescent for a lumbar puncture. Which of the following actions should the nurse take?
Apply topical analgesic cream to the site 1 hr prior to the procedure.

The nurse should apply a topical analgesic to the lumbar site 1 hr prior to the procedure to decrease the adolescent's pain while the lumbar needle is inserted.
A nurse is caring for a school-age child who is receiving cefazolin via intermittent IV bolus. The child suddenly develops diffuse flushing of the skin and angioedema. After discontinuing the medication infusion, which of the following medications should the nurse administer first?
Epinephrine

This child is most likely experiencing an anaphylactic reaction to the cefazolin. According to evidence-based practice, the nurse should first administer epinephrine to

treat the anaphylaxis. Epinephrine is a beta adrenergic agonist that stimulates the heart, causes vasoconstriction of blood vessels in the skin and mucous membranes, and triggers bronchodilation in the lungs.

A nurse is teaching the parent of a preschooler about ways to prevent acute asthma attacks. Which of the following statements by the parent indicates an understanding of the teaching?

"I should keep my child indoors when I mow the yard."

The nurse should instruct the parent to keep the preschooler indoors during lawn maintenance or when the pollen count is increased. Guarding against exposure to known allergens found outdoors, such as grass, tree, and weed pollen, will decrease the frequency of the preschooler's asthma attacks.

A nurse is proving dietary teaching to the parent of a school-age child who has celiac disease. The nurse should recommend that the parent offer which of the following foods to the child?

White rice

The nurse should recommend that the parent offer white rice to the child because it is a gluten-free food. The nurse should instruct the parent that the child will remain on a lifelong gluten-free diet and the child should not consume oats, rye, barley, or wheat, and sometimes lactose deficiency can be secondary to this disease.

A nurse is reviewing the laboratory report of a school-age child who is experiencing fatigue. Which of the following findings should the nurse recognize as an indication of anemia?

Hematocrit 28%

The nurse should recognize that this hematocrit level is below the expected reference range of 32% to 44% for a school-age child. The child can exhibit fatigue, lightheadedness, tachycardia, dyspnea, and pallor due to the decreased oxygen-carrying capacity.

A nurse is preparing to collect a sample from a toddler for a sickle-turbidity test. Which of the following actions should the nurse plan to take?

Perform a finger stick.

The nurse should perform a finger stick on a toddler as a component of the sickle-turbidity test. If the test is positive, hemoglobin electrophoresis is required to distinguish between children who have the genetic trait and children who have the disease.

A nurse is assessing a school-age child who has meningitis. Which of the following findings is the priority for the nurse to report to the provider?

Petechiae on the lower extremities

The presence of a petechial or purpuric rash on a child who is ill can indicate the presence of meningococcemia. This type of rash indicates the greatest risk of serious rapid complications from sepsis and should be reported immediately to the provider.

A nurse is assessing an infant who has a ventricular septal defect. Which of the following findings should the nurse expect?

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Loud, harsh murmur

The nurse should expect to hear a loud, harsh murmur with a ventricular septal defect due to the left-to-right shunting of blood, which contributes to hypertrophy of the infant's heart muscle.

A nurse is creating a plan of care for an infant who has an epidural hematoma from a head injury. Which of the following interventions should the nurse include in the plan?
Implement seizure precautions for the infant.

An infant who has an epidural hematoma is at great risk for seizure activity. Therefore, the nurse should implement seizure precautions for the child.
A nurse is caring for an adolescent who received a kidney transplant. Which of the following findings should the nurse identify as an indication the adolescent is rejecting the kidney?
Serum creatinine 3.0 mg/dL

Creatinine is a byproduct of protein metabolism and is excreted from the body through the kidneys. An elevated serum creatinine level, therefore, can be an indication that the kidneys are not functioning. The nurse should identify that the adolescent's serum creatinine level is higher than the expected reference range of 0.4 to 1.0 mg/dL for an adolescent and can indicate rejection of the kidney.
A nurse in an emergency department is performing an admission assessment on a 2 week-old male newborn. Which of the following findings is the priority for the nurse to report to the provider?
Substernal retractions

When using the airway, breathing, and circulation approach to client care, the nurse should determine that the priority finding to report to the provider is substernal retractions. This finding indicates the newborn is experiencing increased respiratory effort, which could quickly progress to respiratory failure.
A hospice nurse is caring for a preschooler who has a terminal illness. The father tells the nurse that he cannot cope anymore and has decided to move out of the house. Which of the following statements should the nurse make?
"Let's talk about some of the ways you have handled previous stressors in your life."

This statement offers a general lead to allow the parent to express their feelings and previous actions when faced with stressful situations. It also helps the parent to focus on ways that they can cope with the current situation.
A nurse in an emergency department is caring for an adolescent who has severe abdominal pain due to appendicitis. Which of the following locations should the nurse identify as McBurney's point?
A. The nurse should identify this area of the client's abdomen as McBurney's point. This area of the right lower quadrant located about two-thirds of the way between the

umbilicus and the client's anterosuperior iliac spine is the area where a client who has appendicitis is most likely to report pain and tenderness.
A nurse is reviewing the laboratory report of a 7 year-old child who is receiving chemotherapy. Which of the following lab values should the nurse report to the provider?
Hgb 8.5 g/dL

A child receiving chemotherapy is at risk for anemia due to the chemotherapy effects on the blood-forming cells of the bone marrow. The development of anemia is diagnosed through laboratory testing of hemoglobin and hematocrit levels. The nurse should recognize that a hemoglobin level of 8.5 g/dL is below the expected reference range of 10 to 15.5 g/dL for a 7-year-old child and should be reported to the provider.
A nurse is caring for a 15 year-old client who is married and is scheduled for a surgical procedure. The client asks, "who should sign my surgical consent?" Which of the following responses should the nurse make?
"You can sign the consent form because you are married."

The nurse should inform the adolescent that marriage gives adolescents the legal right to consent to surgical procedures and sign other legal documents that they would not otherwise be able to sign due to their age.
A nurse is assessing a 4-year-old child at a well-child visit. Which of the following developmental milestones should the nurse expect to observe?
Cuts an outlined shape using scissors.

The nurse should recognize that an expected developmental milestone of a 4-year-old child is using scissors to cut out a shape.
A nurse is caring for an infant who has respiratory syncytial virus (RSV). Which of the following actions should the nurse implement for infection control?
Have a designated stethoscope in the infant's room.

The nurse should initiate droplet precautions for an infant who has RSV because the virus is spread by direct contact with respiratory secretions. Therefore, designated equipment, such as a blood pressure cuff and a stethoscope, should be placed in the infant's room.
A nurse in an emergency department is caring for a school-age child who has appendicitis and rates their abdominal pain as 7 on a scale of 0 to 10. Which of the following actions should the nurse take?
Give morphine 0.05mg/kg IV

A pain level of 7 on a scale of 0 to 10 is considered severe. The nurse should administer an analgesic medication for pain relief.
A nurse is assessing the vital signs of a 10-year-old child following a burn injury. The nurse should identify that which of the following findings in an indication of early septic shock?
Temperature 39.1° C (102.4° F)

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The nurse should identify that a temperature of 39.1° C (102.4° F) is above the expected reference range of 37° to 37.5° C (98.6° to 99.5° F) for a 10-year-old child.
The nurse should expect a child who has early septic shock to have a fever and chills.
A school nurse is assessing an adolescent who has multiple burns in various stages of healing. Which of the following behaviors should the nurse identify as a possible indication of physical abuse?
Denies discomfort during assessment of injuries.

The nurse should suspect child maltreatment in the form of physical abuse if the adolescent has a blunted response to painful stimuli or injury.
A nurse is caring for a 15 year-old client following a head injury. Which of the following findings should the nurse identify as an indication that the child is developing syndrome of inappropriate antidiuretic hormone secretion (SIADH)?
Mental confusion

A child who has a head injury can develop SIADH as a result of altered pituitary function, leading to an oversecretion of antidiuretic hormone. Oversecretion of antidiuretic hormone leads to a decrease in urine output, hyponatremia, and hypoosmolality due to overhydration. As the hyponatremia becomes more severe, mental confusion and other neurologic manifestations such as seizures can occur.
A nurse is caring for a toddler who has spastic (pyramidal) cerebral palsy. Which of the following findings should the nurse expect? (Select all that apply.)
-Ankle clonus
-Exaggerated stretch reflexes
-Contractures
A nurse in a provider's office if preparing to administer immunizations to a toddler during a well-child visit. Which of the following actions should the nurse plan to take?
Withhold the measles, mumps, and rubella (MMR) vaccine.

The nurse should recognize that an allergy to neomycin with an anaphylactic reaction is a contraindication for receiving the MMR vaccine. Clients who have a severe allergy to eggs or gelatin should not receive this vaccine.
A school nurse is assessing an adolescent who has scoliosis. Which of the following findings should the nurse expect?
A unilateral rib hump

When assessing an adolescent for scoliosis, the school nurse should expect to see a unilateral rib hump with hip flexion. This results from a lateral S- or C-shaped curvature to the thoracic spine resulting in asymmetry of the ribs, shoulders, hips, or pelvis. Scoliosis can be the result of a neuromuscular or connective tissue disorder, or it can be congenital in nature.
A nurse is caring for a preschooler whose father is going home for a few hours while another relative stays with the child. Which of the following statements should the nurse make to explain to the child when their father will return?
"Your daddy will be back after you eat."