a nurse is planning care for a child who has **severe diarrhea**. which of the following actions is the nurse **priority**?

A. Introduce a regular diet
B. Rehydrate
C. Maintain fluid therapy
D. Assess fluid balance
   (Assess first the other three are interventions, before u intervene you have to assess how much fluid imbalance. Check for labs results because it will tell you what kind of fluid is to be given and how much fluid to be replaced. Priority is assessment first)

A nurse is caring for a toddler who's parent states that the child has a **mass in his abdominal** area and his **urine is a pink color.** Which of the following actions is the nurse's **priority**?

A. Schedule the child for an abdominal ultrasound
B. Instruct the parent to avoid pressing on the abdominal area
C. Determine if the child is having pain
D. Obtain a urine specimen for a urinalysis

A nurse is caring for a child who has **acute glomerulonephritis.** Which of the following actions is the nurse's **priority**?

A. Place the child on a no salt added diet
B. Check the Childs weight daily
C. Educate the parents about potential complications
D. Maintain a saline lock (IV access that is attached to any fluids. For emergency)

(inflammation of the kidneys caused by group A beta hemolytic streptococcus, infection. Fluid or fluid retention. Patient with kidney problems affect blood pressure -> High blood pressure because of fluid retention. Salt increases high blood pressure. Lower the salt intake of this patient)

A nurse is caring for a child who has a suspected diagnosis of **bacterial meningitis**. Which of the following is the nurse's priority?

A. Administer antibiotics when available
B. Reduce environmental stimuli (because of increase of ICP and can cause seizures)
C. Document intake and output

D. Maintain seizure precautions

A nurse is collecting data from an **adolescent**. Which of the following represents the **greatest risk for suicide?**

A. Availability of firearms
B. Family conflict
C. Homosexuality
D. Active psychiatric disorder (Mark, mental problems, patients mind is unstable)

A nurse is collecting data from an **infant** who has **otitis media (middle ear infection)**. The nurse should expect which of the following findings?

A. Tugging on the affected ear lobe
B. Bluish green discharge from the ear canal (there's usually no discharge, discharge only comes out if there's opening in the ear drum)
C. Increase in appetite (decrease in appetite)
D. Erythema and edema of the affected auricle (usually no redness in the affected auricle)

(otitis externa: infection of the outer ear)

A nurse is reinforcing reaching with a parent of a 1 month old infant who is to undergo the initial surgery to treat **Hirschsprung's disease** (**a ganglionic megacolon, part of the colon isn't connected to the nerves or not functioning, so there will be an increase size of the colon and stool gets stuck in there**). Which of the following statements should indicate to the nurse that the parent understanding the goal of surgery?

A. "I'm glad that the ostomy is only temporary " (1st there going to cut the nonfunctioning of the colon, and then apply temporary colostomy, after a couple of months they will suture it together)
B. "I'm glad my child will have normal bowel movements now"
C. "I want to learn how to use the feeding tube as soon as possible"
D. "the operation will straighten out the kink in the intestine"

A nurse is caring for an infant who is 1 day postoperative following surgical repair of a cleft lip. Which of the following actions should the nurse take?

A. Apply an antibiotic ointment to the suture site
B. Clear oral secretions using a bulb syringe

C. Feed the infant using a spoon
D. Position the infant on her abdomen

A nurse is reinforcing discharge instructions with a parent of a child who has cystic fibrosis. Which of the following statements by the parent indicates an understanding of the teaching?

A. “I will make sure my child washes her hands before eating”
B. “I will restrict the amount of salt in my child’s meal”
C. “I will put my child in daycare to ensure that she socializes with other children”
D. “I will provide low fat meals for my child

A nurse working at a clinic speaks on the telephone with a parent of a 2-month-old infant. The parent tells the nurse that the infant has projectile vomiting followed by hunger after meals. Which of the following response by the nurse is appropriate?

A. “Bring your infant into the clinic today to be seen”
B. “Burp your child more frequently during feedings”
C. “Give your infant an oral rehydrating solution”
D. “You might want to try switching to different formula”

A nurse is caring for a 4 year old child who is 2 days postoperative following the insertion of a ventriculoperitoneal shunt. Which of the following findings should the nurse identify as the priority . (causes icp hydrocephalus)

A. lethargy (high pitched cry, respiratory changes, bradycardia, wide pulse pressure, irritability)
B. lying flat on the unaffected side
C. respiratory rate 20/min
D. urine output 50 mL in 2hr

a nurse is caring for a child following an open reduction and internal fixation of a fractured femur and application of a cast. The cast has a window cut in it for viewing of the incision. Which of the following actions should the nurse take first?

A. Remove the window and view the incision
B. Turn the client so the cast will dry on all sides
C. Medicate the client for pain

D. Perform neurovascular checks of the affected extremity (check for infection, color, capillary refill, redness)

A nurse is an urgent care clinic is assisting with the care of a toddler who ingested 30 tablets of aspirin. Which of the following substances should the nurse administer to the toddler?

A. Activated charcoal (can work with toxin, poison. Given through ng tube absorbs toxins)
B. Acetylcysteine (antidote for acetaminophen)
C. A chelating agent (usually used for iron)
D. Digoxin immune FAB

A nurse is caring for a 3 year old client who has persistent otitis media. To help identify contributing factors, the nurse should ask the parents which of the following questions?

A. Has your daughter been drinking 6 glasses of water a day
B. Does anyone smoke in the same house as your daughter? (smoking can cause irritation, cause mucus in respiratory and causes otitis media?) (otitis media is purulent color)
C. Does your daughter get water in her ears when you bathe her? (otitis externa, bluish green color)
D. Has your daughter had a lot of earwax in her ears over the last month?

A nurse is collecting data from a 2 year old toddler who has AIDS. The nurse should inspect inside the toddler mouth for which of the following opportunistic infections (fungus infections is usually opportunistic infections)?

A. Candidiasis (also called oral thrush)
B. Gingivitis
C. Canker sores
D. Koplik spots (measles, rubella)

A nurse is caring for a 4 year old child who has dehydration. Which of the following findings should the nurse identify as the priority?

A. Blood glucose 110 mg/dL
B. Potassium 2.5 mEq/L
C. Sodium 142 mEq/L
D. Urine specific gravity 1.025

A nurse is caring for a child who Is postoperative following the insertion of a ventriculorperitoneal shunt. The nurse should place the child in which of the following positions?

A. On the nonoperative side
B. A 45 deg head elevation
C. Prone
D. Supine

A nurse is caring for an infant who is dehydrated and requires IV therapy. The nurse should monitor the infant response to therapy by performing which of the following actions?

A. weighing the infants at the same time everyday
B. Taking the infants vital signs every 2 hr.
C. Measuring the infants head circumference twice per day
D. Counting the number of wet diapers every shift

A nurse is caring for a preschool age child who has croup. Which of the following findings should the nurse report to the provider?

A. Barky cough
B. Paroxysmal attacks of laryngeal spasm at night
C. Hoarseness
D. Drooling (that could mean it can mean there's an epiglottitis causes obstruction of the airway)

A nurse is collecting data from an infant who has hypertrophic pyloric stenosis. Which of the following findings should the nurse expect?

A. Projectile vomiting
B. Bile colored vomit
C. Absent bowel sounds
D. Fever

A school nurse is screening an 11-year-old child for idiopathic scoliosis. Which of the following instructions should the nurse give the child for this examination?

A. Lie prone on the examination table
B. Touch your chin to your chest and then look up at the ceiling
C. Turn to the side and remain in a relaxed position

D. Bend forward from the waist with your head and arms downward

A nurse is collecting data from an infact. Which of the following sites is the most reliable location to check the infats pulse ?

A. Carotid
B. Apical
C. Dorsalis pedis
D. Temporal

A nurse is reinforcing teaching with a parent of a child who has eczema. Which of th following instructions should the nurse include in the teaching

A. Apply a cool wet compress to the affected area
B. Launder clothing with fabric softener
C. Give bubble baths every day
D. Use a wool gloves in the winter time

A nurse is caring for a child who has juvenile rheumatoid arthritis. Which of the following actions should the nurse take?

A. Administer opioids on a schedule (Nsaids)
B. Encourage the child to take daytime naps
C. Apply cool compresses for 20 mins every hour
D. Maintain night splints to the affected joint

A nurse is reinforcing teaching with a parent of an 8-year-old child who has a fracture of the epiphyseal plate. Which of the following statements should the nurse include in the teaching.

A. Fractures in a child take longer to heal than fractures in an adult
B. Normal bone growth can be affected by the fracture
C. Bone marrow can be lost through the fracture
D. Your child will need to increase his calcium intake to 3,000 milligrams daily

A nurse is collecting data from an 8 month old infant who has increased intracranial pressure (ICP) which of the following manifestations should the nurse expect?

A. Insomnia (tired sleepy)

B. Bulging fontanel
C. Low pitched cry (high pitched)
D. Positive babinski reflex

A nurse is caring for a school age child who has a fracture to the right femur. Which of the following findings is the nurse priority?

A. 2+ right pedal pulse
B. respiratory rate 24/min
C. capillary refill less than 2 seconds
D. tingling in the right foot

A nurse is caring for a child who has atopic dermatitis. Which of the following findings should the nurse expect?

A. Nonpruritic erythematous papulse
B. Rash with thick skin
C. Maculopapular lesions between fingers and toes
D. Inflamed area with white exudate

A nurse is assisting with the care of a school age child who has respiratory failure due to pneumonia. Which of the following positons should the nurse encourage to allow maximal lung expansions?

A. Prone
B. Supine
C. Side lying
D. Upright (orthopnic positon, semi fowler, high fowler)

A nurse in a provider's office is reinforcing teaching with a parent of a school age child who has pediculosis capitis. Which of the following instructions should the nurse include in the teaching?

A. Wash all bed linens and dry them in a dryer for at least 20 min
B. Apply permethrin cream twice daily
C. Apply an antifungal treatment ointment once every day
D. Ensure that family pets are treated within 10 days

A nurse is reinforcing teaching with the mother of an infant who has oral candidiasis and is breastfeeding which of the following instructions should the nurse include in the teaching?

A. Wash hands prior to each breastfeeding
B. Swab the infants mouth with salt water twice daily
C. Change to formula feeding with a bottle
D. Hand wash pacifier in warm soapy water each day

A nurse is caring for a school age child who has mild persistent asthma. Which of the following findings should the nurse expect? (select all the apply)
A. Symptoms are continual throughout the day
B. Daytime symtoms occur more than twice per week
C. Nighttime symptoms occur approximately twice per month
D. Minor limitations occur with normal activity
E. Peak expiratory fow (PEF) is greater than or equal to 80% of the predicted value

A nurse is collecting data from a child who has acute appendicitis. Which of the following findings should the nurse expect?
A. WBC 17,000/mm3
B. Left lower quadrant abdominal pain
C. Hyperactive bowel sounds
D. Bradycardia (tachycardia)

A nurse is caring for a toddler who has a cast applied 2 hr ago due to multiple fractures of the right hand of the following findings should the nurse report immediately to the charge nurse?
A. The fingers on the right hand have a capillary refill of 4 seconds
B. The fingertips of the right hand are swollen and bruised
C. The child is not attempting to move her right arm or fingers
D. The parents report the child will not keep the arm elevated on the pillow

A nurse is collecting data from a 3-year-old child who has acute diarrhea and dehydration. Which of the following findings indicates that oral rehydration therapy has been effective?
A. Heart rate 130/min
B. respiratory 24/min
C. urine specific gravity 1.015 (1.010-1.015) higher urine specific gravity is dehydration

D. Capillary refill greater than 3 seconds

A nrse is caring for a school age child who has a new plaster cast on her right arm. Which of the following actions should the nurse take?

A. Position the casted arm in a dependent position (worsen the edema. Elevate it so there wont be edema, elevate it on a pillow)
B. Place a warm moist heat pack on the cast
C. Administer diphenhydramine to relieve itching
D. Move the casted arm with a firm grip

A nurse is caring for a child who is to receive percussion, vibration, and postural drainage. Which of the following actions should the nurse take first?

A. Administer albuterol by nebulizer (open the airway, and loosen the secretions it will be more effective to loosen it up)
B. Percuss the upper posterior chest
C. Perform vibration while the client exhales slowly through the nose
D. Instruct the client to cough

A nurse is caring for an infant who has spina bifida. Which of the following actions should the nurse take?

A. Feed the infant through an BG tube
B. Place the infant in prone position
C. Cover the infants lesion with a dry cloth (cover infant with moist sterile cloth)
D. Perform range of motion exercises to the infant's hips

A nurse is planning care for a child who has epiglottitis. Which of the following actions should the nurse plan to take?

A. Obtain a throat culture
B. prepare the child for a neck radiograph
C. initiate airborne precaution (droplet)
D. visualize the epiglottitis using a tongue depressor (it can stimulate spasm and cause airway obstruction)

(manifestation of epiglottitis the patient has drooling)

A nurse is caring for a child who is experiencing a seizure. Which of the following

Actions should the nurse take?

A. Elevate the childs legs on a pillow
B. Restrain the childs arm
C. Insert a padded tongue blade into the child's mouth
D. Place the child in a side lying position(for aspiration)

A nurse is caring for an infant who has gastroesophageal reflux. The nurse should place the infant in which of the following positions after feeding?

A. Prone (fundamentals)
B. Upright (ATI)
C. Left side
D. Right side

A nurse is contributing to the plan of care for a 2month old infant who has just undergone cleft palate repair. The nurse should contribute which of the following interventions to the clients plan of care?

A. Feed the infant half strength formula for the first 48 hr. (NPO, start with clear liquids not half strength formula)
B. Remove elbow restraints while the infant is sleeping (do not remove the restraint unattended because when they sleep they can still touch the operative site, u can remove it for a short period of time to just monitor)
C. Keep the infant in a side lying position
D. Administer pain medication PRN for the first 48 hr. (it should not be PRN it should be scheduled)

A nurse is receiving hand off report for a toddler who has a fractured right femur and is in **90 degree /90 degree traction**. The nurse should expect to observe which of the following?

A. Skin straps maintaining the affected leg in an extended positon
B. A skeletal pin in the distal end of the femur
C. A padded sling under the knee of the affected leg
D. The buttocks elevated slightly off of the bed

A nurse is caring for a child who is having a tonic clonic seizure and vomiting. Which of th following action the nurse priority

A. Place a pillow under the childs head