2023-2024/PEDSATI PROCTORED FINAL EXAM TEST BANK 200 QUESTIONS AND CORRECT ANSWERS WITH RATIONALES|AGRADE

The nurse is preparing to administer an immunization to a four-year-old child. Which of the following actions should the nurse plan to take?

A- Place the child in a prone position for the immunization

B- request that the child's caregiver leave the room during the immunization

C- administer the immunization using a 24-gauge needle

D- inject the immunization slowly after aspirating for 3 seconds

Answer - c

The nurse should administer an immunization for a 4-year-old child using a 24-gauge needle to minimize the amount of pain experienced by the toddler.

A- The nurse should place the child in an upright sitting position for the immunization because this decreases the child's fear and anxiety.

B- The nurse should allow the caregiver to stay near the child during the immunization to provide a sense of security and reduce the child's anxiety level.D- The nurse should inject the immunization rapidly and avoid aspiration.

These actions decrease the risk of needle displacement and lower the child's fear and anxiety level by decreasing the amount of time it takes to administer the immunization.

A nurse is reviewing the laboratory report of an infant who is receiving treatment for severe dehydration. The nurse should identify which of the following laboratory values indicates effectiveness of the current treatment?

A- Potassium 2.9 mEq/L

B- sodium 140

C- urine specific gravity 1.035

D- BUN 25 mg

Answer- b

The nurse should identify that a sodium level of 140 mEq/L is within the expected reference range and indicates the current treatment regimen the infant is receiving for dehydration is effective.

A- A potassium level of 2.9 mEq/L is below the expected reference range and indicates hypokalemia.

C- A urine specific gravity of 1.035 is above the expected reference range and indicatesconcentrated urine.

D- A BUN level of 25 mg/dL is above the expected reference range and indicates the kidneys arenot excreting BUN as they should be.

The nurse is providing teaching about Social Development to the parents of a preschooler. Which of the following play activities should the nurse recommendfor the child?

A- Play pat-a-cake

B- using a push pull toy

C- creating a scrapbook

D- playing dress-up

Answer - d

The nurse should instruct the parents that at the preschool age, play should focus on social, mental, and physical development. Therefore, playing dress-up is a recommended play activity for this child.

A- Playing pat-a-cake is a recommended play activity for an infant.

B- Using a push pull toy is a recommended play activity for a toddler.

C- Creating a scrapbook is a recommended play activity for a school-age child.

A nurse is teaching the parents of a newborn about ways to prevent sudden infant death syndrome SIDS. Which of the following instructions should the nurse include?

A- Place the infant in a prone position to sleep.

B- Allow the infant to sleep on a large pillow.

C- User soft mattress in the infant's crib.

D- Give the infant a pacifier at bedtime.

Answer- d

The nurse should inform the parent that protective factors against SIDS include breastfeeding and the use of a pacifier when the infant is sleeping.
A- The nurse should instruct the parent to place the infant in a supine position to sleep. Prone and side-lying positions are risk factors for SIDS.
B- Placing the infant on a large pillow to sleep can increase the risk of suffocation, asphyxiation, and SIDS.

C- The nurse should instruct the parent to use a firm mattress and avoid the use of waterbeds, beanbags, or soft mattresses when placing the infant to bed. The use of asoft mattress in the infant's crib is a risk factor for SIDS and can lead to asphyxiation.

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

A- Nasal flaring

B- WBC 11,300

C- diarrhea

D- abdominal distension

Answer- a

When using the airway, breathing, circulation approach to client care, the nurse should place the priority on nasal flaring. **Nasal flaring indicates that the infantis experiencing acute respiratory distress.**
B- The nurse should report a WBC of 11,300/mm3 because it is above the expected reference range and indicates infection. However, another finding is

the priority for the nurse to report. C- The nurse should report diarrhea because it is a manifestation of pneumonia in infants and indicates the current treatment is not effective. However, another finding is the priority for thenurse to report. D- The nurse should report abdominal distension because it is a manifestation of pneumonia ininfants and indicates the current treatment is not effective. However, another finding is the priority for the nurse to report.

A school nurse is assessing a school-age child blood pressure while he is seated in a chair. The child starts to experience a tonic-clonic seizure. Which of the following actions should the nurse take first?

A- Clear the immediate area around the child of hazardous objects

B- loosen the child restrictive clothing

C- assist the child to a side-lying position on the floor

D- apply an oxygen mask to the child

Answer- c

The greatest risk to this child is **aspiration, occlusion of the airway, and bodily injury from falling out of the chair.** The nurse should ease the child down to floor in a side-lying position immediately. This position enables the child's secretions to drain from the mouth, preventing aspiration, and maintaining a patentairway.

A- The nurse should clear the area around the child of hazardous objects. However, this is not the first action the nurse should take.

B- The nurse should loosen the child's restrictive clothing. However, this is not the first action the nurse should take.

D- The nurse should apply an oxygen mask to the child to prevent hypoxia. However, this is not the first action the nurse should take.

A nurse is preparing to administer ibuprofen 5 mg per kg every 6 hours PRN for temperatures above 38.0 degrees Celsius or 100.5 degrees Fahrenheit to an infant who weighs 17.6 lb. The infant has a temperature of 38.4 degrees Celsius or 100 + 1.2 degrees Fahrenheit. Available is ibuprofen liquid 100mg/ 5 ml. how many milliliters should the nurse administer to the infant per dose? Round the answer to the nearest whole number. Use a leading zero if it applies.

Answer: 2 mL

A nurse is receiving change-of-shift Report on for children. Which of the following children should the nurse assesses first?

A- A toddler who has a concussion and an episode of forceful vomiting

B- an adolescent who has infective endocarditis and reports having a headache

C- an adolescent who was placed into Halo traction 1 hour ago and rates his pain at a 6 on a 0-10 scale

D- school-age child who has acute glomerulonephritis and brown colored urine

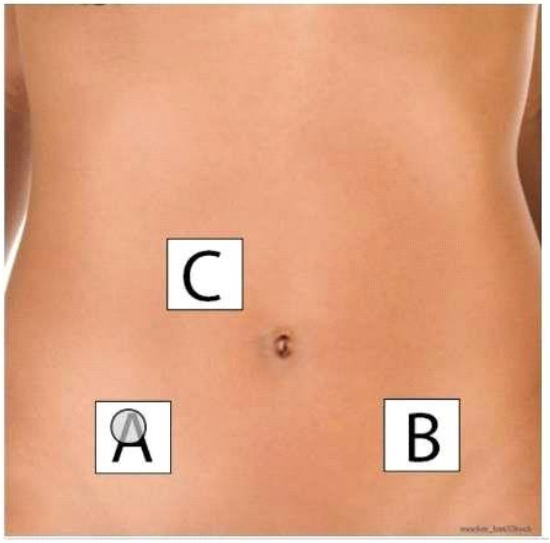
Answer- a

When using the urgent vs. no urgent approach to client care, the nurse should assess this child first. An episode of forceful vomiting is an indication of increased intracranial pressure in a toddler who has a concussion.

B- A report of a headache is no urgent because it is an expected finding for a child who has infective endocarditis; therefore, the nurse should assess another child first.C- A report of moderate pain is no urgent because it is an expected finding for a child who has a new halo traction device; therefore, the nurse should assess another child first.

D- Brown-colored urine is no urgent because it is an expected finding for a school-age child who has acute glomerulonephritis; therefore, the nurse shouldassess another child first.

A nurse in the emergency department is caring for an adolescent who has severe abdominal pain due to appendicitis. Which of the following locationsshould the nurse identify as mcburney's point?



Answer: a

A is correct. The nurse should identify the lower right quadrant of the abdomen between the umbilicus and the anterior iliac crest as the location of **Burney's point**.

B is incorrect. The nurse should not identify the left lower quadrant as the location ofMcBurney's point.
C is incorrect. The nurse should not identify the right upper quadrant as the location ofMcBurney's point.

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

A- Limit the movement of the child large joints.

B- Encourage the child to perform independent self-care.

C- Provide the child with a soft mattress for sleeping.

D- Schedule a 2-hour daily nap for the child in the afternoon.

Answer- b

The nurse should teach the family the importance of encouraging the child to perform independent self-care. This will minimize the child's pain while maximizing mobility.
Encouraging and praising the child's efforts for independence will also increase his self-esteem.

A- Large joints should be exercised regularly to maintain mobility and strengthen muscles.
C- Children who have juvenile idiopathic arthritis should sleep on a firm mattress to enhance comfort and rest. A soft mattress can increase pressure to the affected joints and increase the child's pain.
D- Daytime naps are discouraged because stiffness can occur quickly and easily with inactivity, and naps can interfere with nighttime sleeping.

A nurse is assessing a client who has a new diagnosis of celiac disease. Which of the following clinical manifestations should the nurse expect?
A- Steatorrhea
B- projectile vomiting
C- sunken abdomen
D- weight gain

Answer- a

The nurse should realize that clients who have celiac disease are unable to digest gluten. This will cause damage to the cells in the bowel, leading to malabsorption,steatorrhea, and diarrhea.
B- Clients who have **pyloric stenosis** will exhibit projectile vomiting rather than celiac disease.

C- A distended abdomen, rather than a sunken abdomen, is a manifestation of celiac disease.
D- Weight loss, rather than weight gain, is a manifestation of celiac disease.

A nurse is providing teaching to an adolescent about how to manage tinea pedis. Which of the following statements by the Adolescent indicates an understanding of the teaching?
A- I should buy some plastic shoes to wear at the swimming pool
B- I should wear sandals as much as possible
C- I should place the permethrin cream between my toes twice-daily

D- I should I seal my non washable shoes in plastic bags for a couple of weeks

Answer- a

The use of plastic shoes increases the occurrence of tinea pedis. The nurse should instruct the adolescent to avoid wearing plastic shoes.
B- Sandals allow air to circulate around the feet, decreasing perspiration and eliminating the medium for bacteria and fungus to grow. The nurse should inform the adolescent that wearing sandals, open-toed, or well-ventilated shoes will promote healing of his fungal infection.
C- Permethrin 5% cream is a scabicide used to place on the lesions created by scabies. This treatment is not recommended for tinea pedis.
D- Sealing non-washable items in plastic bags for 14 days is a recommended practice for clients who have pediculosis. This practice is not recommended for tineapedis.

Teaching the parents of a school-aged child who has a new diagnosis of osteomyelitis of the tibia. The nurse should identify that which of the followingstatements by the parents indicates an understanding of the teaching?

my child will have a cast until healing is complete.

My child will receive antibiotics for several weeks.

My child can return to playing sports once he is discharged. My child needs to be in contact isolation.

Answer: b

The nurse should instruct the parent that the child will receive antibiotic therapy for at least 4weeks. Surgery might be indicated if the antibiotics are not successful.
A - incorrect

Weight bearing must be avoided with osteomyelitis. Therefore, the child is placed in comfortable position with the limb supported. There is no indication for a cast.
C- incorrect

Weight bearing should be avoided to prevent complications and minimize pain. Therefore, it will be several weeks to months before the child can play contact sports.
D- incorrect
Contact isolation is NOT necessary, because osteomyelitis is not a communicable illness.

A nurse is auscultating the lungs of an adolescent who has asthma. The nurse should identify the sound as which of the following? Click the audio button tolisten.
A- Biots respiration
B- Chaney Stokes respiration
C- **tackypnea**
D - Bradypnea

Answer- c

The nurse should identify the sound heard during auscultation as tachypnea, which is a rapid, regular breathing pattern. This breathing pattern often occurs with anxiety, fever, metabolic acidosis, or severe anemia.
A- **Biot's respirations** are periods of apnea alternating with two or three shallow breaths.
B- **Cheyne-Stokes respirations** are periods of apnea alternating with periods of hyperventilation.
D- Bradypnea is a slow, regular breathing pattern.

A nurse in an emergency department is caring for a school-age child who is experiencing an anaphylactic reaction. Which of the following is the priorityaction by the nurse?
A- Elevate the head of the child's bed
B- insert a large-bore IV catheter for the child
C- determine the allergen that caused the child's reaction
D- administer IM epinephrine to the

child Answer- d

When using the urgent vs no urgent approach to client care, the nurse determinesthat the priority action is administering IM epinephrine to the child. During an anaphylactic reaction, histamine release causes bronchoconstriction and vasodilation. This is an emergency becauseultimately it causes decreased blood return to the heart.
A- Elevating the head of the child's bed is important to facilitate breathing and circulation. However, it is not the priority action the nurse should take.
B- Inserting a large bore IV catheter is important to facilitate administration of IV fluids and medications. However, it is not the priority action the nurse should take.C- Determining the allergen that caused the child's reaction is important to preventany additional episodes of anaphylaxis. However, it is not the priority action the nurse should take.

A nurse at an urgent care clinic is assessing an adolescent client who has an upper respiratory tract infection. Which of the following findings should the nurse recognize as a manifestation of pertussis?

A- Inflamed throat with exudate

B- purulent eye drainage

C- dry, hacking cough

D- koplik spots on buccal mucosa

Answer- c
The nurse should recognize that a dry, hacking cough is a manifestation of **pertussis**. This disease usually begins with indications of an upper respiratory tract infection, which includes a dry, hacking cough that is sometimes more severeat night.

A- An **inflamed throat with exudate** is a manifestation of **acute streptococcal pharyngitis**.
B- Purulent eye drainage is a manifestation of bacterial **conjunctivitis**.
D- Koplik spots on buccal mucosa are a manifestation of **rubeola (measles).**

A nurse is providing teaching about car seat use to the mother of a six-month- old infant. Which of the following statements by the mother indicates an understanding of the teaching?A- I should secure the car seat using lower anchors and tethers instead of the seat belt