Silvestri: Saunders Comprehensive Review for the NCLEX-RN® Examination, 6th Edition

Child Health

Test Bank

MULTIPLE CHOICE

1. The nurse is caring for an infant with a diagnosis of hydrocephalus and is monitoring the infant for signs of increased intracranial pressure (ICP). The nurse suspects increased ICP if which of the following is noted?
   1. Proteinuria
   2. Bradycardia
   3. A drop in blood pressure
   4. A bulging anterior fontanel

   ANS: 4

   Rationale: An elevated or bulging anterior fontanel indicates an increase in cerebrospinal fluid collection in the cerebral ventricle. Proteinuria, bradycardia, and a drop in blood pressure are not specific signs of increased ICP. Changes in the level of consciousness and a widened pulse pressure are additional signs of increased ICP.

   Test-Taking Strategy: Use the principles associated with excessive fluid buildup in the cranial cavity when answering the question. Fluid accumulation in the cranial cavity will exert pressure on the soft brain tissue. This will cause the anterior fontanel to expand. A method of assessing fluid collection in the cranial cavity is to palpate this anterior fontanel. A full or bulging fontanel will indicate increasing amounts of fluid accumulation. Additionally, correlate the strategic word "hydrocephalus" in the question with "anterior fontanel" in "a bulging anterior fontanel," the correct option. If you had difficulty with this question, review the symptoms associated with hydrocephalus.

   PTS: 1
   DIF: Level of Cognitive Ability: Analyzing
   REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
   OBJ: Client Needs: Physiological Integrity
   TOP: Content Area: Child Health
   MSC: Integrated Process: Nursing Process—Assessment

2. The nurse is caring for a child who has sustained a head injury in an automobile accident and is monitoring the child for signs of increased intracranial pressure (ICP). The nurse monitors for the earliest sign of increased ICP by assessing for:
   1. Apnea
   2. Posturing
   3. Tachycardia
   4. Changes in level of consciousness (LOC)

ANS: 4

Rationale: An altered level of consciousness is an early sign of increased ICP. Late signs of increased ICP include tachycardia, leading to bradycardia, apnea, systolic hypertension, widening pulse pressure, and posturing.

Test-Taking Strategy: Note the strategic words "earliest sign" in the question. "Apnea" and "posturing" can be eliminated first because they are clearly late signs of increased ICP. Recalling that changes in LOC are an indication of concern in any client will assist in directing you to "changes in level of consciousness (LOC)." Review the early signs of increased ICP if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

3. The nurse is providing instructions to the parents of an infant with a ventriculoperitoneal shunt. The nurse includes which of the following instructions?
   1. Call the physician if the infant is fussy.
   2. Expect an increased urine output from the shunt.
   3. Call the physician if the infant has a high-pitched cry.
   4. Position the infant on the side of the shunt when the infant is put to bed.

ANS: 3

Rationale: If the shunt is malfunctioning, the fluid from the ventricle part of the brain will not be diverted to the peritoneal cavity. The cerebrospinal fluid will build up in the cranial area. The result is increased intracranial pressure, which then causes a high-pitched cry in the infant. The infant should not be positioned on the side of the shunt because this will cause pressure on the shunt and skin breakdown. This type of shunt affects the gastrointestinal system, not the genitourinary system, and an increased urinary output is not expected. "Call the physician if the infant is fussy" is a concern only if other signs indicative of a complication are occurring.

Test-Taking Strategy: Knowledge about a ventriculoperitoneal shunt is required to answer the question. Remember that a high-pitched cry in an infant indicates a concern or problem. If you had difficulty with this question, review assessment findings and home care instructions for the parents of a child with a shunt.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.

OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

4. The nurse reviews the plan of care for a child with Reye's syndrome. The nurse prioritizes the nursing interventions included in the plan and prepares to monitor for:
   1. Signs of hyperglycemia
   2. Signs of a bacterial infection
   3. The presence of protein in the urine
   4. Signs of increased intracranial pressure

   ANS: 4

   Rationale: Intracranial pressure and encephalopathy are major symptoms of Reye's syndrome. Protein is not present in the urine. Reye's syndrome is related to a history of viral infections, and hypoglycemia is a symptom of this disease.

   Test-Taking Strategy: This question asks you to select a priority nursing intervention for the child with Reye's syndrome. Recalling that Reye's syndrome is related to a history of viral infection and that hypoglycemia is associated with this syndrome will assist in eliminating "signs of hyperglycemia" and "signs of increased intracranial pressure." Use prioritizing skills to select "signs of increased intracranial pressure" over "the presence of protein in the urine." If you had difficulty with this question, review care of the child with Reye's syndrome.

   PTS: 1
   DIF: Level of Cognitive Ability: Applying
   REF: Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). Maternal child nursing care (4th ed.). St. Louis: Mosby.
   OBJ: Client Needs: Physiological Integrity
   TOP: Content Area: Child Health
   MSC: Integrated Process: Nursing Process—Planning

5. The nurse is providing home care instructions to the mother of a child who is recovering from Reye's syndrome. Which of the following home instructions should the nurse provide to the mother?
   1. Increase the stimuli in the environment.
   2. Give the child frequent small meals, if vomiting occurs.
   3. Avoid daytime naps so that the child will sleep at night.
   4. Check the child's skin and eyes every day for a yellow discoloration.

   ANS: 4

   Rationale: If vomiting occurs in Reye's syndrome, it is caused by cerebral edema and is a sign of intracranial pressure. Decreasing stimuli and providing rest decrease stress on the brain tissue. Checking for jaundice will assist in identifying the presence of liver complications, which are characteristic of Reye's syndrome.

Test-Taking Strategy: Read each option carefully, and think about the manifestations and complications associated with Reye's syndrome. Recalling that increased intracranial pressure is a concern will assist in eliminating "give the child frequent small meals, if vomiting occurs." Eliminate "increase the stimuli in the environment" and "avoid daytime naps so that the child will sleep at night" because they are comparable or alike in that they do not promote a restful environment for the child. Review care of the child with Reye's syndrome if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

6. The nurse working in the day care center is told that a child with autism will be attending the center. The nurse collaborates with the staff of the day care center and assists in planning activities that will meet the child's needs. The nurse understands that the priority consideration in planning activities for the child is to ensure:
   1. Safety with activities
   2. Activities providing verbal stimulation
   3. Social interactions with other children in the same age group
   4. Familiarity with all activities and providing orientation throughout the activities

   ANS: 1

   Rationale: Safety with all activities is a priority in planning activities with the child. The child with autism is unable to anticipate danger, has a tendency for self-mutilation, and has sensoriperceptual deficits. Although providing social interactions, verbal communications, and familiarity and orientation are also appropriate interventions, the priority is safety.

   Test-Taking Strategy: Use Maslow's Hierarchy of Needs theory to answer this question. Physiological needs take priority. When a physiological need does not exist, safety needs are the priority. None of the options addresses a physiological need. "Safety with activities" addresses the safety need. "Activities providing verbal stimulation," "social interactions with other children in the same age group," and "familiarity with all activities and providing orientation throughout the activities" address psychosocial needs. Review care to the child with autism if you had difficulty with this question.

   PTS: 1
   DIF: Level of Cognitive Ability: Applying
   REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
   OBJ: Client Needs: Safe and Effective Care Environment
   TOP: Content Area: Child Health
   MSC: Integrated Process: Nursing Process—Planning

7. The nurse is providing instructions to an adolescent who is taking phenytoin (Dilantin) for the control of seizures. Which of the following statements, if made by the adolescent, indicates a need for further teaching regarding the medication?
   1. "The medication may cause oily skin."
   2. "Drinking alcohol may affect the medication."
   3. "If my gums become sore I need to stop the medication."
   4. "Birth control pills may not be effective when I take this medication."

   ANS: 3

   Rationale: The adolescent should not stop taking antiseizure medications suddenly or without discussing it with a physician or nurse. Acne or oily skin may be a problem for the adolescent, and the adolescent is advised to call a physician for skin problems. Alcohol will lower the seizure threshold, and it is best to avoid the use of alcohol. Birth control pills may be less effective when the client is taking antiseizure medication.

   Test-Taking Strategy: Note the strategic words "need for further teaching." These words indicate a negative event query and the need to select the incorrect statement. Use general principles related to the administration of medication to assist in answering this question. The adolescent needs to be instructed not to stop the medication suddenly without discussing it with a physician or nurse. Review client teaching points related to the administration of medications if you had difficulty with this question.

   PTS: 1
   DIF: Level of Cognitive Ability: Evaluating
   REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
   OBJ: Client Needs: Physiological Integrity
   TOP: Content Area: Child Health
   MSC: Integrated Process: Teaching and Learning

8. The nurse is collecting data on a 7-year-old child who is suspected of having episodes of absence seizures. Which of the following questions to the mother will assist in providing information that will identify the symptoms associated with these types of seizures?
   1. "Does twitching occur in the face and neck?"
   2. "Does the muscle twitching occur on one side of the body?"
   3. "Does the muscle twitching occur on both sides of the body?"
   4. "Does the child have a blank expression during these episodes?"

   ANS: 4

   Rationale: Absence seizures are very brief episodes of altered awareness. There is no muscle activity except eyelid fluttering or twitching. The child has a blank facial expression. These seizures last only 5 to 10 seconds but may occur one after another several times a day. Myoclonic seizures are brief, random contractions of a muscle group that can occur on one or both sides of the body. Simple partial seizures consist of

twitching of an extremity, the face, or the neck, or the sensation of twitching or numbness in an extremity, the face, or the neck.

Test-Taking Strategy: Knowledge of the characteristics of the various types of seizures is required to answer this question. Focusing on the type of seizure identified in the question—absence seizures—may assist in directing you to "Does the child have a blank expression during these episodes?" Review the characteristics of the various types of seizures if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

9. The nurse is reviewing the record of a child with increased intracranial pressure and notes that the child has exhibited signs of decerebrate posturing. On assessment of the child, the nurse would expect to note which of the following if this type of posturing were present?
   1. Rigid extension and tremors of all extremities
   2. Flaccid paralysis of all extremities
   3. Flexion of the upper extremities and extension of the lower extremities
   4. Abnormal extension of the upper and lower extremities with some internal rotation

   ANS: 4

   Rationale: Decerebrate (extension) posturing is an abnormal extension of the upper extremities, with internal rotation of the upper arm and wrist and extension of the lower extremities with some internal rotation. "Flexion of the upper extremities and extension of the lower extremities" describes decorticate posturing. "Rigid extension and tremors of all extremities" and "flaccid paralysis of all extremities" are incorrect and not characteristics of decerebrate posturing.

   Test-Taking Strategy: Knowing the clinical manifestations associated with posturing is required to answer this question. Focusing on the subject, decerebrate, will direct you to "abnormal extension of the upper and lower extremities with some internal rotation." Also recalling that decerebrate posturing indicates extension posturing will assist in answering correctly. If you are unfamiliar with these findings, review the types and characteristics of posturing.

   PTS: 1
   DIF: Level of Cognitive Ability: Analyzing
   REF: Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). Maternal child nursing care (4th ed.). St. Louis: Mosby.
   OBJ: Client Needs: Physiological Integrity
   TOP: Content Area: Child Health

MSC: Integrated Process: Nursing Process—Assessment

10. The nurse is assisting in developing a plan of care for a child who will be returning from the operating room following a tonsillectomy. The nurse plans to place the child in which of the following positions on return from the operating room?
    1. Supine
    2. Side-lying
    3. High-Fowler's and on the left side
    4. Trendelenburg's and on the right side

    ANS: 2

    Rationale: The child should be placed in a prone or side-lying position following tonsillectomy to facilitate drainage. "Supine," "High-Fowler's and on the left side," and "Trendelenburg's and on the right side" will not facilitate drainage.

    Test-Taking Strategy: Visualize each of the positions described in the options. Keeping in mind that the goal is to facilitate drainage will easily direct you to "side-lying." Review positioning procedures following tonsillectomy if you had difficulty with this question.

    PTS: 1
    DIF: Level of Cognitive Ability: Applying
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Planning

11. The nurse provides discharge instructions to the mother of a child following a myringotomy with insertion of tympanostomy tubes. Which of the following statements, if made by the mother, indicates a need for further education?
    1. "My child should not swim in deep water."
    2. "I need to prevent my child from blowing the nose."
    3. "My child can swim in the lake as long as the water is not deep."
    4. "My child can take a shower or bath as long as I place Vaseline on cotton balls or earplugs in the ears."

    ANS: 3

    Rationale: Bath water and lake water are potential sources of bacterial contamination. Diving and swimming deeply under water are prohibited. Parents need to be instructed that the child should not blow the nose for 7 to 10 days. The child's ears need to be kept dry, and Vaseline on cotton balls or earplugs can be placed in the ears during a bath or shower.

    Test-Taking Strategy: Note the strategic words "a need for further education" in the question. These words indicate a negative event query and the need to select the

incorrect statement. Read each option carefully, using the process of elimination and considering the anatomical location of the procedure. This will direct you to "My child can swim in the lake as long as the water is not deep." Review parent discharge instructions following this procedure if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

12. The pediatric nurse in the ambulatory surgery unit is caring for a child following a tonsillectomy. The child is complaining of a dry throat. Which of the following items would the nurse offer to the child?
    1. Cola with ice
    2. A glass of milk
    3. Cool cherry-flavored drink
    4. Green gelatin

    ANS: 4

    Rationale: Following tonsillectomy, cool clear liquids should be administered. Citrus-flavored, carbonated, and extremely hot or cold liquids should be avoided because they may irritate the throat. Red liquids are avoided because they give the appearance of blood if the child vomits. Milk and milk products, including pudding, are avoided because they coat the throat and cause the child to clear his or her throat, thus increasing the risk of bleeding.

    Test-Taking Strategy: Knowledge of foods and fluids to avoid following tonsillectomy is required to answer this question. First, eliminate foods and fluids that may irritate or cause bleeding, which are "cola with ice" and "a glass of milk." The strategic word "cherry" in "cool cherry-flavored drink" should be the clue that this is not an appropriate food item. Review dietary measures following tonsillectomy if you had difficulty with this question.

    PTS: 1
    DIF: Level of Cognitive Ability: Applying
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Implementation

13. The nurse is providing home care instructions to a mother of a 9-year-old child diagnosed with viral conjunctivitis. Antibiotic eye drops are prescribed for the child. The nurse would instruct the mother that the child:

1. Can return to school immediately
2. Cannot return to school until seen by the physician in 1 week
3. Should be kept at home until the antibiotic eye drops have been administered for 1 week
4. Should be kept at home until the antibiotic eye drops have been administered for 24 hours

ANS: 4

Rationale: Viral conjunctivitis is extremely contagious. The child should be kept home from school or day care until the child has received antibiotic eye drops for 24 hours. "Can return to school immediately," "cannot return to school until seen by the physician in 1 week," and "should be kept at home until the antibiotic eye drops have been administered for 1 week" are incorrect.

Test-Taking Strategy: Knowing that viral conjunctivitis is highly contagious will assist in eliminating "can return to school immediately." Eliminate "should be kept at home until the antibiotic eye drops have been administered for 1 week" next, because this time frame is rather lengthy. Knowledge about the action of antibiotics will assist in directing you to "should be kept at home until the antibiotic eye drops have been administered for 24 hours." Review infection control measures related to viral conjunctivitis if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Safe and Effective Care Environment
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Implementation

14. The nurse is providing instructions to a mother of a child with strabismus of the right eye. The physician has prescribed "patching" for the child, and the parent is instructed in the procedure. Which of the following, if stated by the parent, indicates an understanding of the procedure?
    1. "I will place the patch on the left eye."
    2. "I will place the patch on both eyes."
    3. "I will place the patch on the right eye."
    4. "I will alternate the patch from the right to left eye daily."

    ANS: 1

    Rationale: Patching may be used in the treatment of strabismus to strengthen the weak eye. In this treatment, the "good" eye is patched. This encourages the child to use the weaker eye. Therefore "I will place the patch on both eyes," "I will place the patch on the right eye," and "I will alternate the patch from the right to left eye daily." are incorrect. Patching is most successful when done during the preschool years. The schedule for patching is individualized and is prescribed by the ophthalmologist.

Test-Taking Strategy: Knowledge about the physiology associated with strabismus is helpful in answering this question. Remembering that this condition is also called "lazy eye" will direct you to the correct option. It makes sense to patch the unaffected eye to strengthen the muscles in the affected eye. Review the procedure for patching if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Evaluation

15. The nurse is reviewing the physician's prescriptions on a child following a tonsillectomy. Which of the following physician prescriptions would the nurse question?
    1. Suction the child if coughing.
    2. Discharge to home when alert and tolerating fluids.
    3. Provide clear cool liquids to the child when awake.
    4. Instruct the parent to avoid giving the child milk or milk products.

    ANS: 1

    Rationale: Following tonsillectomy, suction equipment should be available, but the child is not suctioned unless there is an airway obstruction. Clear cool liquids are encouraged. Milk and milk products are avoided initially because they coat the throat, causing the child to clear his or her throat and thereby increasing the risk of bleeding. "Discharge to home when alert and tolerating fluids" is an appropriate intervention following tonsillectomy.

    Test-Taking Strategy: Use the process of elimination, and consider the anatomical location of the surgery to assist in answering the question. This should easily direct you to "suction the child if coughing." Review postoperative care following tonsillectomy if you had difficulty with this question.

    PTS: 1
    DIF: Level of Cognitive Ability: Analyzing
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Safe and Effective Care Environment
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Implementation

16. The nurse is caring for a 2-year-old child with an ear infection who requires the administration of antibiotic ear drops. The nurse observes the mother administering the ear drops to the child. Which of the following observations, if made by the nurse, indicates that the mother is performing the procedure correctly?

1. The mother pulls the earlobe down and back.
2. The mother must wear gloves when administering the medication.
3. The mother pulls the earlobe up and back to administer the drops.
4. The mother holds the child in a sitting position when administering the ear drops.

ANS: 1

Rationale: To administer ear drops to a child younger than 3 years, the earlobe should be pulled down and back. In the older child, the earlobe is pulled up and back to obtain a straight canal. Gloves do not need to be worn by the parents, but hands must be washed before and after the procedure. The child needs to be in a side-lying position with the affected ear facing upward to facilitate the flow of medication down the ear canal by gravity.

Test-Taking Strategy: Use the process of elimination. "The mother must wear gloves when administering the medication" can be eliminated because of the close-ended word "must." Next visualize the procedure to assist in eliminating "the mother holds the child in a sitting position when administering the ear drops." From the remaining options, recalling the anatomy of the 2-year-old child's ear canal will direct you to "the mother pulls the earlobe down and back." Review the procedure for administering ear drops to a child if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Evaluation

17. The ambulatory care nurse makes a follow-up telephone call to the mother of a child who underwent a myringotomy with insertion of tympanostomy tubes on the previous day. The mother of the child tells the nurse that the child is complaining of discomfort. The nurse would instruct the mother to:
    1. Call the physician immediately.
    2. Give the child acetaminophen (Tylenol) for the discomfort.
    3. Give the child children's aspirin, and call the physician if it does not help.
    4. Call the local pharmacist regarding a stronger over-the-counter analgesic.

    ANS: 2

    Rationale: Following myringotomy with insertion of tympanostomy tubes, the child may experience some discomfort. It is not necessary to notify the physician, and additionally, this response to the mother may alarm her. Aspirin should not be given to the child. Tylenol can be given to relieve the discomfort. "Call the local pharmacist regarding a stronger over-the-counter analgesic" is inappropriate.

Test-Taking Strategy: "Call the physician immediately" and "call the local pharmacist regarding a stronger over-the-counter analgesic" can easily be eliminated. It is not necessary to call the physician immediately and it is inappropriate for the pharmacist to prescribe a stronger medication. It seems reasonable that the child may have some discomfort following this surgical procedure. Recalling that aspirin should not be given to a child will assist in eliminating "call the local pharmacist regarding a stronger over-the-counter analgesic." If you had difficulty with this question, review postoperative care following myringotomy.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Implementation

18. The nurse is assisting in providing an educational session to new mothers regarding the methods that will decrease the risk of recurrent otitis media in infants. Which of the following statements, if made by a mother in the group, indicates a need for further instruction?
    1. "I need to feed the infant in an upright position."
    2. "I should not provide the infant with a bottle during naptime."
    3. "Bottle-feeding should be discontinued as soon as possible."
    4. "I need to discontinue breast-feeding as soon as possible."

    ANS: 4

    Rationale: To decrease the risk of recurrent otitis media, mothers should be encouraged to breast-feed during infancy, discontinue bottle-feeding as soon as possible, feed the infant in an upright position, and never give the infant a bottle in bed. Additionally, parents should be told not to smoke in the child's presence because passive smoking increases the incidence of otitis media.

    Test-Taking Strategy: Note the strategic words "a need for further instruction" in the question. These words indicate a negative event query and the need to select the incorrect statement. Knowing the physiology related to otitis media will assist in answering the question. Recalling that breast-feeding offers some protection by providing maternal antibodies will assist in directing you to "I need to discontinue breast-feeding as soon as possible." Review measures that will assist in preventing otitis media if you had difficulty with this question.

    PTS: 1
    DIF: Level of Cognitive Ability: Evaluating
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health

MSC: Integrated Process: Teaching and Learning

19. A nursing student is preparing a clinical conference. The topic of the discussion is caring for the child with cystic fibrosis (CF). Which of the following comments by the student would indicate that the student needs further review of information about cystic fibrosis?
    1. It is transmitted as an autosomal recessive trait.
    2. It is a disease that causes mucus that is formed to be abnormally thick.
    3. It is a disease that causes dilation of the passageways of many organs.
    4. It is a chronic multisystem disorder affecting the exocrine glands.

    ANS: 3

    Rationale: CF is a chronic multisystem disorder affecting the exocrine gland. The mucus produced by these glands (particularly those of the bronchioles, small intestine, and pancreatic and bile ducts) is abnormally thick, causing obstruction of the small passageways of these organs. It is transmitted as an autosomal recessive trait.

    Test-Taking Strategy: Note the strategic words "needs further review" in the question. These words indicate a negative event query and the need to select the incorrect statement. Knowledge regarding the physiology associated with CF is required to answer this question. Recalling that obstruction of the small passageways of organs occurs, and careful reading of "it is a disease that causes dilation of the passageways of many organs," will easily direct you to this option. If you are unfamiliar with the pathophysiology associated with CF, review this content.

    PTS: 1
    DIF: Level of Cognitive Ability: Understanding
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Teaching and Learning

20. The nurse reviews the health record of a 2-year-old child and notes that the physician has documented that the results of a Mantoux test have indicated an area of induration measuring 5 mm. The nurse would interpret these results as:
    1. Positive
    2. Negative
    3. Inconclusive
    4. Definitive, requiring a repeat test

    ANS: 2

    Rationale: Induration measuring 10 mm or greater is considered to be a positive result in children younger than 4 years. A reaction of 5 mm or greater is considered to be a positive result for the highest risk groups.

Test-Taking Strategy: Knowledge regarding a positive Mantoux test in children is required to answer this question. "Inconclusive" and "definitive, requiring a repeat test" can be easily eliminated first because they are comparable or alike. Note the child's age in the question to determine the correct option from the remaining two. Also, note that there is no indication in the question that the child is in a high-risk group. If you had difficulty with this question, review the analysis of a Mantoux test in children.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

21. The nurse has provided instructions to the mother of a child with cystic fibrosis (CF) about appropriate dietary measures. Which of the following statements, if made by the mother, indicates an understanding of the diet that should be provided to the child?
    1. "The diet needs to be low in fat."
    2. "The diet needs to be low in protein."
    3. "The diet needs to be high in calories."
    4. "The diet needs to be low in calories."

    ANS: 3

    Rationale: Children with CF are managed with a high-calorie, high-protein diet. Pancreatic enzyme replacement therapy and water-soluble vitamin supplements (A, D, E, and K) are administered. If nutritional problems are severe, supplemental tube feedings or parenteral nutrition is administered. Fats are not restricted unless steatorrhea cannot be controlled by administration of increased pancreatic enzymes.

    Test-Taking Strategy: Knowledge regarding the appropriate diet in the child with CF is required to answer this question. Note the strategic words "indicates an understanding" in the question. Eliminate "the diet needs to be low in fat" and "the diet needs to be low in calories" first because they are comparable or alike. For the remaining options, it is necessary to know that the prescribed diet is one that is high in calories and protein. If you are unfamiliar with this diet plan, review this content.

    PTS: 1
    DIF: Level of Cognitive Ability: Evaluating
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Evaluation

22. The nurse is caring for a hospitalized infant with a diagnosis of bronchiolitis. The nurse positions the infant:

1. In a supine, side-lying position
2. Prone, with the head of the bed elevated 15 degrees
3. With the head at a 60-degree angle with the neck slightly flexed
4. With the head and chest at a 30-degree angle, with the neck slightly extended

ANS: 4

Rationale: The nurse should position the infant with the head and the chest at a 30- to 40-degree angle with the neck slightly extended to maintain an open airway and to decrease pressure of the diaphragm. "In a supine, side-lying position," "prone, with the head of the bed elevated 15 degrees," and "with the head at a 60-degree angle with the neck slightly flexed" do not achieve these goals.

Test-Taking Strategy: Knowledge regarding the care of an infant with bronchiolitis is required to answer this question. Attempt to visualize each of the positions identified in the options. This will assist you in answering the question correctly. Keeping in mind that the goal is to maintain an open airway will assist in directing you to "with the head and chest at a 30-degree angle, with the neck slightly extended." If you had difficulty with this question, review the care of the infant with bronchiolitis.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Implementation

23. The nurse is providing instructions to the mother of a child with croup regarding treatment measures if an acute spasmodic episode occurs. Which of the following statements, if made by the mother, indicates a need for further instruction?
    1. "I will take the child out into the cool, humid night air."
    2. "I should place a steam vaporizer in the child's room."
    3. "I need to place a cool mist humidifier in the child's room."
    4. "I can bring the child into a closed bathroom and have the child inhale steam from running water."

ANS: 2

Rationale: Steam from running water in a closed bathroom and cool mist from a bedside humidifier are effective in reducing mucosal edema. Cool mist humidifiers are recommended over steam vaporizers, which present a danger of scald burns. Taking the child out into the cool, humid night air may also relieve mucosal swelling.

Test-Taking Strategy: Note the strategic words "need for further instruction." These words indicate a negative event query and the need to select the incorrect statement. Use the process of elimination, keeping in mind that the goal is to reduce mucosal edema and to provide a safe environment. Read each option carefully, and you should easily be

directed to "I should place a steam vaporizer in the child's room." Review home care instructions for the child with acute spasmodic croup if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Safe and Effective Care Environment
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

24. The nurse employed in an emergency department is monitoring a child diagnosed with epiglottitis. The nurse notes that the child is leaning forward with the chin thrust out. The nurse interprets this finding as indicating:
    1. Extreme fatigue
    2. The presence of pain
    3. An airway obstruction
    4. The presence of dehydration

    ANS: 3

    Rationale: Clinical manifestations suggestive of airway obstruction include tripod positioning (leaning forward supported by arms, chin thrust out, mouth open), nasal flaring, tachycardia, a high fever, and sore throat. "Extreme fatigue," "the presence of pain," and "the presence of dehydration" are inaccurate interpretations.

    Test-Taking Strategy: Knowledge regarding the assessment findings associated with epiglottitis and airway obstruction is required to answer this question. Focus on the diagnosis identified in the question to assist in directing you to "an airway obstruction." Also, use the ABCs—airway, breathing, and circulation—to assist in directing you to answer the question correctly. Review the assessment findings in airway obstruction if you had difficulty with this question.

    PTS: 1
    DIF: Level of Cognitive Ability: Analyzing
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Assessment

25. The nurse is preparing for administering ribavirin (Virazole) to a child with respiratory syncytial virus (RSV). Which of the following supplies will the nurse obtain for the administration of this medication?
    1. An intravenous (IV) pole
    2. A pair of goggles
    3. A protective isolation gown

4. An intramuscular (IM) syringe

ANS: 2

Rationale: Some caregivers experience headaches, burning nasal passages and eyes, and crystallization of soft contact lenses as a result of administration of ribavirin (Virazole). Specific to this medication is the use of goggles. A mask may be worn. Hand washing is to be performed before and after any child contact. A gown is not necessary. The medication is administered via hood, face mask, or oxygen tent and is not administered by the IM or IV route.

Test-Taking Strategy: Knowledge regarding the effects of this medication is required to answer this question. Knowing that this medication is administered via respiratory inhalation will assist in eliminating "an intravenous (IV) pole" and "an intramuscular (IM) syringe." For the remaining options, it is necessary to know that goggles are required to prevent irritation to the eyes of the caregiver. If you had difficulty with this question, review the concepts related to the administration of this medication.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Safe and Effective Care Environment
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Planning

26. A nursing student is conducting a clinical conference about measures that assist in preventing sudden infant death syndrome (SIDS). The student plans to write on a handout that it is best to place an infant in which of the following positions for sleep?
    1. On the back or prone
    2. On the back or supine
    3. On the stomach or prone
    4. On the stomach or supine

ANS: 2

Rationale: Healthy infants should only be placed on their backs for sleep. This is also referred to as the supine position. "On the back or prone," "on the stomach or prone," and "on the stomach or supine" are not suggested recommendations to assist in preventing SIDS.

Test-Taking Strategy: Remember that when an option contains more than one part, all the parts must be correct for the option to be the answer to the question. Having knowledge of the word "prone," meaning on the abdomen, will allow you to eliminate "on the back or prone," "on the stomach or prone," and "on the stomach or supine." Also, knowing that infants are to be placed in the supine position will lead you to "on the back or supine." Review measures to prevent SIDS if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Safe and Effective Care Environment
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

27. A sweat test is performed on an infant with a suspected diagnosis of cystic fibrosis (CF). The nurse reviews the results of the test and notes that the chloride level is 40 mEq/L. The nurse interprets that this finding is indicative of:
    1. A negative test
    2. A positive test
    3. An unrelated finding
    4. Suggestive of CF and requires a repeat test

    ANS: 4

    Rationale: In a sweat test, sweating on the infant's forearm is stimulated with pilocarpine, the sample is collected on absorbent material, and the amount of sweat chloride is measured. A chloride level higher than 60 mEq/L is considered to be a positive test result. A sweat chloride level lower than 40 mEq/L is considered normal. A sweat chloride level higher than or equal to 40 mEq/L is suggestive of CF and requires a repeat test. "A negative test," "a positive test," and "an unrelated finding" are incorrect interpretations of the test results.

    Test-Taking Strategy: Knowledge about diagnostic results related to the sweat test is required to answer this question. Remember a level of 40 mEq/L is suggestive of CF. If you had difficulty with this question or are unfamiliar with this test, review this content.

    PTS: 1
    DIF: Level of Cognitive Ability: Analyzing
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Assessment

28. The nursing student is caring for an infant with a respiratory infection and is monitoring for signs of dehydration. The nursing instructor asks the student to identify the **most** reliable method of determining fluid loss. The instructor determines that the student understands this method when the student states that the plan is to:
    1. Monitor output.
    2. Monitor body weight.
    3. Assess the mucous membranes.
    4. Obtain a temperature every 2 hours.

ANS: 2

Rationale: Body weight is the most reliable method of measuring body fluid loss or gain. One kilogram of weight change represents 1 L of fluid loss or gain. "Monitor output," "assess the mucous membranes," and "obtain a temperature every 2 hours" are also appropriate measures to assess for dehydration, but the most reliable method is to monitor body weight.

Test-Taking Strategy: Note the strategic words "most reliable" in the question to assist in eliminating "assess the mucous membranes" and "obtain a temperature every 2 hours" first. From the remaining options, recall that it would be very difficult to obtain an accurate measurement of output on an infant. This should direct you to "monitor body weight." Review assessment techniques for determining dehydration if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Understanding
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

29. The nurse is developing a plan of care for a child admitted with a diagnosis of Kawasaki disease. In developing the initial plan of care, the nurse includes to monitor the child for signs of:
    1. Bleeding
    2. Failure to thrive
    3. Congestive heart failure (CHF)
    4. Decreased tolerance to stimulation

ANS: 3

Rationale: Nursing care initially centers on observing for signs of CHF. The nurse monitors for increased respiratory rate, increased heart rate, dyspnea, crackles, and abdominal distention. "Bleeding," "failure to thrive," and "decreased tolerance to stimulation" are not findings directly associated with this disorder.

Test-Taking Strategy: Knowledge that Kawasaki disease is a cause of acquired heart disease in children will assist in directing you to "congestive heart failure (CHF)." If you are unfamiliar with the characteristics of Kawasaki disease, review this content.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). Maternal child nursing care (4th ed.). St. Louis: Mosby.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health

MSC: Integrated Process: Nursing Process—Planning

30. The nurse is reviewing the physician's prescriptions for a child with rheumatic fever (RF) who is suspected of having a viral infection. The nurse notes that acetylsalicylic acid (aspirin) is prescribed for the child. Which of the following nursing actions is **most** appropriate?
    1. Administer the aspirin if the child's temperature is elevated.
    2. Administer the aspirin if the child experiences any joint pain.
    3. Consult with the physician to verify the prescription.
    4. Administer acetaminophen (Tylenol) instead of the aspirin for temperature elevation.

    ANS: 3

    Rationale: Anti-inflammatory agents, including aspirin, may be prescribed for the child with RF. Aspirin should not be given to a child who has chickenpox or other viral infections. The nurse would not administer acetaminophen (Tylenol) without specific physician's prescriptions. "Administer the aspirin if the child's temperature is elevated" and "administer the aspirin if the child experiences any joint pain" are not appropriate actions.

    Test-Taking Strategy: Eliminate "administer acetaminophen (Tylenol) instead of the aspirin for temperature elevation' first because the nurse would not change a physician's prescription without consultation with the physician. Knowledge that aspirin should not be administered to a child with a viral infection will easily direct you to "consult with the physician to verify the prescription." Review the contraindications related to the use of aspirin if you had difficulty with this question.

    PTS: 1
    DIF: Level of Cognitive Ability: Applying
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Implementation

31. The nurse is assigned to care for an infant with tetralogy of Fallot. The mother of the infant calls the nurse to the room because the infant suddenly seems to be having difficulty breathing. The nurse enters the room and notes that the infant is experiencing a hypercyanotic episode. The initial nursing action is to:
    1. Call a code.
    2. Place the infant in a prone position.
    3. Place the infant in a knee-chest position.
    4. Contact the respiratory therapy department.

    ANS: 3

Rationale: If a hypercyanotic episode occurs, the infant is placed in a knee-chest position. The knee-chest position is thought to increase pulmonary blood flow by increasing systemic vascular resistance. This position also improves systemic arterial oxygen saturation by decreasing venous return, so that smaller amounts of highly saturated blood reach the heart. Toddlers and children squat to obtain this position and relieve chronic hypoxia. Therefore "Call a code," "place the infant in a prone position," and "contact the respiratory therapy department" are incorrect.

Test-Taking Strategy: Note the strategic word "initial" in the question. Eliminate "call a code" because no data in the question indicate that calling a code is necessary. "Place the infant in a prone position" is eliminated next, because this position will worsen the condition. Eliminate "contact the respiratory therapy department," because this action would delay treatment and is not an action that is required at this time. Remembering that a toddler or child squats to achieve this position will assist in directing you "place the infant in a knee-chest position." Review care to the infant with a hypercyanotic episode if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Implementation

32. The nurse is caring for an infant with congenital heart disease. Which of the following signs, if noted in the infant, would alert the nurse to the early development of congestive heart failure (CHF)?
    1. Pallor
    2. Strong sucking reflex
    3. Diaphoresis during feeding
    4. Slow and shallow breathing

ANS: 3

Rationale: The early symptoms of CHF include tachypnea, poor feeding, and diaphoresis during feeding. Tachycardia would occur during feeding. Pallor may be noted in the infant with CHF, but it is not an early symptom. A strong sucking reflex is unrelated to the development of CHF.

Test-Taking Strategy: Think about the physiology and the effects on the heart when fluid overload occurs. These concepts will assist in directing you to "diaphoresis during feeding." If you had difficulty with this question, review the early signs of CHF in an infant.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing

REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

33. The nurse reviews the physician's prescriptions for a child with a streptococcal infection. The physician prescribes an antistreptolysin O titer. Based on this prescription, which of the following would the nurse suspect in the child?
    1. Rheumatic fever (RF)
    2. Aortic valve disease (AVD)
    3. Pulmonic valve disease (PVD)
    4. Congestive heart failure (CHF)

    ANS: 1

    Rationale: A diagnosis of RF is confirmed by the presence of two major manifestations or one major and two minor manifestations from the Jones criteria. Additionally, evidence of a recent streptococcal infection is confirmed by positive antistreptolysin O titer, Streptozyme slide tests, or anti-DNase B assays. An antistreptolysin O titer is not a specific laboratory test for the conditions identified in "aortic valve disease (AVD)," "pulmonic valve disease (PVD)," and "congestive heart failure (CHF)."

    Test-Taking Strategy: Knowledge that RF is characteristically associated with streptococcal infection will easily direct you to "rheumatic fever (RF)." If you had difficulty with this question, review the characteristics of RF and the laboratory tests prescribed to help diagnose the condition.

    PTS: 1
    DIF: Level of Cognitive Ability: Analyzing
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Assessment

34. The nurse is caring for a child with congestive heart failure (CHF). The nurse provides instructions to the mother regarding the procedure for administration of the prescribed digoxin (Lanoxin). Which of the following statements, if made by the mother, indicates a need for further education?
    1. "I can mix the medication with food."
    2. "If more than one dose is missed, I need to call the physician."
    3. "I need to take the child's pulse before administering the medication."
    4. "If the child vomits after being given the medication, I should not repeat the dose."

    ANS: 1

Rationale: Medication should not be mixed with food, because this method of administration would not ensure that the child received the prescribed dose. The parents need to be instructed that if the child vomits after the digoxin is administered, they are not to repeat the dose. Additionally, the parents should be instructed that if a dose is missed and is not identified until 4 or more hours later, the dose should not be administered. If more than one dose is missed, the physician needs to be notified.

Test-Taking Strategy: Note the strategic words "a need for further education" in the question. These words indicate a negative event query and the need to select the incorrect option. General knowledge regarding digoxin administration will assist in eliminating "if more than one dose is missed, I need to call the physician," "I need to take the child's pulse before administering the medication," and "If the child vomits after being given the medication, I should not repeat the dose." These are considered correct components of instruction with administration of digoxin. Review these instructions for administering digoxin if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

35. The nurse is caring for a child with a diagnosis of a right-to-left cardiac shunt. On review of the child's record, the nurse would expect to note documentation of which of the following **most** common assessment findings?
    1. Cyanosis
    2. Severe bradycardia
    3. Asymptomatic findings
    4. Higher than normal body weight

ANS: 1

Rationale: The child with a right-to-left shunt will be considerably sicker than a child with a left-to-right shunt. Many of these children will present with symptoms in the first week of life. The most common assessment finding in these children is cyanosis. The child may also become dyspneic after feeding, crying, and other exertional activities. "Severe bradycardia" and "asymptomatic findings" are inaccurate. Many children with a left-to-right shunt may remain asymptomatic. "Higher than normal body weight" is incorrect, because these children usually have lower than normal body weight.

Test-Taking Strategy: Knowledge regarding the physiology associated with a right-to-left shunt will easily direct you to "cyanosis." Remember that the most common assessment finding in this disorder is cyanosis. If you had difficulty with this question, review the manifestations associated with a right-to-left shunt.

PTS: 1

DIF: Level of Cognitive Ability: Analyzing
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

36. The nurse is collecting data on a child with a diagnosis of rheumatic fever (RF). Which of the following questions would the nurse initially ask the mother of the child?
    1. "Has the child been vomiting?"
    2. "Has the child had any diarrhea?"
    3. "Does the child complain of chest pain?"
    4. "Has the child complained of a sore throat within the past few months?"

    ANS: 4

    Rationale: RF characteristically presents 2 to 6 weeks following an untreated or partially treated group A beta-hemolytic streptococcal infection of the upper respiratory tract. Initially, the nurse determines whether any family members have had a sore throat or unexplained fever within the past 2 months. "Has the child been vomiting?" "Has the child had any diarrhea?" and "Does the child complain of chest pain?" are unrelated to RF.

    Test-Taking Strategy: Use the process of elimination. Recalling that RF characteristically presents 2 to 6 weeks following an untreated or partially treated group A beta-hemolytic streptococcal infection of the upper respiratory tract will easily direct you to "Has the child complained of a sore throat within the past few months?" If you had difficulty with this question, review the causes of RF.

    PTS: 1
    DIF: Level of Cognitive Ability: Applying
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Assessment

37. The nurse is reviewing the health record of an infant with a diagnosis of congenital heart disease. The nurse notes documentation in the record that the infant has clubbing of the fingers. The nurse understands that this finding is caused by:
    1. Chronic fatigue
    2. Poor oxygenation
    3. Poor sucking ability
    4. Consistent sucking on the fingers

    ANS: 2

Rationale: The child with congenital heart disease may develop clubbing of the fingers. Clubbing of the fingers is thought to be caused by anoxia or poor oxygenation. "Chronic fatigue," "poor sucking ability," and "consistent sucking on the fingers" are unrelated to this occurrence.

Test-Taking Strategy: Knowledge regarding the cause of clubbing of the fingers is required to answer this question. Focusing on the diagnosis identified in the question will assist in directing you to "poor oxygenation." Review this clinical manifestation noted in congenital heart disease if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Understanding
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

38. The nurse is admitting a child who arrived from the emergency department after treatment for acetaminophen (Tylenol) overdose. The nurse reviews the child's record and expects to note that the child received which of the following for the acetaminophen overdose?
    1. Epoetin alfa (Epogen)
    2. Protamine sulfate
    3. Acetylcysteine (Mucomyst)
    4. Ethylenediaminetetraacetic acid (EDTA)

    ANS: 3

    Rationale: Acetylcysteine (Mucomyst) is the antidote for acetaminophen (Tylenol) overdose. It is administered orally with juice or cola or via nasogastric (NG) tube. Epogen induces erythropoiesis and is used in the treatment of anemia. Protamine sulfate is the antidote for heparin. EDTA is used in the treatment of lead poisoning.

    Test-Taking Strategy: Knowledge regarding the antidote for acetaminophen overdose is required to answer this question. Remember that acetylcysteine is one antidote for acetaminophen overdose. Learn the major antidotes for medication overdose if you are unfamiliar with them.

    PTS: 1
    DIF: Level of Cognitive Ability: Understanding
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Assessment

39. The nurse is monitoring a child who is receiving EDTA with BAL (British anti-Lewisite) for the treatment of lead poisoning. The nurse reviews the laboratory results of the child during treatment with this medication and is particularly concerned with monitoring which of the following laboratory test results?
    1. Cholesterol level
    2. Blood urea nitrogen (BUN) level
    3. Complete blood cell (CBC) count
    4. Hemoglobin and hematocrit (H&H) levels

    ANS: 2

    Rationale: Kidney function tests should be monitored because EDTA is nephrotoxic. The calcium level should also be monitored because EDTA enhances the excretion of calcium. "Cholesterol level," "complete blood cell (CBC) count," and "hemoglobin and hematocrit (H&H) levels" are not the primary concern during treatment with EDTA.

    Test-Taking Strategy: Knowledge regarding the adverse effects of this medication is required to answer this question. "Complete blood cell (CBC) count" and "hemoglobin and hematocrit (H&H) levels" can be eliminated first because a CBC includes an H&H determination. For the remaining options, recalling that many medications are nephrotoxic will easily direct you to "blood urea nitrogen (BUN) level." If you are unfamiliar with this medication, review this content.

    PTS: 1
    DIF: Level of Cognitive Ability: Analyzing
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Assessment

40. The mother of a child with an umbilical hernia calls the clinic and reports to the nurse that the child has been vomiting and is complaining of pain in the abdominal area. The nurse would **most** appropriately instruct the mother to:
    1. Contact the physician.
    2. Keep the child on clear liquids.
    3. Apply an ice pack to the abdomen.
    4. Administer acetaminophen (Tylenol) suppositories to the child.

    ANS: 1

    Rationale: Vomiting, pain, and irreducible mass at the umbilicus are signs of a strangulated hernia. The parents should be instructed to contact the physician immediately if strangulation is suspected. "Keep the child on clear liquids," "apply an ice pack to the abdomen," and "administer acetaminophen (Tylenol) suppositories to the child" are incorrect, can cause harm to the child, and delay emergency treatment measures that are required.

Test-Taking Strategy: Note the strategic words "umbilical hernia" in the question. Knowledge that strangulation is a concern and knowledge of the signs that indicate strangulation will easily direct you to "contact the physician." Review the signs of strangulation of a hernia if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Implementation

41. The nurse is reviewing the physician's documentation in the record of a child admitted with a diagnosis of intussusception. The nurse expects to note that the physician has documented the presence of:
    1. Scleral jaundice
    2. Projectile vomiting
    3. Currant jelly–type stools
    4. Pale-colored and hard stools

    ANS: 3

    Rationale: In the child with intussusception, bright red blood and mucus are passed through the rectum, resulting in what is commonly described as currant jelly stools. The child classically presents with severe abdominal pain that is crampy and intermittent, causing the child to draw the knees in to the chest. Vomiting may be present, but not projectile. "Scleral jaundice" and "pale-colored and hard stools" are not manifestations of this disorder.

    Test-Taking Strategy: Think about the pathophysiology and the clinical manifestations associated with intussusception to answer this question. Recalling that a classic manifestation is currant jelly stools will assist in directing you to "currant jelly–type stools." Review this disorder if you had difficulty with this question.

    PTS: 1
    DIF: Level of Cognitive Ability: Analyzing
    REF: Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). Maternal child nursing care (4th ed.). St. Louis: Mosby.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Assessment

42. The nurse is preparing to care for a newborn infant following creation of a colostomy for the treatment of imperforate anus. In the immediate postoperative period, the nurse plans to inspect the stoma, knowing that it is expected to be:
    1. Bleeding
    2. Gray in color

3. Dark blue in color
4. Red and edematous

ANS: 4

Rationale: A fresh colostomy stoma will be red and edematous, but this will decrease with time. The colostomy site will then be pink, without evidence of abnormal drainage, swelling, or skin breakdown. The colostomy should not be bleeding. A gray or dark blue stoma indicates insufficient circulation and should be reported to the physician immediately.

Test-Taking Strategy: Knowledge regarding the normal expected findings in a fresh colostomy is required to answer this question. Note the strategic words "immediate postoperative period." You would expect redness and edema at this time. Recall the abnormal findings that can occur following this procedure. This will assist in eliminating "bleeding," "gray in color," and "dark blue in color." Review postoperative colostomy assessment if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

43. The nurse is collecting data on an infant with a diagnosis of suspected Hirschsprung's disease. Which of the following questions to the mother will **most** specifically elicit information regarding this disorder?
    1. "Does your infant have diarrhea?"
    2. "Is your infant constantly vomiting?"
    3. "Does your infant constantly spit up feedings?"
    4. "Does your infant have foul-smelling, ribbon-like stools?"

    ANS: 4

    Rationale: Chronic constipation, beginning in the first month of life and resulting in pellet-like or ribbon stools that are foul-smelling, is a clinical manifestation of Hirschsprung's disease. Delayed passage or absence of meconium stool in the neonatal period is the primary sign. Bowel obstruction, especially in the neonatal period, abdominal pain and distention, and failure to thrive are also clinical manifestations. "Does your infant have diarrhea?" "Is your infant constantly vomiting?" and "Does your infant constantly spit up feedings?" are not specific clinical manifestations of this disorder.

    Test-Taking Strategy: Knowledge regarding the clinical manifestations associated with Hirschsprung's disease is required to answer this question. Eliminate "Is your infant constantly vomiting?" and "Does your infant constantly spit up feedings?" because they

are comparable or alike. Recalling that constipation is associated with this disorder will assist in eliminating "Does your infant have diarrhea?" If you are unfamiliar with these symptoms, review this content.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

44. The nurse is caring for a child who was brought to the clinic complaining of severe abdominal pain and is suspected of having acute appendicitis. The child is lying on the examining table, with the knees pulled up toward the chest. The nurse assists the physician with further assessment of the progression of the child's pain, knowing that the physician will palpate the abdomen:
1. Midway between the liver and the gallbladder
2. Midway between the left iliac crest and the umbilicus
3. Midway between the left inguinal area and the acetabulum
4. Midway between the right anterior superior iliac crest and the umbilicus

ANS: 4

Rationale: McBurney's point is usually the location of greatest pain in the child with appendicitis. McBurney's point is midway between the right anterior superior iliac crest and the umbilicus. "Midway between the liver and the gallbladder," "midway between the left iliac crest and the umbilicus," and "midway between the left inguinal area and the acetabulum" will not appropriately assess the progression of pain in the child with appendicitis.

Test-Taking Strategy: Knowledge that the appendix is located in the right side of the abdomen will assist in eliminating "midway between the left iliac crest and the umbilicus" and "midway between the left inguinal area and the acetabulum." Additionally, recalling that the appendix is located in the lower abdominal area will assist in eliminating "midway between the liver and the gallbladder." Review the location of McBurney's point if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Understanding
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

45. The nurse has provided dietary instructions to the mother of a child with celiac disease. The nurse determines that the mother understands the instructions when the mother states to include which of the following in the child's diet?
    1. Corn
    2. Wheat cereal
    3. Rye crackers
    4. Oatmeal biscuits

    ANS: 1

    Rationale: Dietary management is the mainstay of treatment in celiac disease. All wheat, rye, barley, and oats should be eliminated from the diet and replaced with corn and rice. Vitamin supplements, especially fat-soluble vitamins and folate, may be needed in the early period of treatment to correct deficiencies. These are likely to be lifelong restrictions; although small amounts of grains may be tolerated after the ulcerations have healed.

    Test-Taking Strategy: Knowledge regarding the dietary management in celiac disease is required to answer this question. Recalling that corn and rice are substitute food replacements in this disease will easily direct you to "corn." Review the dietary management of this disorder if you had difficulty with this question.

    PTS: 1
    DIF: Level of Cognitive Ability: Evaluating
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Evaluation

46. The nurse is developing a plan of care for an infant being admitted with hypertrophic pyloric stenosis who is scheduled for pyloromyotomy. In the preoperative period, the nurse suggests to document in the plan of care to position the child:
    1. In an infant seat placed in the crib
    2. Prone with the head of the bed elevated
    3. Supine with the head at a 90-degree angle
    4. Supine with the head of the bed at a 30-degree angle

    ANS: 2

    Rationale: In the preoperative period, the infant is positioned prone with the head of the bed elevated to reduce the risk of aspiration. "In an infant seat placed in the crib," "supine with the head at a 90-degree angle," and "supine with the head of the bed at a 30-degree angle" are inappropriate positions for preventing this risk.

    Test-Taking Strategy: Visualize each of the positions to select the correct option. Keeping in mind that aspiration is the concern will easily direct you to "prone with the

head of the bed elevated." Review preoperative care for pyloromyotomy if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Planning

47. The nurse is assigned to care for an infant following a cleft lip repair. The nurse is asked to observe the parent in the procedure for cleaning the lip repair site. The nurse determines that the parent is performing the procedure correctly if the parent uses which of the following solutions to clean the site?
    1. Ice water
    2. Sterile water
    3. Half-strength alcohol
    4. Full strength hydrogen peroxide

    ANS: 2

    Rationale: The lip repair site is cleansed with sterile water using a cotton swab; it is cleansed after feeding and as prescribed. The mother should be instructed to use a rolling motion from the suture line out. "Ice water," "half-strength alcohol," and "full strength hydrogen peroxide" are incorrect.

    Test-Taking Strategy: Use the process of elimination, recalling the importance of asepsis for a surgical site. This concept will direct you to "sterile water." Review the procedure for cleaning the lip repair site if you had difficulty with this question.

    PTS: 1
    DIF: Level of Cognitive Ability: Evaluating
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Health Promotion and Maintenance
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Evaluation

48. The nurse is preparing a plan of care for an infant who will be returning from the recovery room following the surgical repair of a cleft lip located on the right side of the lip. On return from the recovery room, the nurse plans to position the infant:
    1. Prone and flat
    2. Supine and flat
    3. On the left side
    4. On the right side

    ANS: 3

Rationale: Following cleft lip repair, the infant should be positioned supine or on the side lateral to the repair to prevent the suture lines from contacting the bed linens. Immediately after surgery, it is best to place the infant on the left side rather than supine to prevent aspiration if the infant vomits.

Test-Taking Strategy: Consider the anatomical location of the surgical site and the strategic words "*right side"* in answering this question. You should be easily directed to the correct option using these concepts. Review postoperative positioning techniques following cleft lip repair if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Planning

49. The nursing student is asked to administer a tepid bath to a child with a fever. The student avoids which of the following when performing this procedure?
    1. Applies alcohol-soaked cloths over the child's body
    2. Uses a water toy to distract the child during the bath
    3. Places lightweight pajamas on the child after the bath
    4. Squeezes water over the child's body, using the washcloth

ANS: 1

Rationale: Alcohol should never be used for bathing the child with a fever because it can cause rapid cooling, peripheral vasoconstriction, and chilling, thus elevating the temperature further. Washcloths can be used to squeeze water over the child's body. Towels are used to dry the child. Toys, especially water toys, can be used to provide distraction during the bath. Lightweight clothing should be placed on the child after the child is dried.

Test-Taking Strategy: Note the strategic word "avoids" in the question. This strategic word indicates a negative event query and the need to select the incorrect action. "Uses a water toy to distract the child during the bath" and "places lightweight pajamas on the child after the bath" can be easily eliminated. From the remaining options, select "applies alcohol-soaked cloths over the child's body" over "squeezes water over the child's body, using the washcloth" because of the harmful effects of alcohol and the effect of potentially elevating the temperature. Review the procedure for administering a tepid bath if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.

OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Implementation

50. A nurse is caring for a hospitalized child who is receiving a continuous infusion of intravenous (IV) potassium for the treatment of dehydration. The nurse monitors the child closely and notifies the physician if which of the following is noted?
    1. Weight increase of 0.5 kg
    2. Temperature of 100.8º F rectally
    3. Blood pressure (BP) unchanged from baseline
    4. A decrease in urine output to 0.5 mL/kg/hr

    ANS: 4

    Rationale: The priority assessment is to assess the status of urine output. Potassium should never be administered in the presence of oliguria or anuria. If urine output is less than 1 to 2 mL/kg/hr, potassium should not be administered. A slight elevation in temperature would be expected in a child with dehydration. A weight increase of 0.5 kg is relatively insignificant. A BP that is unchanged is a positive indicator unless the baseline was abnormal. However, there is no information in the question to support such data.

    Test-Taking Strategy: Knowledge regarding the effects of potassium on various organ systems is required to answer the question. Recalling that the kidneys play a strategic role in the excretion and reabsorption of potassium will easily direct you to "a decrease in urine output to 0.5 mL/kg/hr." Review the procedures for administering intravenous potassium if you had difficulty with this question.

    PTS: 1
    DIF: Level of Cognitive Ability: Analyzing
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Assessment

51. A female adolescent with type 1 diabetes mellitus has been chosen for her school's cheerleading squad. She visits the school nurse to obtain information regarding adjustments needed in her treatment plan for diabetes. The school nurse instructs the student to:
    1. Eat half the amount of food normally eaten.
    2. Take two times the amount of prescribed insulin on practice and game days.
    3. Take the prescribed insulin 1 hour prior to practice or game time rather than in the morning.
    4. Eat six graham crackers or drink a cup of orange juice prior to practice or game time.

    ANS: 4

Rationale: An extra snack of 15 to 30 g of carbohydrate eaten before activities, such as cheerleader practice, will prevent hypoglycemia. Six graham crackers or a cup of orange juice will provide 15 to 30 g of carbohydrate. The adolescent should not be instructed to adjust the amount or time of insulin administration. Meal amounts should not be decreased.

Test-Taking Strategy: "Take two times the amount of prescribed insulin on practice and game days" and "take the prescribed insulin 1 hour prior to practice or game time rather than in the morning" can be eliminated first, because insulin dosages and times should not be adjusted in this situation. From the remaining options, recalling the manifestations and treatment associated with hypoglycemia will direct you to "eat six graham crackers or drink a cup of orange juice prior to practice or game time." Review treatment to prevent hypoglycemia if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Health Promotion and Maintenance
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Implementation

52. The nurse has been caring for an adolescent newly diagnosed with type 1 diabetes mellitus. The nurse provides instructions to the adolescent regarding the administration of insulin. The nurse tells the adolescent to:
    1. Use only the stomach and thighs for injections.
    2. Rotate each insulin injection site on a daily basis.
    3. Use the same site for injections for 1 month before rotating to another site.
    4. Use one major site for the morning injection and another site for the evening injection for 2 to 3 weeks before changing major sites.

    ANS: 4

    Rationale: To help decrease variations in absorption from day to day, the child should use one location within a major site for the morning injection, rotating to another site for the evening injection, and a third site for the bedtime injection if needed. This pattern should be continued for a period of 2 to 3 weeks before changing major sites. "Use only the stomach and thighs for injections," "rotate each insulin injection site on a daily basis," and "use the same site for injections for 1 month before rotating to another site" are incorrect instructions to the adolescent.

    Test-Taking Strategy: Eliminate "use only the stomach and thighs for injections" first because of the close-ended word "only." From the remaining options, knowledge of the physiology associated with absorption of insulin will easily direct you to "Use one major site for the morning injection and another site for the evening injection for 2 to 3 weeks before changing major sites." If you had difficulty with this question, review insulin administration.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

53. The clinic nurse is caring for an infant who has been diagnosed with primary hypothyroidism. The nurse is reviewing the results of the laboratory tests and would expect to note which of the following?
    1. A normal T_4 level
    2. An elevated T_4 level
    3. An elevated thyroid-stimulating hormone (TSH) level
    4. A decreased TSH level

    ANS: 3

    Rationale: Diagnostic findings in primary hypothyroidism include a low T_4 level and a high TSH level. "A normal T_4 level," "an elevated T_4 level," and "a decreased TSH level" are not diagnostic findings in this condition.

    Test-Taking Strategy: Knowledge regarding the laboratory findings in primary hypothyroidism is required to answer this question. Think about the pathophysiology associated with this disorder and remember an elevated TSH level is noted in primary hypothyroidism. If you had difficulty with this question and are unfamiliar with the laboratory findings associated with this disorder, review this content.

    PTS: 1
    DIF: Level of Cognitive Ability: Analyzing
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Assessment

54. A nursing student is caring for a hospitalized child who has hypotonic dehydration. The nursing instructor asks the student to describe this type of dehydration. The instructor determines that the nursing student understands the physiology associated with this type of dehydration if the student states which of the following?
    1. "It causes the serum sodium level to rise above 150 mEq/L."
    2. "It occurs when the loss of electrolytes is greater than the loss of water."
    3. "It occurs when the loss of water is greater than the loss of electrolytes."
    4. "It occurs when water and electrolytes are lost in approximately the same proportion as they exist in the body."

    ANS: 2

Rationale: Hypotonic dehydration occurs when the loss of electrolytes is greater than the loss of water; in this type of dehydration, the serum sodium level is less than 130 mEq/L. Isotonic dehydration occurs when water and electrolytes are lost in approximately the same proportion as they exist in the body. In this type of dehydration, the serum sodium levels remain normal (135 to 145 mEq/L). "It causes the serum sodium level to rise above 150 mEq/L" and "It occurs when the loss of water is greater than the loss of electrolytes" describe hypertonic dehydration.

Test-Taking Strategy: Knowledge about the various types of dehydration is required to answer this question. However, thinking about the terms *hypo*tonic and *hyper*tonic, and relating these terms to losses or excesses, may help you eliminate options "It causes the serum sodium level to rise above 150 mEq/L," "It occurs when the loss of water is greater than the loss of electrolytes," and "It occurs when water and electrolytes are lost in approximately the same proportion as they exist in the body." Review these types of dehydration if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Understanding
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

55. The nurse is caring for an infant with gastroenteritis who is being treated for dehydration. The nurse reviews the health record and notes that the physician has documented that the infant is mildly dehydrated. Which of the following assessment findings would the nurse find in a child with mild dehydration?
    1. Anuria
    2. Pale skin color
    3. Sunken fontanels
    4. Dry mucous membranes

ANS: 2

Rationale: "Dry mucous membranes" is an assessment characteristic of moderate dehydration. "Anuria" and "sunken fontanels" are assessment characteristics of severe dehydration. In mild dehydration the skin color is pale.

Test-Taking Strategy: Note the strategic words "mildly dehydrated." Knowing that dehydration is classified as mild, moderate, or severe will direct you to selecting "pale skin color." Review the manifestations related to mild, moderate, and severe dehydration if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing

REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

56. The nurse is talking to the parents of a child newly diagnosed with diabetes mellitus. The nurse determines that the parents have a proper understanding of preventing and managing hypoglycemia if the parents state that they will:
1. Administer glucagon immediately if shakiness is felt.
2. Give the child 8 oz of diet cola at the first sign of weakness.
3. Report to the emergency department if the blood glucose level is 65 mg/dL.
4. Carry a glucose source when leaving home in case a hypoglycemic reaction occurs.

ANS: 4

Rationale: The child or parents should carry a source of glucose so it is readily available in the event of a hypoglycemic reaction. LifeSavers or hard candies will provide a source of glucose. A diet carbonated beverage does not meet this need. If the blood glucose level is 65 mg/dL, a source of glucose may be needed, but it is unnecessary to report to the emergency department. Glucagon is used for an unconscious client or if a client experiencing a hypoglycemic reaction is unable to swallow.

Test-Taking Strategy: Recalling the description and pathophysiology of hypoglycemia will assist in answering this question. Use the process of elimination and knowledge of hypoglycemia to assist in directing you to "carry a glucose source when leaving home in case a hypoglycemic reaction occurs." Review the treatment for hypoglycemia if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). Maternal child nursing care (4th ed.). St. Louis: Mosby.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Evaluation

57. The nurse provides instructions to the parent of a newborn to bring the infant to the well-baby clinic for a phenylketonuria (PKU) rescreening blood test. The parent brings the infant to the clinic, and the blood test is drawn. The results of the test indicate a serum phenylalanine level of 1.0 mg/dL. The nurse interprets these results as:
1. Positive
2. Negative
3. Inconclusive
4. Requiring rescreening at age 6 weeks

ANS: 2

Rationale: Phenylketonuria (PKU) is a genetic disorder that is characterized by an inability of the body to utilize the essential amino acid, phenylalanine. Phenylalanine level is checked to screen for this disorder. A normal phenylalanine level in a newborn is 1.2 to 3.4 mg/dL. A result of 1.0 mg/dL is a negative test result. "Positive," "inconclusive," and "requiring rescreening at age 6 weeks" are incorrect.

Test-Taking Strategy: Knowledge of the normal serum phenylalanine level is required to answer this question. Note that the level identified in the question is a low level. This should assist in directing you to "negative." Review this important screening test if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Understanding
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

58. The nurse is reviewing the physician's prescriptions for a child hospitalized with nephrotic syndrome. Which of the following dietary prescriptions would the nurse expect to be prescribed for the child?
    1. A low-fat diet
    2. A full liquid diet
    3. A high-protein, high-salt diet
    4. A normal protein, mild sodium diet

    ANS: 4

    Rationale: A diet that is normal in protein, with a mild sodium restriction (to reduce fluid retention), is normally prescribed for the child with nephrotic syndrome. "A low-fat diet," "a full liquid diet," and "a high-protein, high-salt diet" are incorrect options for this child.

    Test-Taking Strategy: Think about the body organ affected and the pathophysiology of this disorder. Remember that a normal protein and mild sodium restriction is prescribed with this disorder. If you had difficulty with this question, review the diet normally prescribed for the child with nephrotic syndrome.

    PTS: 1
    DIF: Level of Cognitive Ability: Understanding
    REF: Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). Maternal child nursing care (4th ed.). St. Louis: Mosby.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Planning

59. A nursing student caring for a 6-month-old infant is asked to collect a sample for urinalysis from the infant. The student collects the specimen by:
    1. Attaching a urinary collection device to the infant's perineum for collection
    2. Catheterizing the infant using the smallest available Foley catheter
    3. Obtaining the specimen from the diaper by squeezing the diaper after the infant voids
    4. Noting the time of the next expected voiding and preparing to collect the specimen into a cup when the infant voids

    ANS: 1

    Rationale: Although many methods have been used to collect urine from an infant, the most reliable method is the urine collection device. This device is a plastic bag that has an opening lined with adhesive so that it may be attached to the perineum. Urine for certain tests, such as specific gravity, may be obtained from a diaper by collection of the urine with a syringe. Urinary catheterization is not to be done unless specifically prescribed because of the risk of infection. It is not reasonable to try to identify the time of the next voiding to attempt to collect the specimen.

    Test-Taking Strategy: Use the process of elimination to answer the question. Eliminate "noting the time of the next expected voiding and preparing to collect the specimen into a cup when the infant voids" because this is unrealistic. Eliminate "catheterizing the infant using the smallest available Foley catheter" because catheterization is not prescribed, and the risk of infection exists with this procedure. Eliminate "obtaining the specimen from the diaper by squeezing the diaper after the infant voids" because only certain tests can be done on the urine obtained from the diaper. If you had difficulty with this question, review the procedure for collecting urine specimens from an infant and an incontinent child.

    PTS: 1
    DIF: Level of Cognitive Ability: Applying
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Implementation

60. The nurse is collecting data on a child recently diagnosed with glomerulonephritis. Which of the following questions to the mother would elicit data associated with the cause of this disease?
    1. "Has your child had any diarrhea?"
    2. "Have you noticed any rashes on your child?"
    3. "Did your child recently complain of a sore throat?"
    4. "Did your child sustain any injuries to the kidney area?"

    ANS: 3

Rationale: Group A beta-hemolytic streptococcal infection is a cause of glomerulonephritis. Often, the child becomes ill with streptococcal infection of the upper respiratory tract and then develops symptoms of acute poststreptococcal glomerulonephritis after an interval of 1 to 2 weeks. The questions to the mother in "Has your child had any diarrhea?" "Have you noticed any rashes on your child?" and "Did your child sustain any injuries to the kidney area?" are unrelated to a diagnosis of glomerulonephritis.

Test-Taking Strategy: Knowledge regarding the causes of glomerulonephritis is required to answer the question. "Did your child sustain any injuries to the kidney area?" relates to a kidney injury. "Has your child had any diarrhea?" and "Have you noticed any rashes on your child?" are not related to the diagnosis of glomerulonephritis. A streptococcal infection 1 to 2 weeks prior to the development of glomerulonephritis is the classic assessment finding. If you had difficulty with this question, review the causes of glomerulonephritis.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing
REF: Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). Maternal child nursing care (4th ed.). St. Louis: Mosby.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

61. The nurse is reviewing the record of a child diagnosed with nephrotic syndrome. The nurse would expect to note which of the following findings documented in the child's record?
    1. Polyuria
    2. Weight gain
    3. Hypotension
    4. Grossly bloody urine

    ANS: 2

    Rationale: Massive edema resulting in dramatic weight gain is a characteristic finding in nephrotic syndrome. Urine is dark, foamy, and frothy, but only microscopic hematuria is present; frank bleeding does not occur. Urine output is decreased, and hypertension is likely to be present.

    Test-Taking Strategy: Use knowledge regarding the characteristics of nephrotic syndrome and the process of elimination to answer the question. Eliminate "polyuria" and "grossly bloody urine" first, because urine output is most likely to be decreased in a renal disorder and hypertension is more likely to be present. Associate generalized edema with resultant weight gain with nephrotic syndrome. If you had difficulty with this question, review the characteristics of nephrotic syndrome.

    PTS: 1
    DIF: Level of Cognitive Ability: Analyzing

REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

62. The nurse is planning discharge instructions for the mother of a child following orchiopexy, which was performed on an outpatient basis. Which of the following is a priority in the plan of care?
1. Wound care
2. Pain control measures
3. Measurement of intake
4. Cold and heat applications

ANS: 1

Rationale: The most common complications associated with orchiopexy are bleeding and infection. Discharge instruction should include demonstration of proper wound cleansing and dressing and teaching parents to identify signs of infection, such as redness, warmth, swelling, or discharge. Testicles will be held in a position to prevent movement, and great care should be taken to prevent contamination of the suture line. Analgesics may be prescribed but are not the priority, considering the options presented. "Measurement of intake" is not necessary. "Cold and heat applications" is not a prescribed treatment measure.

Test-Taking Strategy: Note the strategic word "priority" in the question. Use Maslow's Hierarchy of Needs theory to answer the question. Of the options presented, the potential for infection (wound care) is the physiological priority. "Pain control measures" is important but not the priority, given the options listed. Use of heat and cold, as suggested in "cold and heat applications," is not prescribed. Measurement of intake is not required. Review home care measures following orchiopexy if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Planning

63. A nursing student is assigned to care for a child following surgery to correct cryptorchidism. The nursing instructor reviews the plan of care developed by the student and determines that the student is adequately prepared to care for the child if the student identifies which priority in the plan of care following this type of surgery?
1. Prevent tension on the suture.
2. Force oral fluids, and monitor I&O.
3. Monitor urine for glucose and acetone.

4. Encourage coughing and deep breathing every hour.

ANS: 1

Rationale: When a child returns from surgery, the testicle is held in position by an internal suture that passes through the testes and scrotum and is attached to the thigh. It is important not to dislodge this suture, and it should be immobilized for 1 week. The most common complications are bleeding and infection. Depending on the type of anesthesia used, "encourage coughing and deep breathing every hour" may be appropriate, but it is not the priority. Although it is important to maintain adequate hydration, it is inappropriate and unnecessary to force fluids. Testing urine for glucose and acetone also is not related to surgery.

Test-Taking Strategy: Read the question carefully, noting that the priority nursing action is specific to this type of surgery. Eliminate "force oral fluids, and monitor I&O" because of the strategic word "force." For the remaining options focus on the surgical procedure and note the relationship between the surgical procedure and "prevent tension on the suture." If you had difficulty with this question, review the nursing care following the surgical correction of cryptorchidism.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

64. A nurse is developing a plan of care for a 4-year-old child scheduled for a renal biopsy. Based on the developmental level of the child the nurse considers which of the following?
    1. Masturbation is common in this age group.
    2. Body image may be a concern for the child.
    3. Fears of mutilation may be present in the child.
    4. The urination pattern will cause embarrassment for the child.

ANS: 3

Rationale: During the preschool years, a child's fears of separation and mutilation are great, because the child is facing the developmental task of trusting others. As the child gets older, fears about virility and reproductive ability may surface. Body image is a concern for the adolescent. Masturbation is most common in the toddler age group as they discover their genital organs" Masturbation is common in this age group," "body image may be a concern for the child," and "the urination pattern will cause embarrassment for the child" are not accurate occurrences in this age group.

Test-Taking Strategy: Use knowledge regarding the stages of growth and development to answer the question. Focusing on the age of the child and the principles related to

developmental stages will easily direct you to “fears of mutilation may be present in the child”. If you had difficulty with this question, review the stages of growth and development.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Psychosocial Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Planning

65. The mother of a newborn male infant with hypospadias asks the nurse why circumcision cannot be performed. The **most** appropriate response by the nurse is which of the following?
1. “Circumcision will cause an infection.”
2. “Circumcision is not performed in a newborn.”
3. “Circumcision will cause difficulty with urination.”
4. “Circumcision has been delayed to save tissue for surgical repair.”

ANS: 4

Rationale: The infant should not be circumcised because the dorsal foreskin tissue will be used for surgical repair of the hypospadias. This defect will most likely be corrected during the first year of life to limit the psychological effects on the child. “Circumcision will cause an infection.” “Circumcision is not performed in a newborn.” and “Circumcision will cause difficulty with urination.” are inaccurate statements.

Test-Taking Strategy: Use the process of elimination, considering the diagnosis of the child as presented in the question. You should easily be able to eliminate “Circumcision will cause an infection.” “Circumcision is not performed in a newborn.” and “Circumcision will cause difficulty with urination.” Additionally, “Circumcision has been delayed to save tissue for surgical repair.” is the only option that relates to the diagnosis identified in the question. Review circumcision and the surgical procedure related to the repair of the hypospadias if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Implementation

66. The nursing instructor is observing a nursing student caring for an infant with a diagnosis of bladder exstrophy. The nursing student provides appropriate care to the infant by:
1. Covering the bladder with a sterile gauze dressing

2. Covering the bladder with a dry sterile dressing
3. Applying sterile water soaks to the bladder mucosa
4. Covering the bladder with a sterile, nonadhering dressing

ANS: 4

Rationale: Care should be taken to protect the exposed bladder tissue from drying while allowing drainage of urine. This is best accomplished by covering the bladder with a sterile, nonadhering dressing. The use of gauze should be avoided because this type of dressing adheres to the mucosa and may damage the delicate tissue when removed. Sterile dressings and dressings soaked in solutions can also dry out and damage the mucosa when removed.

Test-Taking Strategy: Use the process of elimination in answering the question. Note that "covering the bladder with a sterile gauze dressing," "covering the bladder with a dry sterile dressing," and "applying sterile water soaks to the bladder mucosa" are comparable or alike. These types of dressings can cause damage to the bladder mucosa. Also, note the strategic word "nonadhering" in the correct option. If you had difficulty with this question, review care to the infant with bladder exstrophy.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

67. The nurse is developing a plan of care for a 10-year-old child diagnosed with acute glomerulonephritis. The nurse determines that which of the following is a priority for the child?
1. Promoting bed rest
2. Restricting oral fluids
3. Encouraging visits from friends
4. Allowing the child to play with the other children in the playroom

ANS: 1

Rationale: Bed rest is required during the acute phase, and activity is gradually increased as the condition improves. Providing for quiet play according to the developmental stage of the child is important. Fluids should not be forced or restricted. Visitors should be limited to allow for adequate rest.

Test-Taking Strategy: Use the process of elimination to answer the question. Eliminate "encouraging visits from friends" and "allowing the child to play with the other children in the playroom" because rest is a priority. Although play and socialization may be an appropriate priority for some illnesses and the developmental needs of the sick child should always be considered, in this case rest is the priority over socialization. Although

fluids should be offered throughout the day, intake must reflect output and should not be restricted or forced. Review the appropriate nursing interventions for the child with glomerulonephritis if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Planning

68. The nurse is collecting data on a child brought to the health care clinic by the mother with a one-week-old cat scratch. While assessing the scratch the nurse notes redness, heat, swelling, and red streaking surrounding the area. The child states that the scratch hurts. Cellulitis is diagnosed. When providing home care instructions, which of the following statements made by the mother indicates a need for further education?
1. "The child should rest in bed."
2. "I should apply cool, moist soaks every 4 hours."
3. "I should take the child's temperature and watch for a fever."
4. "The affected extremity should be elevated and immobilized."

ANS: 2

Rationale: The child with cellulitis should rest in bed, and the affected extremity should be elevated and immobilized. Warm moist soaks applied every 4 hours increase circulation to the infected area, relieve pain, and promote healing. Frequent hand washing is essential to prevent the spread of infection. The child should be carefully monitored for signs of sepsis, increased fever, chills, and confusion, or for the spread of infection.

Test-Taking Strategy: Note the strategic words "need for further education." These words indicate a negative event query and the need to select the incorrect statement. Use the process of elimination to assist in answering the question. Also, use the principles related to heat and cold to assist in directing you to "I should apply cool, moist soaks every 4 hours." If you had difficulty with this question, review the treatment management of cellulitis.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

69. The nurse is providing instructions to the mother of a child with herpetic gingivostomatitis. Which of the following responses, if stated by the mother after teaching, would indicate that further instruction is required?
    1. "I will offer my child soft, bland foods."
    2. "I will encourage my child to drink fluids."
    3. "I will give my child frozen ice pops to assist with fluid intake."
    4. "I will not give my child anything to eat for 2 days to allow the lesions to heal and crust over."

    ANS: 4

    Rationale: Fluid intake is very important, and the child must be encouraged to drink. Frozen ice pops, noncitrus juices, and flat soft drinks are best. Small feedings of bland soft foods should be offered to the child. Parents need to be reassured that a few days without solid food will not harm the child as long as fluid intake is adequate, but an NPO status is not appropriate. Parents should also be taught to contact the physician if the child develops signs of dehydration. The child would not be kept NPO; in fact, dehydration is a concern with these children.

    Test-Taking Strategy: Note the strategic words "further instruction is required" in the question. These words indicate a negative event query and the need to select an incorrect statement. Use knowledge regarding care of the child with an oral infection. Knowing that dehydration can occur more quickly in a child will assist in directing you to "I will not give my child anything to eat for 2 days to allow the lesions to heal and crust over." as the correct answer. If you had difficulty with this question, review treatment for the child with an oral infection.

    PTS: 1
    DIF: Level of Cognitive Ability: Evaluating
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Teaching and Learning

70. The nurse is caring for a child who was burned in a house fire. The nurse develops a plan of care for monitoring the child during the treatment for burn shock. The nurse identifies which of the following assessments as providing the **most** accurate guide to determine the adequacy of fluid resuscitation?
    1. Heart rate
    2. Lung sounds
    3. Level of consciousness
    4. Amount of edema at the site of the burn injury

    ANS: 3

    Rationale: The sensorium, or level of consciousness, is an important guide to the adequacy of fluid resuscitation. The burn injury itself does not affect the sensorium, so

the child should be alert and oriented. Any alteration in sensorium should be evaluated further. A neurological assessment would determine the level of consciousness in the child. "Heart rate," "lung sounds," and "amount of edema at the site of the burn injury," although important in the assessment of the child with a burn injury, would not provide an accurate assessment of the adequacy of fluid resuscitation.

Test-Taking Strategy: Note the strategic words "most accurate" in the question. Although "Heart rate," "lung sounds," and "amount of edema at the site of the burn injury" may provide some information related to fluid volume in a burn injury, from the options provided, neurological assessment and level of consciousness are "most accurate." Review assessments during fluid resuscitation and treatment for burn shock if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). Maternal child nursing care (4th ed.). St. Louis: Mosby.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Evaluation

71. A 2-year-old child is being transported to the trauma center from a local community hospital for treatment of a burn injury that is estimated as covering over 40% of the body. The burns are both partial- and full-thickness burns. The nurse is asked to prepare for the arrival of the child and gathers supplies, anticipating that which of the following will be prescribed initially?
    1. Insertion of a Foley catheter
    2. Insertion of a nasogastric tube
    3. Administration of an anesthetic agent for sedation
    4. Application of an antimicrobial agent to the burns

    ANS: 1

    Rationale: A Foley catheter is inserted into the child's bladder so that urine output can be accurately measured on an hourly basis. Although pain medication may be required, the child would not receive an anesthetic agent and should not be sedated. The burn wounds would be cleansed after assessment, but this would not be the initial action. IV fluids are administered at a rate sufficient to keep the child's urine output at 1 to 2 mL/kg of body weight per hour for children weighing less than 30 kg, thus reflecting adequate tissue perfusion. A nasogastric tube may or may not be required but would not be the priority intervention.

    Test-Taking Strategy: Note the strategic word "initially" in the question. "Administration of an anesthetic agent for sedation" can be eliminated first because the child should not be sedated and an anesthetic agent would not be administered. Eliminate "insertion of a nasogastric tube" next, knowing that a nasogastric tube may or may not be required. From the remaining options, knowledge that fluid resuscitation and determining the adequacy of the amounts of fluid are essential will direct you to

"insertion of a Foley catheter." Review the treatment of burns if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing
REF: Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). Maternal child nursing care (4th ed.). St. Louis: Mosby.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Planning

72. The nurse reinforces instructions to the mother of a child diagnosed with pediculosis (head lice). Permethrin 1% (Nix) has been prescribed. Which of the following statements, if made by the mother regarding the use of the medication, indicates a need for further education?
    1. "I need to purchase the medication from the pharmacy."
    2. "After rinsing out the medication, I need to avoid washing my child's hair for 24 hours."
    3. "I need to shampoo my child's hair, apply the medication, and leave it on for 10 minutes and then rinse it out."
    4. "I need to shampoo my child's hair, apply the medication, and leave the medication on for 24 hours."

    ANS: 4

    Rationale: Nix is an over-the-counter antilice product that kills both lice and eggs with one application and has residual activity for 10 days. It is applied to the hair after shampooing and left for 10 minutes before rinsing out. The hair should not be shampooed for 24 hours after the rinsing treatment.

    Test-Taking Strategy: Note the strategic words "a need for further education" in the question. These words indicate a negative event query and the need to select the incorrect statement. Remember that it is applied to the hair after shampooing and left for 10 minutes before rinsing. Review this treatment if you had difficulty with this question.

    PTS: 1
    DIF: Level of Cognitive Ability: Evaluating
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Teaching and Learning

73. The nurse is reviewing the health care record of an infant suspected of having unilateral hip dysplasia. Which of the following assessment findings would the nurse expect to note documented in the infant's record regarding this condition?
    1. Full range of motion in the affected hip
    2. An apparent short femur on the unaffected side

3. Asymmetrical adduction of the affected hip when placed supine, with the knees and hips flexed
4. Asymmetry of the gluteal skin folds when the infant is placed prone and the legs are extended against the examining table

ANS: 4

Rationale: Asymmetry of the gluteal skin folds when the infant is placed prone and the legs are extended against the examining table is noted in hip dysplasia. Asymmetrical abduction of the affected hip, when an infant is placed supine with the knees and hips flexed, would also be an assessment finding in hip dysplasia in infants beyond the newborn period. An apparent short femur on the affected side is noted, as well as limited range of motion.

Test-Taking Strategy: Focus on the diagnosis and think about its pathophysiology. Visualize each of the assessment findings described in the options. This will assist in directing you to "asymmetry of the gluteal skin folds when the infant is placed prone and the legs are extended against the examining table." If you had difficulty with this question, review the assessment finding in hip dysplasia.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

74. The nurse is implementing a teaching plan for a 4-month-old child who has been diagnosed with developmental dysplasia of the hip (DDH). The child will be placed in the Pavlik harness. Which of the following statements by the family would indicate that they understand the care of their child while placed in the Pavlik harness?
    1. "I know that the harness must be worn continuously."
    2. "I will bring my child back to the orthopedic office in a month so the straps can be checked."
    3. "I realize that I will also need to put two diapers on my child so that the harness does not get soiled."
    4. "I will watch for any redness or skin irritation where the straps are applied and call the doctor if there is any irritation."

    ANS: 4

    Rationale: If stabilization of the hip is required, a cast is initially applied. This is kept in place for 3 to 6 months until the hip is stabilized. After this is completed, and if further treatment is required, a Pavlik harness is the treatment of choice next. A Pavlik harness is a removable abduction brace. This is a procedure that requires the brace be checked every 1 to 2 weeks for adjustment of the straps. The use of double diapering is not

recommended for DDH because of the possibility of hip extension. Because there are straps applied to the child's skin, it is important to check the skin of the child frequently.

Test-Taking Strategy: Knowledge regarding care of the child in a Pavlik harness is required to answer this question. Use of the process of elimination and knowing that the child must return to the orthopedic office in 1 to 2 weeks for strap adjustment will allow you to eliminate "I will bring my child back to the orthopedic office in a month so the straps can be checked." Also, knowing that the Pavlik harness is removable will allow you to eliminate "I know that the harness must be worn continuously." because this states that the harness should be worn continuously. It is also not recommended that double diapering be done with children who are diagnosed with DDH, so this will eliminate "I realize that I will also need to put two diapers on my child so that the harness does not get soiled." This will lead you to the correct response, as stated in "I will watch for any redness or skin irritation where the straps are applied and call the doctor if there is any irritation." If you had difficulty with this question, review teaching components for caregivers of children who are placed in a Pavlik harness.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Evaluation

75. The nurse is caring for a child who fractured the ulna bone and had a cast applied 24 hours ago. The child tells the nurse that the arm feels like it is falling asleep. Which of the following nursing actions would be most appropriate?
    1. Report the findings to the physician.
    2. Document the findings, and reassess the situation in 4 hours.
    3. Encourage the child to keep the arm elevated for the next 24 hours.
    4. Tell the child that this is normal and will disappear when the cast is dry.

ANS: 1

Rationale: A child's complaint of pins and needles or of the extremity falling asleep needs to be reported to the physician. These complaints indicate the possibility of circulatory impairment and paresthesia. Paresthesia is a serious concern because paralysis can result if the problem is not corrected. The five *P's* of vascular impairment are pain, pallor, pulselessness, paresthesia, and paralysis. Prompt intervention is critical if neurovascular impairment is to be prevented.

Test-Taking Strategy: Knowledge regarding assessment findings in a child with circulatory impairment from a cast is required to answer this question. Focus on the child's complaints and the signs of circulatory impairment. This should easily direct you to "report the findings to the physician." "Document the findings, and reassess the situation in 4 hours," "encourage the child to keep the arm elevated for the next 24 hours," and "tell the child that this is normal and will disappear when the cast is dry"

would delay treatment and could lead to serious circulatory impairment problems. Review care to the child with a cast if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Implementation

76. An adolescent is seen in the emergency department following an athletic injury. It is suspected that the child has sprained an ankle. X-rays have been obtained, and a fracture has been ruled out. The nurse is providing instructions to the adolescent regarding home care for treatment of the sprain. Which of the following instructions would the nurse provide to the adolescent?
    1. Elevate the extremity, and maintain strict bed rest for a period of 7 days.
    2. Immobilize the extremity, and maintain the extremity in a dependent position.
    3. Apply heat to the injured area every 4 hours for the first 48 hours, and then begin to apply ice.
    4. Apply ice to the injured area for a period of 30 minutes every 4 to 6 hours for the first 24 to 48 hours.

ANS: 4

Rationale: The injured area should be wrapped immediately to support the joint and control the swelling. Ice is applied to reduce the swelling and should be applied for not longer than 30 minutes every 4 to 6 hours for the first 24 to 48 hours. The joint should be immobilized and elevated, but strict bed rest for a period of 7 days is not required. A dependent position will cause swelling in the affected area.

Test-Taking Strategy: Use the process of elimination, focusing on the diagnosis. Noting the extended time frame in "elevate the extremity, and maintain strict bed rest for a period of 7 days" will assist in eliminating this option. Recalling that elevation is required in a nondependent position will assist in eliminating "immobilize the extremity, and maintain the extremity in a dependent position." Recalling the principles related to heat and cold will assist in eliminating "apply heat to the injured area every 4 hours for the first 48 hours, and then begin to apply ice." Review home care measures for the child with a sprain if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

77. The nurse is reinforcing instructions to the mother of a child who has a plaster cast applied to the left arm. Which of the following statements, if made by the mother, indicates a need for further education?
    1. "I should use a heat lamp to help the cast dry."
    2. "I should cover the cast with plastic when the child bathes or showers."
    3. "I should call the physician if the cast feels warm or hot or has an unusual smell or odor."
    4. "I should keep small toys and sharp objects away from the cast and be sure that my child does not put anything inside the cast."

    ANS: 1

    Rationale: The mother needs to be instructed not to use a heat lamp to help the cast dry because of the risk associated with a burn injury from the heat lamp. "I should cover the cast with plastic when the child bathes or showers." "I should call the physician if the cast feels warm or hot or has an unusual smell or odor." and "I should keep small toys and sharp objects away from the cast and be sure that my child does not put anything inside the cast." are appropriate instructions.

    Test-Taking Strategy: Note the strategic words "indicates a need for further education." These words indicate a negative event query and the need to select the incorrect statement. Knowledge regarding routine cast care should easily direct you to "I should use a heat lamp to help the cast dry." Review home care instructions regarding cast care if you had difficulty with this question.

    PTS: 1
    DIF: Level of Cognitive Ability: Evaluating
    REF: Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). Maternal child nursing care (4th ed.). St. Louis: Mosby.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Teaching and Learning

78. The nurse is assisting a physician during the examination of an infant with developmental hip dysplasia. The physician performs the Ortolani maneuver. The nurse determines that the infant exhibits a positive response to this maneuver if which of the following is noted?
    1. A shrill cry from the infant
    2. Asymmetry of the affected hip
    3. Reduced range of motion in the affected hip
    4. A palpable click during abduction of the affected hip

    ANS: 4

    Rationale: In the Ortolani maneuver, the examiner abducts both hips. A positive finding is a palpable click on the affected side during abduction. Crying is expected. Asymmetry and reduced range of motion of the affected hip are not positive signs of this maneuver.

Test-Taking Strategy: Knowledge regarding assessment findings and these maneuvers is required to answer this question. Think about the pathophysiology associated with this condition. Noting the strategic word "positive" in the question will assist in directing you to the correct option. Review the maneuver if you had difficulty with this question. Remember that this maneuver should be performed only by a physician or trained health care provider.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

79. The nurse provides instructions to the parents of an infant with hip dysplasia regarding care of the Pavlik harness. Which of the following statements, if made by one of the parents, indicates an understanding of the use of the harness?
1. "I can remove the harness to bathe my infant."
2. "I need to remove the harness to feed my infant."
3. "I need to remove the harness to change the diaper."
4. "My infant needs to remain in the harness at all times."

ANS: 1

Rationale: The harness should be worn 23 hours a day and should be removed only to check the skin and for bathing. The hips and buttocks should be supported carefully when the infant is out of the harness. The harness does not need to be removed for diaper changes or feedings. "My infant needs to remain in the harness at all times." is incorrect.

Test-Taking Strategy: Attempt to visualize this harness in answering the question. This will assist in eliminating "I need to remove the harness to feed my infant." and "I need to remove the harness to change the diaper." Select "I can remove the harness to bathe my infant." over "My infant needs to remain in the harness at all times." noting the close-ended word "all" in the latter. Review home care instruction regarding this harness if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Evaluation

80. The nurse is providing instructions to the parents of a child with scoliosis regarding the use of a brace. Which of the following statements, if made by one of the parents, indicates a need for further instructions?
    1. "I cannot place powder under the brace."
    2. "I need to place a soft shirt on my child under the brace."
    3. "I need to encourage my child to perform prescribed exercises."
    4. "I need to be sure to apply lotion on the skin under the brace."

    ANS: 4

    Rationale: The use of lotions or powders should be avoided with a brace because they can become sticky or cake under the brace, causing irritation. "I cannot place powder under the brace." "I need to place a soft shirt on my child under the brace." and "I need to encourage my child to perform prescribed exercises." are appropriate interventions for the use of a brace on a child.

    Test-Taking Strategy: Note the strategic words "a need for further instructions" in the question. These words indicate a negative event query and the need to select the incorrect statement. Careful reading of the options will assist in directing you to "I need to be sure to apply lotion on the skin under the brace." Review home care instructions regarding the care of a child in a brace if you had difficulty with this question.

    PTS: 1
    DIF: Level of Cognitive Ability: Evaluating
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Teaching and Learning

81. The nurse is caring for a child with a fracture who is placed in skeletal traction. The nurse monitors for the most serious complication associated with this type of traction by assessing for a(n):
    1. Lack of appetite
    2. Elevated temperature
    3. Decrease in the urinary output
    4. Increase in the blood pressure

    ANS: 2

    Rationale: The most serious complication associated with skeletal traction is osteomyelitis, an infection involving the bone. Organisms gain access to the bone systemically or through the opening created by the metal pins or wires used with the traction. Osteomyelitis may occur with any open fracture. Clinical manifestations include complaints of localized pain, swelling, warmth, tenderness, an unusual odor from the fracture site, and an elevated temperature. "A lack of appetite," "a decrease in the urinary output," and "an increase in the blood pressure" are not specifically associated with osteomyelitis.

Test-Taking Strategy: Note that the question addresses skeletal traction. Recalling that skeletal traction involves an invasive procedure will direct you to "an elevated temperature." Review the complications associated with skeletal traction if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

82. The nurse is collecting data on a 12-month-old child with iron deficiency anemia. Which of the following findings would the nurse expect to note in this child?
    1. Bradycardia
    2. Tachycardia
    3. Hyperactivity
    4. A reddened appearance to the cheeks of the face

    ANS: 2

    Rationale: Clinical manifestations of iron deficiency anemia will vary with the degree of anemia but usually include extreme pallor with a porcelain-like skin, tachycardia, lethargy, and irritability.

    Test-Taking Strategy: Use the process of elimination, and think about the manifestations that would be noted in anemia. Eliminate "a reddened appearance to the cheeks of the face" because pallor rather than a reddened color would most likely be noted. Eliminate "hyperactivity" because when an iron deficiency occurs, the child would be lethargic and irritable rather than hyperactive. Next, eliminate "bradycardia" because tachycardia would occur as the body attempts to compensate for the low hemoglobin and hematocrit levels. Review the clinical manifestations associated with iron deficiency anemia if you had difficulty with this question.

    PTS: 1
    DIF: Level of Cognitive Ability: Analyzing
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Assessment

83. Oral iron is prescribed for a child with iron deficiency anemia. The nurse provides instructions to the mother regarding the administration of the iron. The nurse instructs the mother to administer the iron:
    1. Between meals

2. Just before a meal
3. Just after the meal
4. With a fruit low in vitamin C

ANS: 1

Rationale: The mother should be instructed to administer oral iron supplements between meals. The iron should be given with a citrus fruit or juice high in vitamin C because vitamin C increases the absorption of iron by the body.

Test-Taking Strategy: Use the process of elimination to answer this question. Note that "just before a meal" and "just after the meal" are comparable or alike in that they suggest administering the iron with a food supplement. Recalling that vitamin C increases the absorption of iron by the body will assist in eliminating "with a fruit low in vitamin C." Review the administration of iron supplements if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Implementation

84. The nurse provides instructions to the mother of a child with sickle cell disease. Which of the following statements, if made by the mother, indicates a need for further education?
    1. "I need to be sure that my child has adequate rest periods."
    2. "I need to take my child's temperature and watch for a fever."
    3. "I need to encourage my child to drink large amounts of fluids."
    4. "I need to make sure that my child spends some time in the sun to help prevent a sickle cell crisis."

ANS: 4

Rationale: The nurse should instruct the mother to encourage fluid intake 1.5 to 2 times the daily requirements. Adequate rest periods should be provided, and the child should not be exposed to cold or heat stress. The mother should be taught how to take the child's body temperature and how to use a thermometer properly. Sources of infection should be avoided, as should prolonged exposure to the sun.

Test-Taking Strategy: Use the process of elimination to answer this question. Note the strategic words "need for further education." These words indicate a negative event query and the need to select the incorrect statement. Knowing that cold and heat stress can precipitate a sickle cell crisis will easily direct you to the correct option. If you had difficulty with this question, review home care instructions for the child with sickle cell disease.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

85. The nurse is reviewing the laboratory results of a child with aplastic anemia and notes that the white blood cell (WBC) count is 2000 cells/mm^3 and the platelet count is 150,000 cells/mm^3. Which of the following nursing interventions will the nurse incorporate into the plan of care?
1. Avoid unnecessary injections.
2. Maintain strict neutropenic precautions.
3. Encourage quiet play activities.
4. Encourage the child to use a soft toothbrush.

ANS: 2

Rationale: The normal WBC count ranges from 5000 to 10,000 cells/mm^3, and the normal platelet count ranges from 150,000 to 400,000 cells/mm^3. Strict neutropenic procedures would be required if the WBC count were low to protect the child from infection. Precautionary measures to prevent bleeding should be taken when a child has a low platelet count. These include no injections, no rectal temperatures, use of a soft toothbrush, and abstinence from contact sports or activities that could cause an injury.

Test-Taking Strategy: Note that the platelet count is normal and that the WBC count is low. Recall that a low WBC count places the client at risk for infection. This will assist in eliminating "avoid unnecessary injections," "encourage quiet play activities," and "encourage the child to use a soft toothbrush." Review normal WBC and platelet counts if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Safe and Effective Care Environment
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Planning

86. The nursing student is assigned to care for a child with hemophilia. The nursing instructor reviews the plan of care with the student and asks the student to describe the characteristics of this disorder. Which of the following statements, if made by the student, indicates a need for further research?
1. Males inherit hemophilia from their fathers.
2. Hemophilia A results from deficiency of factor VIII.
3. Females inherit the carrier status from their fathers.

4. Hemophilia is inherited in a recessive manner via a genetic defect on the X chromosome.

ANS: 1

Rationale: Males inherit hemophilia from their mothers, and females inherit the carrier status from their fathers. Some females who are carriers have an increased tendency to bleed, and, although it is rare, females can have hemophilia if their fathers have the disorder and their mothers are carriers of the genetic disorder. Hemophilia is inherited in a recessive manner via a genetic defect on the X chromosome. Hemophilia A results from a deficiency of factor VIII. Hemophilia B (Christmas disease) is a deficiency of factor IX.

Test-Taking Strategy: Note the strategic words "need for further research." These words indicate a negative event query and the need to select the incorrect statement. An important point to remember is that males inherit hemophilia from their mothers, and females inherit the carrier status from their fathers. Review this disorder if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Understanding
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

87. The nurse is providing instructions to the mother of a 3-year-old child with hemophilia regarding care of the child. Which of the following statements, if made by the mother, indicates a need for further education?
    1. "I need to cancel all the dental appointments that I made for my child."
    2. "If my child gets a cut, I should hold pressure on it until the bleeding stops."
    3. "I should check the house and remove any household items that can easily fall over."
    4. "I should move furniture with sharp corners out of the way and pad the corners of the furniture."

ANS: 1

Rationale: The nurse needs to stress the importance of immunizations, dental hygiene, and routine well-child care. "If my child gets a cut, I should hold pressure on it until the bleeding stops." "I should check the house and remove any household items that can easily fall over." and "I should move furniture with sharp corners out of the way and pad the corners of the furniture." are appropriate care measures. The mother is instructed regarding actions in the event of blunt trauma, especially trauma involving the joints, and is told to apply prolonged pressure to superficial wounds until the bleeding has stopped.

Test-Taking Strategy: Note the strategic words "need for further education" in the question. These words indicate a negative event query and the need to select the incorrect statement. Knowledge that bleeding is a concern in this disorder will assist in eliminating "If my child gets a cut, I should hold pressure on it until the bleeding stops." "I should check the house and remove any household items that can easily fall over." and "I should move furniture with sharp corners out of the way and pad the corners of the furniture." which include measures of protection and safety for the child. If you had difficulty with this question, review care of the child with hemophilia.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

88. A child is brought to the emergency department after falling from a high swing and landing on the back. The nurse notes that the client also has hemophilia. Because of the client's history and the nature of the injury, the nurse should first collect data about:
1. Blood in the urine
2. Oxygen saturation
3. Presence of headache
4. Presence of slurred speech

ANS: 1

Rationale: Because the kidneys are located in the flank region of the body, trauma to the back area can cause hematuria, particularly in the child with hemophilia. The nurse would be most concerned about the child's airway and respiratory rate if the child sustained an injury to the neck region. Headache and slurred speech are associated with head trauma.

Test-Taking Strategy: Focus on the data provided in the question to answer correctly. Noting the child's history of hemophilia should direct your thinking to bleeding as a concern. Noting the anatomical location of the injury and the relationship to the location of the kidneys will easily direct you to "blood in the urine." Review care of the client with hemophilia if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing
REF: Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). Maternal child nursing care (4th ed.). St. Louis: Mosby.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

89. The nurse is asked to prepare for the hospital admission of a child with sickle cell disease (SCD) who is being admitted for the treatment of vaso-occlusive pain crisis. The nurse prepares for the admission, anticipating that which of the following will be prescribed for the child?
    1. NPO status
    2. Intravenous (IV) fluids
    3. Meperidine (Demerol) for pain
    4. Intubation for the administration of oxygen

    ANS: 2

    Rationale: IV fluid and increased oral fluids are a component of the treatment plan for the child with vaso-occlusive crisis. Management of the severe pain that occurs with vaso-occlusive crisis includes the use of opioid analgesics, such as morphine sulfate and hydromorphone. Demerol is contraindicated because of its side effects and the increased risk of seizures with its use. Oxygen is administered when hypoxia is present and the oxygen saturation level is less than 95%. Intubation is not necessary to treat vaso-occlusive crisis.

    Test-Taking Strategy: Knowledge about the treatment measures for vaso-occlusive crisis is required to answer this question. "Intubation for the administration of oxygen" can be easily eliminated first, knowing that intubation is not necessary. Knowing about pain management and knowing that hydration is necessary will assist in eliminating "NPO status" and "meperidine (Demerol) for pain" and direct you to the correct option. Review care of the client with SCD if you had difficulty with this question.

    PTS: 1
    DIF: Level of Cognitive Ability: Applying
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Planning

90. A nursing student is assigned to care for a child with sickle cell disease (SCD). The nursing instructor asks the student to describe the causative factors related to this disease. Which of the following statements, if made by the student, indicates a need for further research?
    1. SCD is an autosomal recessive disease.
    2. If each parent carries the trait, the children will inherit the trait.
    3. Children with the HbS (sickle cell hemoglobin) trait are not symptomatic.
    4. If one parent has the HbS trait and the other parent is normal, there is a 50% chance that each offspring will inherit the trait.

    ANS: 2

    Rationale: SCD is an autosomal recessive disease. Children with the HbS trait are not symptomatic. If one parent has the HbS trait and the other parent is normal, there is a

50% chance that each offspring will inherit the trait. If each parent carries the trait, there is a 25% chance that their child will be normal, a 50% chance that the child will carry the trait, and a 25% chance that each child will have the disease.

Test-Taking Strategy: Note the strategic words "need for further research." These words indicate a negative event query and the need to select the incorrect option. Knowledge of the causative factors related to SCD is necessary to answer this question. If you had difficulty with this question, review this content.

PTS: 1
DIF: Level of Cognitive Ability: Understanding
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

91. The nurse is caring for a child with hemophilia and is reviewing the results that were sent from the laboratory. The nurse would expect to note which of the following results in this child?
    1. Shortened prothrombin time (PT)
    2. Prolonged prothrombin time (PT)
    3. Shortened partial thromboplastin time (PTT)
    4. Prolonged partial thromboplastin time (PTT)

    ANS: 4

    Rationale: PTT measures the activity of thromboplastin, which is dependent on intrinsic factors. In hemophilia, the intrinsic clotting factor VIII (antihemophilic factor) is deficient, resulting in a prolonged PTT. "Shortened prothrombin time (PT)," "prolonged prothrombin time (PT)," and "shortened partial thromboplastin time (PTT)" are incorrect. The PT may not necessarily be affected in this disorder.

    Test-Taking Strategy: Knowledge about the laboratory tests used to monitor hemophilia and the expected results is required to answer this question. Remember that the PTT is prolonged. Review these laboratory tests if you had difficulty with this question.

    PTS: 1
    DIF: Level of Cognitive Ability: Analyzing
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Assessment

92. A child is seen in the health care clinic for complaints of fever. On data collection, the nurse notes that the child is pale, is tachycardic, and has petechiae. Aplastic anemia is

suspected. Which of the following diagnostic tests will confirm the diagnosis of aplastic anemia?
1. Platelet count
2. Granulocyte count
3. Red blood cell count
4. Bone marrow biopsy

ANS: 4

Rationale: Although the diagnosis of aplastic anemia may be suspected from the child's history and the results of a complete blood count (CBC), a bone marrow biopsy must be performed to confirm the diagnosis.

Test-Taking Strategy: Knowledge about diagnostic evaluation in a child with aplastic anemia is required to answer this question. Note the strategic word "confirm" in the question. This should assist in directing you to "bone marrow biopsy" because a biopsy is the only diagnostic test that will confirm the presence of aplastic anemia. If you had difficulty with this question, review the diagnostic tests related to aplastic anemia.

PTS: 1
DIF: Level of Cognitive Ability: Understanding
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

93. The nurse is collecting data on a 9-year-old child suspected of having a brain tumor. Which of the following questions would the nurse ask to elicit data related to the classic symptoms of a brain tumor?
1. "Do you have trouble seeing?"
2. "Do you feel tired all the time?"
3. "Do you have headaches late in the day?"
4. "Do you feel sick to your stomach, and do you throw up in the morning?"

ANS: 4

Rationale: The classic symptoms of children with brain tumors are headache and morning vomiting related to the child getting out of bed. Headaches worsen on arising but improve during the day. Fatigue may occur but is a vague symptom. Visual changes may occur, including nystagmus, diplopia, and strabismus, but these signs are not the hallmark symptoms with a brain tumor.

Test-Taking Strategy: Note the strategic words "classic symptoms" in the question. Focusing on the subject, the clinical manifestations associated with a brain tumor will assist in eliminating "Do you have trouble seeing?" "Do you feel tired all the time?" and "Do you have headaches late in the day?" If you are unfamiliar with these clinical manifestations, review this content.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

94. The nurse has reviewed the physician's prescriptions for a child suspected of a diagnosis of neuroblastoma and is preparing to implement diagnostic procedures that will confirm the diagnosis. The nurse **most** appropriately prepares to:
1. Collect a 24-hour urine sample.
2. Perform a neurological assessment.
3. Assist with a bone marrow aspiration.
4. Send the child to the radiology department for a chest x-ray.

ANS: 1

Rationale: Neuroblastoma is a solid tumor found only in children. It arises from neural crest cells that develop into the sympathetic nervous system and the adrenal medulla. Typically, the tumor infringes on adjacent normal tissue and organs. Neuroblastoma cells may excrete catecholamines and their metabolites. Urine samples will indicate elevated vanillylmandelic acid (VMA) levels. A bone marrow aspiration will assist in determining marrow involvement. A neurological examination and a chest x-ray may be performed but will not confirm the diagnosis.

Test-Taking Strategy: Use the process of elimination in answering this question. Focus on the strategic word "confirm" and the pathophysiology associated with this diagnosis. "Perform a neurological assessment" and "send the child to the radiology department for a chest x-ray" can be eliminated easily, because they will not confirm the diagnosis. Focusing on the origin of the tumor location will assist in eliminating "assist with a bone marrow aspiration." If you are unfamiliar with this type of tumor, review this content.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Planning

95. The nurse is asked to prepare for the admission of a child to the pediatric unit with a diagnosis of Wilms tumor. The nurse is developing a plan of care for the child and suggests including which of the following in the plan of care?
1. Monitor the temperature for hypothermia.
2. Monitor the blood pressure for hypotension.
3. Inspect the urine for the presence of hematuria at each voiding.

4. Palpate the abdomen for an increase in the size of the tumor every 8 hours.

ANS: 3

Rationale: If Wilms tumor is suspected, the tumor mass should not be palpated. Excessive manipulation can cause seeding of the tumor and cause spread of the cancerous cells. Fever (not hypothermia), hematuria, and hypertension (not hypotension) are clinical manifestations associated with Wilms tumor.

Test-Taking Strategy: Read the question and each option carefully. Knowledge that this tumor is located in the kidney will assist in directing you to "inspect the urine for the presence of hematuria at each voiding." If you are unfamiliar with the interventions for the child with Wilms tumor, review this disorder.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Planning

96. The nurse is monitoring the laboratory values of a child with leukemia who is receiving chemotherapy. The nurse prepares to implement bleeding precautions if the child becomes thrombocytopenic and the platelet count is less than _____ cells/mm^3.
1. 80,000
2. 100,000
3. 120,000
4. 150,000

ANS: 1

Rationale: If a child is thrombocytopenic, precautions need to be taken because of the increased risk of bleeding. The precautions include limiting activity that could result in head injury, using soft toothbrushes, checking urine and stools for blood, and administering stool softeners to prevent straining with constipation. Additionally, suppositories and rectal temperatures are avoided. The normal platelet count ranges from 150,000 to 400,000 cells/mm^3.

Test-Taking Strategy: Focus on the subject, the need to implement bleeding precautions. Read each of the options carefully, and recall the value that indicates severe thrombocytopenia in a child. Select the option that identifies the lowest platelet count. If you are unfamiliar with the normal platelet count and precautions that need to be implemented, review this content.

PTS: 1
DIF: Level of Cognitive Ability: Applying

REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Safe and Effective Care Environment
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Planning

97. The nurse is providing home care instructions to the mother of a child receiving radiation therapy. Which of the following statements, if made by the mother, indicates a need for further education?
1. "I should dress my child in loose clothing."
2. "My child may need more rest periods because the radiation will cause fatigue."
3. "I won't need to limit the amount of sun that my child gets."
4. "I need to try to provide food and fluids to prevent dehydration."

ANS: 3

Rationale: Sun protection is essential during radiation treatments. The child should not be exposed to sun during these treatments. "I should dress my child in loose clothing." "My child may need more rest periods because the radiation will cause fatigue." and "I need to try to provide food and fluids to prevent dehydration." are appropriate measures for the child during radiation therapy.

Test-Taking Strategy: Use the process of elimination, noting the strategic words "need for further education." These words indicate a negative event query and the need to implement the incorrect statement. Read each option carefully, noting the strategic words "won't need to limit" in "I won't need to limit the amount of sun that my child gets." If you had difficulty with this question, review the client teaching points related to radiation therapy.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

98. The nurse is reviewing the record of a 10-year-old child suspected of having Hodgkin's disease. The nurse anticipates noting which of the following characteristic manifestations documented in the assessment notes?
1. Fever
2. Malaise
3. Painful lymph nodes in the supraclavicular area
4. Painless and movable lymph nodes in the cervical area

ANS: 4

Rationale: Clinical manifestations specifically associated with Hodgkin's disease include painless, firm, and movable adenopathy in the cervical and supraclavicular area. Hepatosplenomegaly is also noted. Although anorexia, weight loss, fever, and malaise are associated with Hodgkin's disease, these manifestations are vague and can be seen in many disorders.

Test-Taking Strategy: Note the strategic words "characteristic manifestations" in the question. Eliminate "fever" and "malaise" first because these symptoms are general and vague. Next, think about the pathophysiology associated with Hodgkin's disease. Recalling that painless adenopathy is associated with Hodgkin's disease will direct you to "painless and movable lymph nodes in the cervical area." Review the clinical manifestations related to Hodgkin's disease if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

99. The nurse is reviewing the laboratory and diagnostic test results of a child scheduled to be seen in the clinic. The nurse notes that the physician documented that diagnostic studies revealed the presence of Reed-Sternberg cells. The nurse prepares to assist the physician to discuss which of the following with the parents of the child?
    1. Treatment options for leukemia
    2. Treatment options for neuroblastoma
    3. Treatment options for Hodgkin's disease
    4. Treatment options for infectious mononucleosis

    ANS: 3

    Rationale: Hodgkin's disease is a neoplasm of lymphatic tissue. The presence of giant, multinucleated cells (Reed-Sternberg cells) is the hallmark of this disease. The presence of blast cells in the bone marrow is indicative of leukemia. Infectious mononucleosis and Epstein-Barr virus have been associated with Hodgkin's disease, but the exact relationship is unknown. Elevated vanillylmandelic acid (VMA) urinary levels are found in children with neuroblastoma.

    Test-Taking Strategy: Think about the pathophysiology associated with Hodgkin's disease. Recalling that the Reed-Sternberg cell is characteristic of Hodgkin's disease will easily direct you to "treatment options for Hodgkin's disease." Review the clinical manifestations associated with Hodgkin's disease if you had difficulty with this question.

    PTS: 1
    DIF: Level of Cognitive Ability: Understanding

REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Planning

100. The nurse is monitoring for bleeding in a child following surgery for removal of a brain tumor. The nurse checks the head dressing and notes the presence of dried blood on the back of the dressing. The child is alert and oriented, and the vital signs and neurological signs are stable. Which of the following nursing actions would be **most** appropriate initially?
1. Change the dressing.
2. Document the findings.
3. Recheck the dressing in 1 hour.
4. Check the operative record to determine whether a drain is in place.

ANS: 4

Rationale: The initial nursing action is to determine whether a drain is in place because this could attribute to the drainage seen on the dressing. The nurse would not change the dressing without a physician's prescription. Rechecking the dressing is an appropriate action, but it is not the initial action. The findings would be documented, but the initial action would be to assess the cause of the drainage further.

Test-Taking Strategy: Read the information in the question carefully to answer the question. Note that the drainage is dried blood and that the child is alert with stable vital and neurological signs. Noting the strategic word "initially" will assist in directing you to "check the operative record to determine whether a drain is in place." Review care of the child following this surgical procedure if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Implementation

101. A child is scheduled for allogeneic bone marrow transplantation (BMT). The parent of the child asks the nurse about the procedure. The nurse tells the parent that this type of transplantation involves:
1. Aspiration of bone marrow from the child
2. Obtaining bone marrow from the child's twin
3. Obtaining bovine (cow) bone marrow and administering it to the child
4. Obtaining bone marrow from a donor who matches the child's tissue type

ANS: 4

Rationale: In allogeneic BMT, a donor who matches the child's tissue type is found. That bone marrow is then given to the child. Syngeneic BMT is done when the child has an identical twin. In autologous BMT, the child undergoes general anesthesia for aspiration of his or her bone marrow, which is then processed in the laboratory and frozen until that marrow needs to be infused back into the child. "Obtaining bovine (cow) bone marrow and administering it to the child" is not used in a BMT.

Test-Taking Strategy: Knowledge about the three types of BMT procedures is required to answer this question. Remember that in an allogeneic BMT, a donor who matches the child's tissue type is found. If you are unfamiliar with these procedures, review this procedure.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Implementation

102. The student nurse is presenting a clinical conference, and the topic of discussion is human immunodeficiency virus (HIV) in children. The student is focusing the discussion on the methods of transmission of the virus. Which of the following would be included in the discussion?
1. HIV cannot be spread by hugging, holding, or touching other people.
2. HIV can be transmitted from open wounds but only if there is skin-to-skin contact.
3. HIV is only able to be transmitted from an infected mother to her baby through breast milk.
4. HIV infection cannot be transmitted by unprotected sexual intercourse if the female uses an intrauterine device as birth control.

ANS: 1

Rationale: HIV cannot be spread by using the same toilet seat, bathtub, or shower; coughing or sneezing; or hugging, holding, or touching people. HIV can be spread from unprotected sexual intercourse regardless of birth control, from sharing of needles, from an infected mother to her baby through breast milk and vaginal secretions during the birth process, or from open wounds if there is blood-to-blood contact.

Test-Taking Strategy: Use the process of elimination. Eliminate "HIV can be transmitted from open wounds but only if there is skin-to-skin contact" and "HIV is only able to be transmitted from an infected mother to her baby through breast milk" because of the closed-ended word "only." For the remaining options, use knowledge regarding transmission of the HIV virus to assist in answering this question. This knowledge will direct you to "HIV cannot be spread by hugging, holding, or touching other people." Review the transmission modes of HIV infection if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Understanding
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Safe and Effective Care Environment
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

103. The nurse is reviewing the laboratory results of studies on a 4-month-old infant and notes that the human immunodeficiency virus (HIV) antibody test is positive. The nurse determines that this test result indicates which of the following?
1. The infant has HIV.
2. The infant is infected with the HIV virus.
3. The mother is infected with the HIV virus.
4. This is a significant result, indicating a repeat test in 1 month.

ANS: 3

Rationale: A positive HIV antibody test result in a child younger than 18 months indicates only that the mother is infected, because maternal IgG antibodies persist in infants for 6 to 9 months and, in some cases, as long as 18 months. "The infant has HIV," "the infant is infected with the HIV virus," and "this is a significant result, indicating a repeat test in 1 month" are incorrect interpretations of this laboratory result.

Test-Taking Strategy: Knowledge regarding the diagnostic tests used for the purpose of testing for HIV is required to answer this question. It is also necessary to focus on the age of the child, because this makes a difference in terms of diagnostic test results. Review these tests for HIV if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Understanding
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

104. The nurse is caring for a child with acquired immunodeficiency syndrome (AIDS) and notes the presence of mouth sores. The nurse provides instructions to the mother regarding maintaining adequate nutritional intake in the child. Which of the following statements, if made by the mother, indicates a need for further education?
1. "I should weigh my child each morning."
2. "It is best to store the food at room temperature."
3. "Salty foods are important to maintain an appropriate sodium level in the child."
4. "Milk, juice, or water should really be offered after a meal rather than before a meal."

ANS: 3

Rationale: The mother should be instructed to offer foods high in protein and calories and to give vitamin and mineral supplements if prescribed. Milk, juice, and water should be administered to the child after meals because children can fill up on liquids before eating. If mouth sores are present, offer the child a Popsicle to lick, or ice before meals, to numb the mouth. Salty or spicy foods should be avoided because they irritate mouth sores. The child should be weighed each morning, and calorie intake should be reviewed every 24 hours.

Test-Taking Strategy: Note the strategic words "need for further education" in the question. These words indicate a negative event query and the need to select the incorrect statement. Use the process of elimination, recalling that spicy or salty foods can irritate mouth sores. If you had difficulty with this question, review interventions for the child with a potentially altered nutritional status.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

105. The nurse is reviewing the immunization schedule for a child with human immunodeficiency virus (HIV) infection with the mother. Which of the following will be a component of the instructions that the nurse provides to the mother?
    1. Immunizations will not be given to the child with HIV infection.
    2. The child and the siblings will need to receive inactivated polio vaccine.
    3. The immunization schedule needs to be altered because of the HIV infection.
    4. Immunizations will be given to the child with HIV infection but will not be initiated until the child is 3 years old.

ANS: 2

Rationale: The mother should be instructed that the child with HIV infection should keep immunizations up to date. The child with HIV infection and the siblings will receive an inactivated polio vaccine because the child with HIV infection is immunocompromised. All household members will receive the influenza vaccine. The immunization schedule would not be altered in any other way, and it is important for the mother to understand clearly the immunization schedule.

Test-Taking Strategy: Use the process of elimination to answer this question. Eliminate "the immunization schedule needs to be altered because of the HIV infection" and "immunizations will be given to the child with HIV infection but will not be initiated until the child is 3 years old" first because they are comparable or alike. Knowledge that the child with HIV infection is immunocompromised will easily direct you to "the child and the siblings will need to receive inactivated polio vaccine" from the remaining options. If you had difficulty with this question review the immunization schedule for a child with HIV infection.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Health Promotion and Maintenance
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Implementation

106. A $CD4^+$ count has been prescribed for a child with human immunodeficiency virus (HIV) infection. The nurse has explained to the mother the purpose of the blood test. Which of the following comments by the mother would indicate that further explanation is required for the mother to understand the purpose of the blood test?
1. "The $CD4^+$ count is used to determine the child's immune status."
2. "The $CD4^+$ count identifies the specific diagnosis of HIV infection."
3. "The $CD4^+$ count is used to identify the risk for disease progression."
4. "The $CD4^+$ count identifies the need for *Pneumocystis jiroveci* pneumonia prophylaxis after 1 year of age."

ANS: 2

Rationale: $CD4^+$ counts are used to assess a young child's immune status, risk for disease progression, and need for *P. jiroveci* pneumonia prophylaxis after 1 year of age. These counts are measured at 1 and 3 months, every 3 months until the age of 2 years, and at least every 6 months thereafter. More frequent monitoring of $CD4^+$ counts is indicated when *P. jiroveci* pneumonia prophylaxis and antiretroviral therapy are recommended. The $CD4^+$ count is not diagnostic of HIV infection.

Test-Taking Strategy: Note the strategic words "further explanation is required" in the question. These words indicate a negative event query and the need to select the incorrect statement. Note that "The $CD4^+$ count identifies the specific diagnosis of HIV infection." identifies the test as determining the diagnosis of HIV, which is already stated in the question. If you had difficulty with this question, review the purpose of the $CD4^+$ count.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

107. The nurse is providing instructions to the mother of a child who has been exposed to human immunodeficiency virus (HIV) infection. The nurse instructs the mother to notify the physician if which of the following symptoms occurs in the child?
1. Hyperactivity
2. Lethargy or fatigue

3. Irritability and fussiness
4. Coughing or chest congestion

ANS: 4

Rationale: The mother should be instructed to call the physician if the child develops a fever higher than 101° F; has vomiting and diarrhea, a decreased appetite, difficulty in swallowing, or drooling; develops rashes or sores on the skin; or has coughing or chest congestion. The mother should also notify the physician if ear pain, ear pulling, or drainage from the ears occurs; wounds appear that do not heal; or the child is exposed to chickenpox. "Hyperactivity," "lethargy or fatigue," and "irritability and fussiness" identify vague symptoms, which are nonspecific to the subject of the question.

Test-Taking Strategy: Use the process of elimination and knowledge regarding indications for physician notification to answer this question. Eliminate "hyperactivity," "lethargy or fatigue," and "irritability and fussiness" because these symptoms are vague and nonspecific to the subject of the question. If you had difficulty with this question, review measures for the child exposed to HIV.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Implementation

108. A 3-year-old child with human immunodeficiency virus (HIV) infection is being discharged from the hospital. The nurse is providing instructions to the mother regarding home care and infection control measures. Which of the following statements, if made by the mother, indicates a need for further education?
1. "I should discard any unused food immediately."
2. "If the nipple becomes soft and sticky, I will discard the nipple."
3. "I need to wash all vegetables carefully before preparing them."
4. "I should wash the eating utensils, baby bottle, and dishes in the dishwasher."

ANS: 1

Rationale: The parents should be instructed to cover unused food and formula and refrigerate. They should also be informed to discard unused refrigerated food or formula after 24 hours. "If the nipple becomes soft and sticky, I will discard the nipple." "I need to wash all vegetables carefully before preparing them." and "I should wash the eating utensils, baby bottle, and dishes in the dishwasher." are accurate instructions related to basic infection control.

Test-Taking Strategy: Knowledge regarding basic infection control measures is required to answer this question. Note the strategic words "need for further education" in the question. These words indicate a negative event query and the need to select the

incorrect statement. Also, note the strategic word "immediately" in "I should discard any unused food immediately." Discarding unused food immediately is unnecessary. Review these important infection control measures if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Safe and Effective Care Environment
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

109. The nurse is providing instructions to the mother of a child with human immunodeficiency virus (HIV) infection regarding immunizations. Which of the following statements, if made by the mother, indicates an understanding of the immunization schedule?
1. "The hepatitis B vaccine is not to be given to my child."
2. "My child will receive all the vaccines like any other child."
3. "Family members in the household need to receive the influenza vaccine."
4. "Blood tests need to be evaluated before any immunizations are given to my child."

ANS: 3

Rationale: A child with HIV infection will receive the same immunizations as other children except for live vaccines. All household members receive the influenza vaccine. "Blood tests need to be evaluated before any immunizations are given to my child." is not necessary and is inaccurate.

Test-Taking Strategy: "Blood tests need to be evaluated before any immunizations are given to my child." can be easily eliminated. From the remaining options, recalling that inactivated vaccines need to be administered to the child with HIV infection and siblings will assist in eliminating "My child will receive all the vaccines like any other child." Careful reading of the remaining options will easily direct you to "Family members in the household need to receive the influenza vaccine." Review immunizations for the immunodeficient child if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Health Promotion and Maintenance
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Evaluation

110. A child was seen in the health care clinic and received an immunization of DPT (diphtheria, pertussis, tetanus) vaccine. One hour later, the mother calls the clinic and

tells the nurse that the injection site is painful and red. Which of the following instructions would the nurse provide to the mother?
1. Call the physician.
2. Apply warm compresses on the site.
3. Return to the health care clinic immediately.
4. Apply cold compresses for 24 hours following the injection.

ANS: 4

Rationale: For painful or red injection sites, the nurse should instruct the mother to apply cold compresses for the first 24 hours and then to use warm or cold compresses as long as needed. "Call the physician," "apply warm compresses on the site," and "return to the health care clinic immediately" are incorrect. It is not necessary for the mother to bring the child to the clinic immediately, and it is not necessary for the mother to contact the physician.

Test-Taking Strategy: Knowledge regarding home care instructions for the mother of a child who received an immunization is required to answer this question. Use the process of elimination in answering the question, eliminating "call the physician" and "return to the health care clinic immediately" first because they are comparable or alike. Using the principles related to heat and cold will assist in directing you to "apply cold compresses for 24 hours following the injection." If you had difficulty with this question, review home care measures following immunization.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Health Promotion and Maintenance
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Implementation

111. The nurse is preparing to administer an MMR (measles, mumps, and rubella) vaccine to a 15-month-old child. Prior to administering the vaccine, which of the following questions would the nurse ask the mother of the child?
1. "Has the child had any sore throats?"
2. "Has the child been eating properly?"
3. "Is the child allergic to any antibiotics?"
4. "Has the child been exposed to any infections?"

ANS: 3

Rationale: Prior to the administration of MMR vaccine, a thorough health history needs to be obtained. MMR is used with caution in a child with a history of an allergy to gelatin, eggs, or neomycin, because the live measles vaccine is produced by chick embryo cell culture and MMR also contains a small amount of the antibiotic neomycin. "Has the child had any sore throats?" "Has the child been eating properly?" and "Has

the child been exposed to any infections?" are not contraindications to administering immunizations.

Test-Taking Strategy: Knowledge regarding the contraindications related to administering the MMR vaccine is required to answer this question. When thinking about contraindications to this vaccine, think about allergic reactions. Remember that MMR is used with caution in a child with a history of an allergy to gelatin, eggs, or neomycin. If you had difficulty with this question, review the nursing implications related to the administration of MMR.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing
REF: Lehne, R. (2010). Pharmacology for nursing care (7th ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

112. A child is seen in the health care clinic, and the nurse suspects the presence of pinworm infection (enterobiasis). The nurse instructs the mother as to how to obtain a cellophane tape rectal specimen. Which of the following statements, if made by the mother, indicates an understanding of the correct procedure to obtain the specimen?
1. "I need to collect the specimen after I give my child a bath."
2. "I need to collect the first bowel movement of the day and place it in a sealed container."
3. "I need to place a piece of transparent cellophane tape lightly over the anal area as soon as my child awakens and bring it to the clinic for examination."
4. "I need to place a piece of transparent cellophane tape lightly over the anal area after my child has a bowel movement and bring it to the clinic for examination."

ANS: 3

Rationale: Diagnosis of pinworm is confirmed by direct visualization of the worms. Parents can view the sleeping child's anus with a flashlight. The worm is white, thin, and about 1 inch long, and it moves. A simple technique, the cellophane tape slide method, is used to capture worms and eggs. Transparent tape is lightly touched to the anus and then applied to a slide for examination. The best specimens are obtained as the child awakens, before toileting or bathing.

Test-Taking Strategy: Knowledge regarding the procedure related to the cellophane tape slide for the diagnosis of pinworm is required to answer this question. Eliminate "I need to collect the first bowel movement of the day and place it in a sealed container." and "I need to place a piece of transparent cellophane tape lightly over the anal area after my child has a bowel movement and bring it to the clinic for examination." first because they are comparable or alike. For the remaining options, select "I need to place a piece of transparent cellophane tape lightly over the anal area as soon as my child awakens and bring it to the clinic for examination." over "I need to collect the specimen after I give my child a bath." knowing that the skin after bathing will not provide an adequate specimen. If you are unfamiliar with this procedure, review this content.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Evaluation

113. An adolescent is seen in the health care clinic with complaints of chronic fatigue. On physical examination, the nurse notes that the adolescent has swollen lymph nodes. Laboratory test results indicate the presence of Epstein-Barr virus (mononucleosis). The nurse informs the mother of the test results and provides instruction regarding care of the adolescent. Which of the following statements, if made by the mother, indicates an understanding of care measures?
1. "I need to keep my child on bed rest for 3 weeks."
2. "I will call the physician if my child is still feeling tired in 1 week."
3. "I need to isolate my child so that the respiratory infection is not spread to others."
4. "I need to call the physician if my child complains of abdominal pain or left shoulder pain."

ANS: 4

Rationale: The mother needs to be instructed to notify the physician if abdominal pain, especially in the left upper quadrant, or left shoulder pain occurs, because this may indicate splenic rupture. Children with enlarged spleens are also instructed to avoid contact sports until splenomegaly resolves. Bed rest is not necessary, and children usually self-limit their activity. No isolation precautions are required, although transmission can occur via saliva, close intimate contact, or contact with infected blood. The child may still feel tired in 1 week as a result of the virus.

Test-Taking Strategy: Knowledge regarding the organs affected in mononucleosis will assist in answering this question. "I need to keep my child on bed rest for 3 weeks." and "I need to isolate my child so that the respiratory infection is not spread to others." can be eliminated first because they are unnecessary interventions in this disease. From the remaining two options, knowledge that splenic rupture is a concern will direct you to "I need to call the physician if my child complains of abdominal pain or left shoulder pain." Review care to the child with this infection if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Evaluation

114. The nurse is caring for a hospitalized child with a diagnosis of measles (rubeola). In preparing to care for the child, which of the following supplies would the nurse bring to the child's room to prevent transmission of the virus?
    1. Mask and gloves
    2. Gown and gloves
    3. Goggles and gloves
    4. Gown, gloves, and goggles

    ANS: 1

    Rationale: Rubeola is transmitted via airborne particles or direct contact with infectious droplets. Respiratory isolation is required, and a mask should be worn by those in contact with the child. Gowns, gloves, and goggles are not specifically indicated for care of the child with rubeola. Any articles that are contaminated should be bagged and labeled.

    Test-Taking Strategy: Knowledge regarding the route of transmission of rubeola is required to answer this question. Remembering that rubeola is transmitted via airborne particles or direct contact with infectious droplets will easily direct you to "mask and gloves." Review the route of transmission and therapeutic management if you had difficulty with this question.

    PTS: 1
    DIF: Level of Cognitive Ability: Applying
    REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
    OBJ: Client Needs: Safe and Effective Care Environment
    TOP: Content Area: Child Health
    MSC: Integrated Process: Nursing Process—Planning

115. The nurse is caring for a child with a diagnosis of roseola. The nurse provides instructions to the mother regarding the prevention of the transmission of the infection to siblings and other household members. Which of the following instructions does the nurse provide?
    1. Isolate the child from others because the virus is transmitted by breathing and coughing.
    2. Wash sheets and towels used by the child separately in bleach to prevent spread of the infection to others.
    3. Avoid allowing the children to share drinking glasses or eating utensils, because the disease is transmitted through saliva.
    4. Have the child use a separate bathroom for urination and bowel movements to prevent the spread of infection through urine and feces.

    ANS: 3

    Rationale: Roseola is transmitted via saliva, so others should not share drinking glasses or eating utensils. "Isolate the child from others because the virus is transmitted by breathing and coughing," "wash sheets and towels used by the child separately in bleach

to prevent spread of the infection to others," and "have the child use a separate bathroom for urination and bowel movements to prevent the spread of infection through urine and feces" are not accurate instructions regarding the prevention of the transmission of roseola.

Test-Taking Strategy: Knowledge regarding the transmission of roseola virus is required to answer this question. Recalling that roseola is transmitted via saliva will assist in directing you to "avoid allowing the children to share drinking glasses or eating utensils, because the disease is transmitted through saliva." If you had difficulty with this question, review the transmission of the roseola virus.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Safe and Effective Care Environment
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Implementation

116. A child hospitalized with pertussis is in the convalescent stage, and the nurse is preparing the child for discharge. The nurse has provided instructions to the parents for home care of the child. Which of the following statements, if made by a parent, indicates a need for further education?
1. "It is important that my child drinks plenty of fluids."
2. "We need to try to maintain a quiet environment to prevent episodes of coughing spells."
3. "We need to teach the other members of the family how to use good hand washing techniques to prevent the spread of infection."
4. "I need to make sure that the child is isolated from the other children for at least 2 weeks to prevent the spread of the virus to them."

ANS: 4

Rationale: Pertussis is transmitted by direct contact or respiratory droplets from coughing. The infectious period occurs during the catarrhal stage (from the first to second week until the fourth week). Respiratory isolation is not required during the convalescent stage.

Test-Taking Strategy: Note the strategic words "need for further education" in the question. These words indicate a negative event query and the need to select the incorrect statement. Use the process of elimination, knowing that respiratory isolation is not required in the convalescent period. If you had difficulty with this question, review the characteristics of pertussis.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.

OBJ: Client Needs: Safe and Effective Care Environment
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

117. A child is seen in a health care clinic, and a diagnosis of chickenpox is confirmed. The mother expresses concern for two other children at home. She asks the nurse if the child is infectious to the other children. The most appropriate response by the nurse is:
1. "The infectious period occurs after the lesions begin."
2. "The infectious period begins when the lesions begin to crust."
3. "The infectious period is not known, and it is possible that the children may develop the chickenpox."
4. "The infectious period begins 1 to 2 days before the onset of the rash to about 5 days after the onset of the lesions and crusting of the lesions."

ANS: 4

Rationale: The infectious period of chickenpox is 1 to 2 days before the onset of the rash to about 5 days after the onset of the lesions and the crusting of the lesions. "The infectious period occurs after the lesions begin." "The infectious period begins when the lesions begin to crust." and "The infectious period is not known, and it is possible that the children may develop the chickenpox." are inaccurate.

Test-Taking Strategy: Knowledge about the infectious period associated with chickenpox is required to answer this question. Option "The infectious period is not known, and it is possible that the children may develop the chickenpox." can easily be eliminated first because of the words "not known." For the remaining options, select "The infectious period begins 1 to 2 days before the onset of the rash to about 5 days after the onset of the lesions and crusting of the lesions." because it is the umbrella option. If you had difficulty with this question, review the infectious period associated with chickenpox.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Safe and Effective Care Environment
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Implementation

118. A child is being discharged from the hospital following heart surgery. Prior to discharge, the nurse reviews the discharge instructions with the mother. Which of the following statements if made by the mother indicates a need for further education?
1. "Quiet activities are allowed."
2. "The child should play inside for now."
3. "Visitors are not allowed for at least 1 month."
4. "The regular schedule regarding naps should be resumed."

ANS: 3

Rationale: Visitors without signs of any infection are allowed to visit the child. The mother should be instructed, however, that the child needs to avoid large crowds of people for 1 week following discharge. "Quiet activities are allowed." "The child should play inside for now." and "The regular schedule regarding naps should be resumed." are accurate instructions regarding activity following heart surgery.

Test-Taking Strategy: Note the strategic words "need for further education" in the question. These words indicate a negative event query and the need to select the incorrect statement. Use the process of elimination, considering the effects of the surgery on the child. Also noting the lengthy time period in "Visitors are not allowed for at least 1 month." will direct you to this option. Review child activity guidelines following heart surgery if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Evaluating
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Health Promotion and Maintenance
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

MULTIPLE RESPONSE

1. Cerebral palsy (CP) is a term applied to a disorder that impairs movement and posture. The effects on perception, language, and intellect are determined by the type that is diagnosed. What are the potential warning signs of CP? **Select all that apply.**
   1. The infant's arms or legs are stiff or rigid.
   2. By 8 months of age, the infant can sit without support.
   3. A high risk factor for CP is very low birth weight.
   4. The child has strong head control but a limp body posture.
   5. If the infant is able to crawl, only one side is used to propel himself or herself.
   6. The infant has feeding difficulties, such as poor sucking and swallowing.

   ANS: 1, 3, 5, 6

   Rationale: "The infant's arms or legs are stiff or rigid," "a high risk factor for CP is very low birth weight," "if the infant is able to crawl, only one side is used to propel himself or herself," and "the infant has feeding difficulties, such as poor sucking and swallowing" are potential warning signs of CP. By 8 months of age, if the infant cannot sit up without support, this would be considered a potential warning sign, because this developmental task should be completed by this time. The infant with a potential diagnosis of CP has poor head control by 3 months of age, when head control should be strong.

   Test-Taking Strategy: Focus on the subject, the potential warning sign of CP. By reading each option carefully and using knowledge of the characteristics of cerebral

palsy, you will be able to select the correct warning signs of CP. If you are unfamiliar with the warning signs and characteristics of CP, review this content.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing
REF: Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). Maternal child nursing care (4th ed.). St. Louis: Mosby.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Assessment

2. A child is brought to the emergency department, and a fracture of the left lower arm is suspected. The mother states that the child was rollerblading and attempted to break a fall with an outstretched arm. Diagnostic x-rays of the child reveal that a fracture is present. A plaster of Paris cast is applied to the arm, and the nurse provides instructions to the mother regarding cast care at home. Which teaching points would the nurse provide the mother? **Select all that apply.**
   1. The cast should be dry in about 6 hours.
   2. The cast is water-resistant, so the child is able to take a bath or a shower.
   3. The cast will mold to the body part.
   4. The cast needs to be kept dry, because when wet it will begin to disintegrate.
   5. Keep the cast elevated for the first day on pillows.
   6. Make sure that the child can frequently wiggle the fingers.

   ANS: 3, 4, 5, 6

   Rationale: "The cast will mold to the body part," "the cast needs to be kept dry, because when wet it will begin to disintegrate," "keep the cast elevated for the first day on pillows," and "make sure that the child can frequently wiggle the fingers" are all important components of a teaching plan for a parent. Plaster of Paris is a heavier material than that used in a synthetic cast. It molds easily to the extremity and is less expensive than a synthetic cast. It takes about 24 hours to dry, but drying time could be longer, depending on the size of the cast. Plaster of Paris is not water-resistant and, when wet, will begin to disintegrate. The cast should be elevated on a pillow for the first day to decrease swelling as the cast begins to mold to the arm. As the cast molds, it is imperative that the child can wiggle the fingers, because the extremity continues to swell. If the child can wiggle the fingers, adequate motion is present. Color and sensation of the fingers should also be assessed.

   Test-Taking Strategy: Focus on the strategic word "plaster" in the question and use knowledge regarding the differences between plaster casts and synthetic casts to answer this question. Using the process of elimination, you will easily select "the cast will mold to the body part," "the cast needs to be kept dry, because when wet it will begin to disintegrate," "keep the cast elevated for the first day on pillows," and "make sure that the child can frequently wiggle the fingers." If you had difficulty with this question, review nursing care of the child with a plaster cast.

   PTS: 1

DIF: Level of Cognitive Ability: Applying
REF: Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). Maternal child nursing care (4th ed.). St. Louis: Mosby.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Teaching and Learning

3. The clinic nurse is assessing a child suspected of having juvenile rheumatoid arthritis (JRA). Which of the following assessment items would the nurse expect to find in a child who has been diagnosed with JRA? **Select all that apply.**
   1. Hematuria
   2. Morning stiffness
   3. Painful, stiff, and swollen joints
   4. Limited range of motion of the joints
   5. Stiffness that develops later in the day
   6. History of late afternoon temperature, with temperature spiking up to 105° F

   ANS: 2, 3, 4, 6

   Rationale: Clinical manifestations associated with JRA include intermittent joint pain that lasts longer than 6 weeks and painful, stiff, and swollen joints that are warm to the touch, with limited range of motion. The child will complain of morning stiffness and may protect the affected joint or refuse to walk. Systemic symptoms include malaise, fatigue, lethargy, anorexia, weight loss, and growth problems. A history of a late afternoon fever with temperature spiking up to 105° F will also be part of the clinical manifestations.

   Test-Taking Strategy: Knowledge regarding the clinical manifestations associated with JRA is required to answer this question. Thinking about the pathophysiology associated with this disorder and careful reading of each option will direct you to the correct ones. If you are unfamiliar with these manifestations, review this content.

   PTS: 1
   DIF: Level of Cognitive Ability: Analyzing
   REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
   OBJ: Client Needs: Physiological Integrity
   TOP: Content Area: Child Health
   MSC: Integrated Process: Nursing Process—Assessment

4. Which of the following interventions are appropriate for a child placed in protective isolation for neutropenia? **Select all that apply.**
   1. Placing the child on a low-bacteria diet
   2. Changing dressings using sterile technique
   3. Peeling fruits and vegetables before allowing the child to eat them
   4. Allowing fresh-cut flowers in the room as long as they are kept in a vase with water
   5. Allowing individuals who are ill to visit as long as they wear a mask

ANS: 1, 2, 3

Rationale: For the hospitalized neutropenic child, flowers or plants should not be kept in the room because standing water and damp soil harbor *Aspergillus* and *Pseudomonas* species, to which these children are very susceptible. Fruits and vegetables not peeled before being eaten harbor molds and should be avoided until the white blood cell count rises. The child is placed on a low-bacteria diet. Dressings are always changed using sterile technique. Individuals who are ill are not allowed to visit the client.

Test-Taking Strategy: Knowledge regarding protective isolation procedures required in a neutropenic child will assist in answering this question. Noting the strategic words "low-bacteria" in "placing the child on a low-bacteria diet," "sterile" in "changing dressings using sterile technique," and "peeling" in "peeling fruits and vegetables before allowing the child to eat them" will assist in selecting these options. Review protective isolation procedures for the neutropenic child if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.
OBJ: Client Needs: Safe and Effective Care Environment
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Implementation

COMPLETION

1. Augmentin 500 mg orally every 6 hours is prescribed for a child with an upper respiratory infection. The medication is supplied as 200 mg/5 mL. How many milliliters will be administered in each dose? **(Enter the answer in the space provided.)**
Answer: _____ mL

ANS: 12.5

Rationale: Use the ratio and proportion medication calculation formula.

$$500\,\text{mg} : X\,\text{mL} = 200\,\text{mg} : 5\,\text{mL}$$

$$2500 = 200X$$

$$X = 12.5\,\text{mL}$$

Test-Taking Strategy: Use the medication calculation formula to answer the question and verify the answer with a calculator. Make sure that the answer makes sense. Review the formula for medication calculations if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Applying

REF: Potter, P., & Perry, A. (2009). Fundamentals of nursing (7th ed.). St. Louis: Mosby.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Child Health
MSC: Integrated Process: Nursing Process—Implementation

SHORT ANSWER

1. A mother brings her child to the emergency department. Based on the child's sitting position, drooling, and apparent respiratory distress, a diagnosis of epiglottis is suspected. In anticipation of the physician's prescriptions, number the following actions in the appropriate order for delivering nursing interventions for this child. (Number 1 is the first action, and number 6 is the last action.)
   1 Prepare for assisted ventilation and have necessary equipment available.
   2 Obtain a pulse oximetry reading.
   3 Obtain an axillary temperature.
   4 Assess breath sounds by auscultation.
   5 Obtain weight for correct antibiotic dose infusion.
   6 Ask the mother about the precipitating events related to the child's condition.

   ANS: 1, 3, 4, 2, 5, 6

   Rationale: The highest priority with epiglottis is to have assisted ventilation available, because the highest risk with this child is complete airway obstruction. Physiological interventions continue to have the highest priority, with assessment of breath sounds and then obtaining pulse oximetry being next highest in priority. Once the airway is stabilized, the temperature can be obtained. At this time, the child should be stabilized and the weight can be obtained. The last priority is asking about precipitating events, which is done once physiological needs are met.

   Test-Taking Strategy: In prioritizing the options, consider Maslow's Hierarchy of Needs theory. Basic needs must be met first. Assisted ventilation is necessary. In addition to this, consider the ABCs—airway, breathing, and circulation—in prioritizing interventions. The lowest priority is asking the mother about precipitating events. If you had difficulty with this question, review the important treatment measures for the child with epiglottitis.

   PTS: 1
   DIF: Level of Cognitive Ability: Applying
   REF: Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). Maternal child nursing care (4th ed.). St. Louis: Mosby.
   OBJ: Client Needs: Physiological Integrity
   TOP: Content Area: Child Health
   MSC: Integrated Process: Nursing Process—Planning