Which client requires immediate intervention by the RN?

A. A child with cystic fibrosis who is constipated.
B. A toddler with chicken pox who is scratching,
C. A child with acute renal failure and hyperkalemia.
D. An adolescent with a migraine and photophobia.

A 7 year old male is referred to the school clinic because he fainted on the playground. His height is 3 feet, 7 inches (107.5 cm), he weighs 55 pounds (25 kilograms), and his body mass index (BMI) is 20.9. Which assessment finding is most important for the RN to address?

A. He consumed2 bottles of water in 30 minutes prior to fainting.
B. Since age 3 he has experienced exercise induced asthma.
C. Reports drinking 3-4 high calorie, carbonated beverages daily.
D. The child's father has a history of fainting when exercising.

The RN of a 6 year old girl is concerned about her child's obesity. The child's weight plots at the 75th percentile, and height at the 25th percentile. The child's body mass index (BMI) is at the 85th percentile for age and gender. Which interventions should the RN implement? (Select All That Apply)

A. Explain that the child is likely to grow into her weight.
B. Determine the child's usual physical activity pattern.
C. Obtain the child's 3- day diet history based on the mothers input.
D. Inquire as to whether or not the school has a physical education program.
E. Tell the mother that girls hit their growth spurt before boys so eating more is expected.

(B, C, and D) are correct. The child's growth parameters, particularly her BMI, indicate that she is overweight. (B and D) assess for the child's level of activity, which should be evaluated and increased if possible. (C) Provides information about the quantity and quality of the child's dietary intake, which is information that is needed to create an individualized diet teaching plan. (A) Does not consider the serious health and psychological consequences associated with childhood obesity. Girls do not hit their growth spurt before boys in preadolescence, but this child is only 6 years of age and the child's obesity should not be negated because of this growth and development expectation. (e)

A toddler with hemophilia is being discharged from the hospital. Which teaching should the RN include in the discharge instructions to the mother?

A. Apply padding on the sharp corners of the furniture.

B. Prevent the client from running inside the house.
C. Give an 81 mg tablet of aspirin for pain relief.
D. Use a soft bristle toothbrush from frequent cleaning.

The RN is examining an infant for possible cryptorchidism. Which examine technique should be used?

A. Place the infant in a side lying position to facilitate the exam.
B. Hold the penis and extract the foreskin gently.
C. Cleanse the penis with an antiseptic-soaked pad.
D. Place the infant in a warm room and use a calm approach.

An infant who has been diagnosed with a tracheoesophageal fistula (TEF). What nursing intervention is indicated for this infant prior to surgical repair?

A. Provide frequent sips of liquid.
B. Give isotonic enemas as prescribed.
C. Maintain nothing by mouth status.
D. Prepare the infant for a barium enema.

An adolescent with non- Hodgkin's lymphoma (NHL) is complaining of a sore mouth two days after beginning chemotherapy. What activity should the RN implement?

A. Encourage large meals during steroid and chemotherapy.
B. Provide lemon glycerin swabs and dilute peroxide oral rinses.
C. Recommend fluids using citrus juices and drinking with a straw.
D. Frequent use of saline oral rinses and a soft sponge toothbrush.

A child with acute laryngotracheobronchitis (croup) received epinephrine 2 hours ago in the emergency room, and now is being prepared for discharge to go home. The RN should instruct the parents to take which action if the child's uncontrolled coughing reoccurs?

A. Call for emergency transportation to the hospital.
B. Increase the fluid intake to liquefy the secretions.
C. Administer a dose of the prescribed cough medicine.
D. Sit with the child in the bathroom with hot steam.

Moist, warm air (D) promotes bronchodilation, which helps relieve spasms that cause the coughing. If the symptoms continue or worsen, the child may need to be transported to the

hospital (A). Fluids will thin the secretions (B) and cough medicine (C) may decrease cough, but neither of these interventions decrease swelling or dilate the airway to improve breathing.

The RN is performing a routine examination of a 6-month old infant at the community health clinic. Records indicate that the child weighed 3 kg at birth. The clinic uses lbs to describe weight. When assessing this child, approximately what weight, in lbs, should the RN consider to be within normal range for this child?

A. 15 to 18 lbs.
B. 12 to 15 lbs.
C. 9 to 11.5 lbs.
D. 6 to 7.5 lbs.

Birth weight should at least be double at this time.

When developing a teaching plan for an adolescent male who was recently diagnosed with Type 1 Diabetes Mellitus, the RN should instruct the client to eat a source of sugar if which symptom occurs?

A. Excessive thirst.
B. Racing pulse.
C. Profuse perspiration.
D. Seeing spots.

Tachycardia is one of the symptoms of hypoglycemia.

A breast feeding mother returns to work when her infant is 5 months old. She is having difficulty pumping enough milk to mete her infant's dietary requirements. Which suggestion should the RN provide to this mother?

A. Mix infants formula with breast milk.
B. Supplement with an iron-rich formula.
C. Introduce baby food for one meal daily.
D. Offer a follow-up transitional formula.

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

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

The RN is assessing an infant with aortic stenosis and identifies bilateral fine crackles in both lung fields. Which additional finding should the RN expect to obtain?

A. Vigorous feeding and sanitation.
B. Hemiplegia.
C. Fever.
D. Hypotension and tachycardia.

A child with possible Duchenne muscular dystrophy (MD) undergoes an electro-myelogram (EMG). Following the procedure, the child's parents tell the RN that the child is complaining of sore muscles. How should the RN respond?

A. Explain that muscle aches and pain are commonly experienced by children with this form of muscular dystrophy.
B. Advise the parents that children with chronic diseases may seek attention by reporting pain or other unpleasant symptoms.
C. Encourage the parents to monitors the child's body temperature for the next 24 hours and report a rise above 101 degree F.
D. Offer reassurance that muscle soreness following this procedure is temporary and does not indicate a problem.

During an EMG, small needles are placed in the muscles to record contractions. This can cause temporary muscle aches following the procedure (D). Muscle weakness and hypertrophy, followed by atrophy are associated with MD rather than pain (A). Muscle soreness is an expected finding following an EMG and does not indicate attention-seeking behavior (C). It is not necessary to monitor body temperature (C) following EMG.

The heart rate of a 3 year old with a congenital heart defect has steadily decreased over the last few hours, and is now at 76 beats/minutes; the previous reading 4 hours ago was 110 beats/minutes. Which additional clinical finding should be reported immediately to the healthcare provider?

A. Respiratory rate of 25 bpm.
B. Urine output of 20 mL/hr.
C. Oxygen saturation of 94%.
D. Blood pressure of 70/40

The HCP prescribes epinephrine 0.01 mg/kg IM for a child with asthma who weighs 55 lbs. The available medication is labeled, 1 mg/ml. based on the child's weight, how many mL should the RN administer?

After receiving a single fluid bolus of 20 mL/kg of NS, a child's heart rate is 140 bpm, blood pressure 70/50, and capillary refill is 6 seconds. The child is anxious and crying. Which intervention should the RN implement first?

A. Repeat the NS bolus as prescribed.
B. Allow the child to assist with caregiving.
C. Recommend age appropriate activities.
D. Encourage the caregiver to remain at bedside.

The RN should instruct the parents of an 8 year old child who has sickle cell anemia to be alert for which complaint from the child?

A. "I'm shorter than everyone else."
B. "I'm really hot and thirsty."
C. "I don't want to eat any vegetables."
D. "I have to urinate every few hours."

Parents needs to be alert to situations where dehydration may be a possibility. Symptoms such as decreased urinary output and increased thirst indicate dehydration, which precipitate a sickle cell crisis (B). (A) Is sometimes expected with children with sickle cell anemia, especially if the child experiences many crisis. Many children do not like vegetables (C). Needing to urinate every few hours is not a warning sign for a possible sickle cell crisis (D); in fact, it may indicate adequate hydration.

The RN is assessing an 8 month old who has a cough, axillary temperature of 100, and rhinorrhea. What information is most important for the RN to obtain from this child's mother?

A. Living conditions.
B. Labor and delivery history of the infant.
C. Immunization status of the infant.
D. Alcohol and drug intake of the mother.

A milder form of pertussis occurs in children who are partially immunized, so immunization status (C) Is important in planning care. In the catarrhal stage, the clinical manifestations resemble upper respiratory infection. Information on (A) is not an immediate concern, but discharge planning should include discussion of family health problems or environmental conditions that could affect the infant. (B and D) are more important in planning the care of a newborn infant, but are not significant for a child 8 months of age.

During a routine clinic visit, the RN determines the 5 year old girl's systolic blood pressure is greater than the 90th percentile. What action should the RN implement next?

A. Take the blood pressure two more times during the visit and determine the average of the three readings.
B. Measure the child's blood pressure three times during the visit and determine the highest of the readings.
C. Conduct a head to toe assessment and omit repeated blood pressures during the examination.
D. Refer the child to the HCP and schedule evaluation of blood pressure in two weeks.

A child with hemophilia arrives at the clinic with a swollen knee after falling off a bicycle. What action should the RN implement first?

A. Initiate an IV site and begin infusing normal saline.
B. Type and cross for possible transfusion.
C. Monitor the child's vital signs frequently.
D. Apply ice pack and compression dressing to knee.

Rest, Ice, Compression (D), and elevation are immediate treatments that should be implemented to reduce swelling and bleeding in the joint. Blood loss within the knee is not immediately life threatening, so further assessment is needed to determine if an infusion of normal saline (A), or a blood transfusion (B) are indicated. Baseline vitals should be obtained, but frequent vital signs (C) are not immediately indicated.

What snack is best to provide a 6 year old on prescribed bedrest while receiving treatment for osteomyelitis?

A. Milkshakes.
B. Soup broth.
C. Apple sauce.
D. Popsicle.

A young child with osteomyelitis needs high calorie/ high protein snacks to maintain adequate nutrition and promote healing, and a milkshake (A) is the best choice to meet this dietary objective. (B, C, and D) are low in protein and provide minimal calories.

An 8 year old is admitted to the emergency Department because of lower right quadrant pain, nausea, and vomiting. Which assessment of the abdomen should the RN conduct after all other assessments are complete?

A. Percussion.

B. Palpation.
C. Inspection.
D. Auscultation.

A one month old male infant is brought to the clinic by his mother who states that her son has been vomiting forcefully after each meal for the last three days. The infant is afebrile, dehydrated, and pyloric stenosis is suspected. What other findings should the RN identify that are consistent with pyloric stenosis?

A. Perianal diaper rash from persistent diarrhea.
B. Rooting, hunger, and irritability.
C. Bile-stained emesis.
D. An olive-shaped mass in the abdominal area.

A RN is evaluating a young child with atopic dermatitis. Which question should the RN ask the parent while obtaining the child's history?

A. "Does the child have any nausea or vomiting?"
B. "Has the child displayed any symptoms of asthma or hay fever?"
C. "Can any particular stress be associated with onset of rash?"
D. "What time of the day does the rash appear on the body?"

Atopic dermatitis is known to be associated with asthma and hay fever (B). There is no significant association between atopic dermatitis and gastrointestinal symptoms (A). There is no evidence that stress can cause atopic dermatitis, although stress is associated with the disease during exacerbations (C). The rash persists over a period of time, and is not associated with diurnal pattern (D).

A 3 month old with myelomeningocele and atonic bladder is catheterized every 4 hours to prevent urinary retention. The home health RN notes that the child developed episodes of sneezing, urticaria, watery eyes, and a rash in the diaper area. What action is most important for the RN to take?

A. Auscultate the lungs for respiratory pneumonia.
B. Draw blood to analyze for streptococcal infection.
C. Change to latex free gloves when handling infant.
D. Apply zinc oxide to perineum with each diaper change.

A rash with urticaria, sneezing, and watery eyes are classic symptoms of an allergic reaction. Latex allergy is a serious threat created by the repeated catheterizations using pre-packaged

gloves, so the RN should use latex free gloves (C). The skin rash and urticaria are not typical of (A or B). (D) is ineffective in treating in allergic reaction.

A 17 year old male student with cystic fibrosis talks with the school RN about his disease and wonders how it will affect getting married and having children. Which relevant information would the RN include in this discussion?

A. He should undergo cystic fibrosis screening before having children.
B. Impotence is a frequent problem for males with cystic fibrosis.
C. If the father is a carrier, 50 % chance of the offspring will have cystic fibrosis.
D. He is likely to have infertility problems and needs further evaluation.

A female of child bearing age receives a rubella vaccination. She has two children at home, age 13 months and 3 years. Which instruction s most important for the RN to provide to this client?

A. Inquire if anyone in the family is allergic for eggs.
B. Tell the mother to isolate the children for 3 days.
C. Encourage the client to immunize the children.
D. Assess the family history for incidence of rubella.

A child weighing 67 lbs receives a prescription for benztropine (Cogentin) 0.61 mg IV q12 hours. This drug is available as 1 mg/ml ampoules. How many mL should the RN administer?

0.61 ml/ dose

D/H x V= 0.61 ml/1mg x 1 mL = 0.61 mL/dose.

A 12 year old boy with leukemia is being discharged from the hospital with a white blood cell count (WBC) count of 4,000 / mm^3. He is scheduled to receive antineoplastic chemotherapy as an outpatient. What instruction should the RN include in this child's discharge plan?

A. Avoid eating at buffets, smorgasbords, and salad bars.
B. Spend time resting with family pets, but only cats and dogs.
C. Swim weekly at the neighborhood pool for neuromuscular integrity.
D. Have all visitors wear protective masks when coming to the home.

Neutropenia (WBC below 5,000 mm^3) in a pediatric client with leukemia increases the risk of infection, so it is important for the client to avoid large crowds and situations where there is an elevated risk of exposure to infection organisms, such as public eating places (A). This child should also avoid (b AND c. (D) is impractical and expensive; the child needs protection from the visitors, so it is better to have this child to wear a mask.

A 12 year old is admitted to the hospital with possible encephalitis, and a lumbar puncture is scheduled. Which information should the RN provide this child concerning the procedure?

A. Explain that fluids can't be taken for 8 hours before the procedure and for 4 hours after the procedure.
B. Tell the child to expect loud clicking noises during the procedure that may be slightly annoying.
C. Describe the side lying, knees to chest position that must be assumed during the procedure.
D. Reassure the child that there will be no restrictions on activity after the procedure is completed.

Lying still on one side with the knees to the chest (C) is the position required to conduct a lumbar puncture (LP). Encephalitis is diagnosed with LP and analysis of CSF cultures. Keeping the client NPO is not required prior to an LP, and fluids are encouraged, not restricted (A) following an LP to replace the CSF that was removed. (B) Happens when the MRI is done. Activity is restricted (D) following an LP because the child must lie flat to avoid having a spinal headache.

A 10 year old girl is diagnosed with inflammatory bowel disease (IBD). Her mother is concerned that she will experience developmental delays as the result of this disorder. How should the RN respond?

A. She will only experience developmental delays if weight loss can't be controlled.
B. Scheduling a private tutor can help to prevent developmental delays.
C. She is at high risk for a number of different problems, including developmental delays.
D. Growth failure is a concern, but developmental delays are not likely to occur.

Growth failure (D) is a unique and important problem associated with IBD in the pediatric population. Weight loss (A) is seen with IBD, but is not associated with developmental delays. (B and C) ae not associated with IBD as the age of onset typically occurs in late childhood or early adolescent.

A hospitalized child stiffens and starts to seize as the RN enters the room. What actions should the RN take? (Select All That Apply)

A. Instruct the parents to leave the room.
B. Pad side rails with available pillows and blankets.
C. Notify the emergency response team.
D. Monitor duration and progress of the seizure.
E. Turn client to the side if possible.

(B, D, and E) are correct. Prevention of injury is the top priority when the client seizes, and passing rails (B) helps prevent injuries during a seizure. (D) Provides valuable information about

the seizure, which can help with diagnoses and treatment. Maintaining an open airway is essential, and turning the client to the side (E) helps prevent aspiration. The parents should be allowed to stay with the child (A). Calling the emergency response team (C) is not indicated.

How should the RN respond to the concerned parents of a 15 month old who is not yet able to self-feed with a spoon?

A. Tell parents to guide the child's hand when using a spoon.
B. Suggest using foods that can be eaten with fingers.
C. Discuss possible causes for delay with self-feeding.
D. Encourage longer mealtimes to practice eating with a spoon.

By 18 months of age, most toddlers have achieved the developmental milestone of bringing a spoon to their mouth without turning it over. Finger food (B) are appropriate for a 15 month old child's motor skills and allow independence, a psychosocial developmental task of the toddler. Guiding the child's hand (A) does not help to improve this motor skill and usually frustrates the toddler who wants to do things for themselves. (C) Might be recommended if the child's developmentally delayed. Longer mealtimes only lengthen the time the child sits at the table (D) and do not contribute to development of this motor skill.

During a well child visit for their child, one of the parents who have an autosomal dominant disorder tells the RN, "We don't plan on having any more children, the next child is likely to inherit this disorder." How should the RN respond?

A. Explain that the risk of inheriting the disorder decreases by 50% with each child the couple has.
B. Encourage the couple to reconsider their decision since the inheritance pattern may be sex linked.
C. Confirm that there is a 50% chance of their future child inheriting this disorder.
D. Acknowledging that the next child will inherit the disorder since the first child did not.

A child who has been vomiting for the past 3 days is admitted for correction of fluid and electrolyte imbalances. What acid based imbalance is this child likely to exhibit?

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

Metabolic acidosis (B) results from repeated vomiting and loss of gastric hydrochloric acid, which depletes the concentration of H ions and raises the plasma ph. (A and C) are respiratory