Hesi Critical Thinking

1. The nurse is working in the emergency department (ED) of a children's medical center. Which client should the nurse assess first?

Correct - 3-The child hit by a car should be assessed first because he or she may have life- threatening injuries that must be assessed and treated promptly.

2. The 8-year-old client diagnosed with a vaso-occlusive sickle cell crisis is complaining of a severe headache. Which intervention should the nurse implement first?

Correct - 2-Because the client is complaining of a headache, the nurse should first rule out cerebrovascular accident (CVA) by assess- ing the client's neurological status and then determine whether it is a headache that can be treated with medication.

3. The 6-year-old client who has undergone abdominal surgery is attempting to make a pinwheel spin by blowing on it with the nurse's assistance. The child starts crying because the pinwheel won't spin. Which action should the nurse implement first?

Correct -1. The nurse should always praise the child for attempts at cooperation even if the child did not accomplish what the nurse asked.

4. The nurse is caring for clients on the pediatric medical unit. Which client should the nurse assess first?

Correct - 4. A pulse oximeter reading of less than 93% is significant and indicates hypoxia, which is life threatening; therefore, this child should be assessed first.

5. The nurse has received the a.m. shift report for clients on a pediatric unit. Which medication should the nurse administer first?

Correct - 3-Sliding scale insulin is ordered ac, which is before meals; therefore, this medication must be administered first after receiving the a.m. shift report.

4-Routine medications have a 1-hour leeway before and after the scheduled time; therefore, this medication does not have to be adminis- tered first.

6. A 5-year-old boy is being admitted to the hospital to have his tonsils removed. Which information should the nurse collect before this procedure?

D. Reactions to previous hospitalizations

Rationale

Assess how the child reacted to hospitalization and any complications. If the child reacted poorly, he or she may be afraid now and will need special preparation for the examination that is to follow. The other items are not significant for the procedure

7. A 6-month-old infant has been brought to the well-child clinic for a check-up. She is currently sleeping. What should the nurse do first when beginning the examination?

) Auscultate the lungs and heart while the infant is still sleeping.

Rationale

When the infant is quiet or sleeping is an ideal time to assess the cardiac, respiratory, and abdominal systems. Assessment of the eye, ear, nose, and throat are invasive procedures and should be performed at the end of the examination.

6. The nurse enters the client's room and realizes the 9-month-old infant is not breath- ing. Which interventions should the nurse implement? Prioritize the nurse's actions from first (1) to last (5).

Rationale

Correct Answer: 4, 5, 3, 2, 1

4. The nurse must first determine the infant's responsiveness by thumping the

baby's feet.
5. The nurse should then open the child's
airway using the head-tilt chin-lift tech- nique, with care taken not to hyperextend the neck. Then the nurse should look, listen, and feel for respirations.
3. The nurse then administers quick puffs of air while covering the child's mouth and nose, preferably with a rescue mask.
2. The nurse should determine whether the infant has a pulse by checking the brachial artery.
1. If the infant has no pulse, the nurse should begin chest compressions using two fingers at a rate of 30:2.
7. The 3-year-old client has been admitted to the pediatric unit. Which task should the nurse instruct the unlicensed assistive personnel (UAP) to perform first?
Correct - 1.The first intervention after the child is ad- mitted to the unit is to orient the parents and child to the room, the call system, and the hospital rules, such as not leaving the child alone in the room.
8. The clinic nurse is preparing to administer an intramuscular (IM) injection to the 2-year-old toddler. Which intervention should the nurse implement first?
Correct - 2-The nurse must explain any procedure in words the child can understand. It does not matter how old the child is.
. The nurse is writing a care plan for the 5-year-old child diagnosed with gastroenteritis. Which client problem is priority?
Correct - 2-The child diagnosed with gastroenteritis is at high risk for hypovolemic shock resulting from vomiting and diarrhea; therefore, maintaining fluid and elec- trolyte homeostasis is priority.
10. Which data would warrant immediate intervention from the pediatric nurse? 1. Proteinuria for the child diagnosed with nephrotic syndrome.
Correct - 3-Drooling indicates the child is having trouble swallowing, and the epiglottis is at risk of completely occluding the air- way. This warrants immediate interven- tion. The nurse should notify the HCP and obtain an emergency tracheostomy tray for the bedside.
11. Which client should the pediatric nurse assess first after receiving the a.m. shift report? 4. The 13-month-old child diagnosed with diarrhea who has sunken eyeballs and
decreased urine output.
Rationale
Correct - 4. Sunken eyeballs and decreased urine out- put are signs of dehydration, which is a life-threatening complication of diarrhea; therefore, this child should be assessed first.
12. The pediatric clinic nurse is triaging telephone calls. Which client's parent should the nurse call first?
1. The 4-month-old child who had immunizations yesterday and the parent is report- ing a high-pitched cry and a 103°F fever.
Correct 1-A high fever and high-pitched crying may indicate a reaction to the immunizations; therefore, this parent needs to be called first to bring the child to the clinic.

13. The parent of a 12-year-old male child with a left below-the-knee cast calls the pediatric clinic nurse and tells the nurse, "My son's foot is cold and he told me it feels like his foot is asleep." Which action should the nurse implement first?
3. Instruct the parent to elevate the left leg on two pillows.
Correct - 3. The nurse should first take care of the client's body by having the parent elevate the left leg.
14. Which child requires the nurse to notify the healthcare provider?
1. The 1-year-old child with iron deficiency anemia who has dark-colored stool.
2. The 3-year-old child with phenylketonuria (PKU) whose parent does not feed the child any meat or milk products.
3. The 5-year-old child with rheumatic heart fever who is having difficulty breathing.
4. The 7-year-old child diagnosed with acute glomerulonephritis who has dark "tea"-colored urine.
Rationale
Correct - 3-A complication of rheumatic heart disease is valvular disorders that may be mani- fested by respiratory problems; therefore, the nurse should notify the child's health- care provider.
15. The pediatric nurse on the surgical unit has just received a.m. shift report. Which client should the nurse assess first?
1. The 3-week-old child 1 day postoperative with surgical repair of a myelomeningocele who has bulging fontanels.
Correct - 1-Bulging fontanels is a sign of increased intracranial pressure, which is a compli- cation of neurological surgery; therefore, this child should be assessed first.
16. The charge nurse has assigned a staff nurse to care for an 8-year-old client diagnosed with cerebral palsy. Which nursing action by the staff nurse would warrant immediate intervention by the charge nurse?
4. The staff nurse places the child in semi-Fowler's position to eat lunch.
Rationale
Correct - 4-The child should be positioned upright to prevent aspiration during meals; there- fore, this action would require the charge nurse to intervene.
17. The nurse and the unlicensed assistive personnel (UAP) are caring for clients on the pediatric unit. Which action by the nurse indicates appropriate delegation?
4. The nurse checks to make sure the UAP's delegated tasks have been completed.
Rationale
Correct - 4. The last step of delegating to a UAP is for the nurse to evaluate and determine whether the delegated tasks have been completed and performed correctly. This indicates the nurse has delegated appropriately.
18. The nurse on a pediatric unit has received the a.m. shift report and tells the unlicensed assistive personnel (UAP) to keep the 2-year-old child NPO for a procedure. At 0830, the nurse observes the mother feeding the child. Which action should the nurse implement first?
1. Determine what the UAP did not understand about the instruction.
Rationale
Correct - 1.Communication to the UAP must be clear, concise, correct, and complete. The nurse must determine why there was a lack of communication, which resulted in the child receiving food; therefore, this action should be implemented first.

19. The charge nurse on the six-bed pediatric burn unit is making shift assignments and has one registered nurse (RN), one scrub technician, one unlicensed assistive personnel (UAP), and a unit secretary. Which client care assignment indicates the best use of the hospital personnel?
1. The RN performs daily whirlpool dressing changes.
2. The unit secretary transcribes the HCP's orders.
3. The scrub technician medicates the client prior to dressing changes. 4. The UAP places the current laboratory results on the chart.
1-The scrub technician is assigned to perform daily whirlpool dressing changes, which is a lengthy procedure. Therefore, assigning the one RN to this task would be inappropriate because he or she cannot be unavailable for an extended period of time.
**2-One of the responsibilities of the unit secretary is to transcribe the HCP's orders, but the licensed nurse retains total responsibility for the correctness and accuracy of the transcribed orders.
3-The scrub technician cannot administer medications.
4-The unit secretary and laboratory personnel are responsible for posting laboratory data into the client's charts. The UAP should be on the unit taking care of the clients.
20. The RN and the UAP are caring for clients on a pediatric surgical unit. Which tasks would be most appropriate to delegate to the UAP? Select all that apply.
1. Pass dietary trays to the clients.
2. Obtain routine vital signs on the clients.
3. Complete the preoperative checklist.
4. Change linens on the clients' beds.
5. Document the clients' intake and output.
1, 2, 4, and 5 are correct.
1. The UAP can pass the dietary trays to the clients because it does not require judgment.
2. One of the responsibilities of the UAP is taking routine vital signs on clients.
3. The nurse must complete the preoperative checklist because it requires nursing judgment to determine whether the client is ready for surgery.
4. One of the responsibilities of the UAP is changing bed linens.
5. The UAP can document the client's in- take and output, but the UAP cannot evaluate the numbers.
21. Which client should the charge nurse on the pediatric unit assign to the most experienced nurse?
1. The 4-year-old child diagnosed with hemophilia receiving factor VIII.
2. The 8-year-old child with headaches who is scheduled for a CT scan.
3. The 6-year-old child recovering from a sickle cell crisis.
4. The 11-year-old child newly diagnosed with rheumatoid arthritis.
1-The administration of blood products does not require the most experienced nurse.
2-Preparing a child for a routine procedure does not require the most experienced nurse.
3-The child recovering from a sickle cell crisis would not require the most experienced nurse.

**4-The child newly diagnosed with a chronic disease, which will have acute exacerba- tions, requires extensive teaching; there- fore, the most experienced nurse should be assigned to this child and family.
22. The charge nurse is making shift assignments on a pediatric oncology unit. Which delegation/assignment would be most appropriate?
1. Delegate the unlicensed assistive personnel (UAP) to obtain routine blood work from the central line.
2. Instruct the licensed practical nurse (LPN) to contact the leukemia support group.
3. Assign the chemotherapy-certified RN to administer chemotherapeutic medication.
4. Have the dietitian check the meal trays for the amount eaten.
1-Only an RN can withdraw blood from a
central line.
2. The social worker or case manager is respon-
sible for referring clients to support groups. This is not an expected responsibility of a floor nurse/LPN.
**3. Only chemotherapy-certified RNs can administer antineoplastic, chemothera- peutic medications. This is a national minimal standard of care according to the Oncology Nursing Society.
4. The dietician is responsible for ensuring that the proper food is provided along with evalu- ating the child's nutritional intake, not checking the amount of food eaten—this is the responsibility of the nursing staff.
23. The nurse observes the unlicensed assistive personnel (UAP) bringing a cartoon video to a 6-year-old female child on bed rest so that she can watch it on the television. Which action should the nurse take?
1. Tell the UAP that the child should not be watching videos.
2. Explain that this is the responsibility of the child life therapist.
3. Praise the UAP for providing the child with an appropriate activity. 4. Notify the charge nurse that the UAP gave the child videos to watch.
1. A 6 year old child on best rest needs an appropriate activity to help with distraction; a cartoon video would be an age appropriate activity.
2. The child life therapist is responsible for
recreational and developmental activity for the hospitalized child, but any staff member should address the child's psychosocial needs.
**3. Part of the delegation process is to evaluate the UAP's performance of duties, and the nurse should praise any initiative on the part of the UAP in being a client advocate.
4. Videos are one of the few age-appropriate activities to occupy a 6-year-old on bed rest; therefore, there is no reason to notify the charge nurse.
24. Which newborn should the nurse in the neonatal intensive care unit (NICU) assign to a new graduate who has just completed an NICU internship?
1. The 1-day-old infant diagnosed with a myelomeningocele.
2. The 2-week-old infant who was born 6 weeks premature.
3. The 3-hour-old infant who is being evaluated for esophageal atresia. 4. The 1-week-old infant diagnosed with tetralogy of Fallot.
1-The newborn with the myelomeningocele has a portion of the spinal cord and mem- branes protruding through the back and is at risk for hydrocephalus and meningitis; this client should be assigned to a more experi- enced nurse.

**2-The new graduate who has completed the NICU internship should be able to care for a premature infant because care is primarily supportive.
3-Esophageal atresia, a congenital anomaly in which the esophagus does not completely develop, is a clinical and surgical emergency. It puts the newborn at risk for aspiration be- cause the upper esophagus ends in a blind pouch with the lower part of the esophagus connected to the trachea. This newborn should be assigned to a more experienced nurse.
4-Tetralogy of Fallot is a cyanotic, congenital anomaly. It includes a combination of four defects of the heart, all of which result in unoxygenated blood being pumped into the systemic circulation. This newborn must be assigned to an experienced nurse.
25. The newly hired nurse is working on a pediatric unit and needs the unlicensed assistive personnel (UAP) to obtain a urine specimen on an 11-month-old infant. Which statement made to the UAP indicates the nurse understands the delegation process?
1. "Be sure to weigh the diaper when obtaining the urine specimen."
2. "Do you know how to apply the urine collection bag?"
3. "Use a small indwelling catheter when obtaining the urine specimen." 4. "I need for you to get a urine specimen on the infant."
1-Weighing the diaper is the procedure for de- termining the infant's urinary output and is not part of the procedure for obtaining a urine specimen.
**2-The NCSBN position paper in 1995 defined delegation as transferring to a competent individual the authority to perform a selected nursing task in a se- lected situation. The nurse retains the accountability for the delegation. The nurse must determine whether the UAP has the ability and knowledge to perform a task. This question clarifies whether the UAP has the ability to obtain a urine specimen.
3-Obtaining a urine specimen with an in- dwelling catheter on an 11-month-old infant would require more expertise than a UAP would have on the pediatric unit. Furthermore, it does not determine whether the UAP understands how to do the procedure.
4. This statement does not determine whether the UAP understands how to perform the procedure of obtaining a urine specimen from an 11-month-old infant.
26. Which task is most appropriate for the pediatric nurse to delegate to the unlicensed assistive personnel (UAP)?
1. Ask the UAP to orient the parents and child to the room.
2. Tell the UAP to prepare the child for an endoscopy.
3. Request the UAP to log roll the client who had a spinal surgery. 4. Instruct the UAP to assess the child's developmental level.
**1-The UAP can orient the parents and child to the room, and demonstrate how to use the call light, how the bed works, or how the television works.
2-The UAP cannot prepare a child for en- doscopy; this requires assessment and evaluation to determine if the child is ready for the procedure.
3-There must be at least two people to log roll a child, and the UAP cannot do this procedure alone.
4-The nurse cannot delegate assessment to the UAP.
27. Which behavior by the unlicensed assistive personnel (UAP) warrants intervention by the nurse?

1. The UAP weighs the child's diaper on a scale and records the urine output on the intake & output (I&O) sheet.
2. The UAP sits with the child while the parent goes down to the cafeteria to get something to eat.
3. The UAP bathes the child with congenital dislocated hip with the Pavlik harness on the child.
4. The UAP applies wrist restraints on the 7-month-old who is 1 day postoperative cleft palate repair.
1-The UAP can weigh the diapers and obtain urine output. The nurse must evaluate the output.
2-A child under 12 years of age cannot be left alone in the room, and the UAP could stay with the child while the parent gets some- thing to eat.
3-The Pavlik harness should not be removed, so bathing the child in the harness is appro- priate and does not warrant intervention.
**4- The 7-month-old should have elbow restraints, not wrist restraints. Elbow restraints prevent the child from putting fingers into the mouth, but allow the child to move the arms.
28. The nurse is caring for pediatric clients. Which tasks are most appropriate to assign to an unlicensed assistive personnel (UAP) and/or a licensed vocational nurse (LPN)? Select all that apply.
1. Instruct the LPN to teach the parent of a child new diagnosed with type 1 diabetes.
2. Tell the UAP to apply an ice collar to the child who is 1 day postoperative tonsillectomy.
3. Ask the UAP to place ointment on a child's diaper rash around the anal area.
4. Request the LPN to double-check the medication dose for the child receiving an antibiotic.
5. Tell the LPN to transcribe the healthcare provider's orders for the child with cystic fibrosis.
2, 3, 4, and 5 are correct.
1. The nurse cannot assign teaching to the LPN.
2. The UAP can apply an ice collar since the client is stable.
3. The UAP can apply ointment to a diaper rash—it is a medication but it can be applied by the UAP.
4. The LPN can double-check a dose of medication. The nurse can assign med- ication administration to an LPN.
5. The LPN can transcribe a healthcare provider's orders.
29. The nurse is discharging a 4-month-old child with a temporary colostomy. Which intervention should the nurse implement?
1. Request the UAP to complete the discharge written documentation.
2. Tell the LPN to show the parent how to irrigate the colostomy.
3. Ask the UAP to remove the child's intravenous catheter.

4. Request the UAP to escort the parent and child to the car.
1-The nurse cannot delegate teaching to the UAP.
2-The LPN could teach a client how to irrigate a colostomy, but a 4-month-old is incontinent of stool; therefore, irrigating the colostomy is not done.
3-The LPN or nurse should remove the IV catheter of a 4-month-old child, not the UAP.
**4-The UAP can escort the child and parents to the car.
30. The unlicensed assistive personnel (UAP) tells the nurse the child with Down syndrome who is 2 days postoperative appendectomy is having pain. Which intervention should the nurse implement first?
1. Tell the UAP to check the child's vital signs.
2. Assess the child's abdominal dressing and pain immediately.
3. Notify the healthcare provider.
4. Check the MAR for last time pain medication was administered.
1-The UAP can take vital signs but the nurse should assess the child to determine whether this is routine postoperative pain (expected), or whether a complication is occurring.
**2. A rule of thumb—if anyone else gives the nurse information about a client, the nurse should first assess the client before
taking any further action.
3. The nurse may need to notify the HCP, but not before assessing the child.
4. The nurse may need to administer pain med- ication but not prior to assessing the child.
31. The 8-year-old male child in the pediatric unit is refusing to ambulate postoperatively. Which intervention would be most appropriate?
1. Give the child the option to ambulate now or after lunch.
2. Ask the parents to insist the child ambulate in the hall.
3. Refer the child to the child developmental therapist.
4. Tell the child he can watch a video game if he cooperates.
**1.The nurse should offer the child choices that ensure cooperation with the therapeutic regimen. The choices are when the child will ambulate, not whether the child will ambulate.
2. The nurse could ask the parents for help in making sure the client ambulates, but this may cause a rift in the nurse/parent/child re- lationship. This is not the most appropriate intervention.
3. The child development therapist could assist with activities that would encourage the client to ambulate, but the nurse should take control of the situation and ensure the client ambulates. This is not the most appropriate intervention.
4. This is bribery, and the nurse should not use this technique to ensure cooperation with the therapeutic regimen.
32. The clinic nurse overhears a mother in the waiting room tell her 6-year-old son, "If you don't sit down and be quiet, I am going to get the nurse to give you a shot." Which action should the nurse implement?
1. Do not take any action because the mother is attempting to discipline her son. 2. Tell the child the nurse would not give him a shot because the mother said to.
3. Report this verbally abusive behavior to Child Protective Services.
4. Tell the mother this behavior will cause her son to be afraid of the nurses.

1. The nurse must take action or the child will
be afraid of the nurse.
2. The nurse should discuss the inappropriate
comment with the mother, not with the child.
3. If every nurse who overheard this type of comment reported it to Child Protective Services, it would only unnecessarily increase the workload in an already overloaded system. Furthermore, reporting perceived potential abuse to Child Protective Services is a very serious accusation.
**4. The nurse should explain to the mother that threatening the child with a shot will cause the child to be frightened of healthcare professionals. This type of comment is inappropriate and should not be used to discipline a child.
33. The parents of an infant born with Down syndrome are holding their infant and crying. The father asks, "I have heard children like this are hard to take care of at home." Which referral would be most appropriate for the parents?
1. The Web site for the National Association for Down Syndrome.
2. The hospital chaplain.
3. A Down syndrome support group. 4. A geneticist.
1. There is a Web site to obtain information about Down syndrome, but this type of re- ferral would not be the most appropriate for parents who need to deal with emotional as- pects of having a child with special needs.
2. The hospital chaplain is an important part of the multidisciplinary healthcare team but would not have specialized knowledge re- garding caring for a special needs child.
**3. According to the NCLEX-RN® test plan, referrals are included in management of care. The most appropriate referral would be to a support group where other parents who have special needs children can share their feelings and provide ad- vice on how to care for their child in the home.
4. Although Down syndrome results from a trisomy chromosome 21, it is primarily associated with maternal age over 35 years. Furthermore, a geneticist would not have specialized knowledge regarding caring for a special needs child.
34. The charge nurse on the pediatric unit hears the overhead announcement of Code Pink (infant abduction), newborn nursery. Which action should the charge nurse implement?
1. Send a staff member to the newborn nursery.
2. Explain the situation to the clients and visitors.
3. Continue with the charge nurse's responsibilities.
4. Station a staff member at all the unit exits.
1. The newborn nursery does not need any more people in the area. Personnel are needed to monitor any and all exits.
2. The purpose of using code names to alert hospital personnel of emergency situations is to avoid panic among the clients and visitors; therefore, the nurse should not explain the situation to the clients and visitors.
3. Any time there is an overhead emergency an- nouncement, the charge nurse is responsible for following the hospital emergency plan.
**4. Code Pink means an infant has been abducted from the newborn nursery. The priority intervention is to prevent the ab- ductor from taking the child from the hospital, which can be prevented by plac- ing a staff member at all of the unit exits.

35. The mother of a 4-year-old child diagnosed with Duchenne's muscular dystrophy is overwhelmed and asks the nurse, "I have been told a case manager will come and talk to me. What will they do for me?" Which statement indicates the nurse understands the role of the case manager?
1. "You will have a case manager so that the hospital can save money."
2. "She will make sure your child gets the right medication for muscular dystrophy."
3. "She will help you find the resources you need to care for your child."
4. "The case manager helps your child to have a normal life expectancy."
1.Even though case management is a strategy to ensure coordination of care while reduc- ing costs, the nurse should not share this with the mother.
2. The case manager is not responsible for ensuring that the client receives the correct medication; it is the responsibility of the HCP.
**3. According to the NCLEX-RN® test blueprint, questions on case management are included. The case manager will coordinate the care for a client with a chronic illness with other members of the multidisciplinary healthcare team. This attempts to prevent duplication of ser- vices and allows the mother to have a specific individual to coordinate services to meet the child's needs.
4. The life expectancy of a child with Duchenne's muscular dystrophy is approximately 25 years. The case manager is not responsible for help- ing the child have a normal life expectancy.
36. The nurse is assigned to the pediatric unit performance improvement committee. The unit is concerned with IV infection rates. Which action should the nurse implement first when investigating the problem?
1. Contact central supply for samples of IV start kits.
2. Obtain research to determine the best length for IV dwell time.
3. Identify how many IV infections have occurred in the last year. 4. Audit the charts to determine if hospital policy is being followed.
1 .Although this would not be the first step in investigating a problem, this action may be initiated if it is determined to be the cause for the increase in infection rates.
2. The nurse should utilize evidenced-based practice research when proposing changes because it is part of the performance im- provement process, but it is not the first in- tervention when investigating the problem.
**3. The first intervention is to determine the extent of the problem and who owns the problem. The NCLEX-RN® test blue- print includes performance improvement (quality improvement) in the manage- ment of care content.
4. This action may need to be implemented once it is determined whether there is a problem with IV infection rates. However, this would be the second step in the process.
37. The clinic nurse is discussing a tubal ligation with a 17-year-old adolescent with Down syndrome. The adolescent does not want the surgery, but her parents (who are also in the room) are telling her she must have it. Which statement by the nurse would be an example of the ethical principle of justice?
1. "I think this requires further discussion before scheduling this procedure."
2. "You will not be able to have children after you have this procedure."
3. "You should have this procedure because you could not care for a child." 4. "You can refuse this procedure and your parents can't make you have it."