Table of Contents

Table of Contents 1
Chapter 01: The Past, Present, and Future 2
Chapter 02: Human Reproductive Anatomy and Physiology 12
Chapter 03: Fetal Development 22
Chapter 04: Prenatal Care and Adaptations to Pregnancy 31
Chapter 05: Nursing Care of Women with Complications During Pregnancy 40
Chapter 06: Nursing Care of Mother and Infant During Labor and Birth 50
Chapter 07: Nursing Management of Pain During Labor and Birth 60
Chapter 08: Nursing Care of Women with Complications During Labor and Birth 70
Chapter 09: The Family After Birth 79
Chapter 10: Nursing Care of Women with Complications After Birth 88
Chapter 11: The Nurses Role in Womens Health Care 97
Chapter 12: The Term Newborn 106
Chapter 13: Preterm and Postterm Newborns 116
Chapter 14: The Newborn with a Perinatal Injury or Congenital Malformation 125
Chapter 15: An Overview of Growth, Development, and Nutrition 135
Chapter 16: The Infant 145
Chapter 17: The Toddler 155
Chapter 18: The Preschool Child 164
Chapter 19: The School-Age Child 173
Chapter 20: The Adolescent 182
Chapter 21: The Childs Experience of Hospitalization 191
Chapter 22: Health Care Adaptations for the Child and Family 200
Chapter 23: The Child with a Sensory or Neurological Condition 209
Chapter 24: The Child with a Musculoskeletal Condition 219
Chapter 25: The Child with a Respiratory Disorder 229
Chapter 26: The Child with a Cardiovascular Disorder 238
Chapter 27: The Child with a Condition of the Blood, Blood-Forming Organs, or Lymphatic System 246
Chapter 28: The Child with a Gastrointestinal Condition 256
Chapter 29: The Child with a Genitourinary Condition 267
Chapter 30: The Child with a Skin Condition 276
Chapter 31: The Child with a Metabolic Condition 286
Chapter 32: Childhood Communicable Diseases, Bioterrorism, Natural Disasters and the Maternal-Child Patient 296
Chapter 33: The Child with an Emotional or Behavioral Condition 305
Chapter 34: Complementary and Alternative Therapies in Maternity and Pediatric Nursing 315

provide the nurse with information about whether the woman can deliver vaginally?
a. Diagonal conjugate
b. Obstetric conjugate
c. Transverse diameter
d. Anteroposterior diameter

ANS: B
This measurement determines if the fetus can pass through the birth canal.

DIF: Cognitive Level: Comprehension REF: Page 26 OBJ: 8
TOP: Female Reproductive System KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

14. The nurse has explained menstruation to a 13-year-old girl. What statement indicates the girl needs additional education?
a. Periods last about 5 days.
b. My cycle should get regular in 6 months.
c. I should expect heavy bleeding with clots.
d. Periods come about every 4 weeks.

ANS: C
Clots are not normally seen in menstrual discharge. A normal menstrual flow is 30 to 40 mL blood and 30 to 50 mL serous fluid.

DIF: Cognitive Level: Comprehension REF: Page 27 OBJ: 9
TOP: Female Reproductive Cycle KEY: Nursing Process Step: Evaluation
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

15. A mother asks the nurse, When will I know my child has entered puberty? What will the nurse state based on an understanding of changes associated with puberty?
a. Your daughter will have her first period.
b. Youll recognize puberty by the mood swings.
c. The child becomes interested in the opposite sex.
d. Secondary sex characteristics such as pubic hair, appear

ANS: D
Puberty begins when the secondary sex characteristics appear. Puberty ends when mature sperm are formed in the male and when regular menstrual cycles occur in the female.

DIF: Cognitive Level: Comprehension REF: Page 20 OBJ: 1 | 2
TOP: Puberty KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

16. A nurse is planning to teach couples about the physiology of the sex act. What correct information will the nurse provide?
a. Fertilization of an ovum requires penetration by several sperm.
b. An ovum must be fertilized within 24 hours of ovulation.
c. It takes 4 to 5 days for sperm to reach the fallopian tubes.
d. Sperm live for only 24 hours following ejaculation.

ANS: B
After ovulation, the egg lives for only 24 hours. Sperm must be available during that time if fertilization is to occur.

DIF: Cognitive Level: Comprehension REF: Page 29 OBJ: 6
TOP: Physiology of the Sex Act KEY: Nursing Process Step: Planning
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

17. A newly married couple tells the nurse they would like to wait a few years before starting a family. Which

Breast milk provides maternal antibodies to the infant that give the child acquired immunity from some diseases for several months.

DIF: Cognitive Level: Comprehension REF: Page 27 OBJ: 4
TOP: Properties of Breast Milk KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

26. A female patient reports her menstrual cycle consistently occurs every 32 days. What day of her cycle can the woman anticipate ovulation?
a. 14
b. 16
c. 18
d. 20

ANS: C
Ovulation occurs when a mature ovum is released from the follicle about 14 days before the onset of the next menstrual period.

DIF: Cognitive Level: Analysis REF: Page 27 OBJ: 9
TOP: Menstrual Cycle KEY: Nursing Process Step: Evaluation
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

MULTIPLE RESPONSE

27. The nurse conducting a sex education class for junior high students describes some cultural rites celebrating the entry to adulthood. What information would the nurse include? (Select all that apply.)
a. Bar mitzvah
b. Displays of bravery
c. Receiving part of their inheritance
d. Ritual circumcision
e. Displays of self-defense

ANS: A, B, D, E
Some cultures celebrate the entry to adulthood with rites such as displays of strength, bravery, self-reliance, and self-defense. Ritual circumcisions and bar and bat mitzvahs are also entry rites to adulthood. Lack of such rituals can sometimes confuse young people because there is no evidence of acceptance as an adult.

DIF: Cognitive Level: Knowledge REF: Page 20 OBJ: 2
TOP: Rites of Passage KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

28. The nurse is reading a pregnant patients history and physical. What information does the nurse recognize might indicate the need for a cesarean delivery? (Select all that apply.)
a. History of childhood rickets
b. Immobile coccyx
c. Prepregnant weight of 100 pounds
d. Avid horse rider
e. Pelvic fracture 3 years ago

ANS: A, B, E
Pelvic conditions that may predispose to a cesarean delivery are childhood rickets, pelvic fracture, and immobile coccyx.

DIF: Cognitive Level: Comprehension REF: Page 27 OBJ: 8
TOP: Pelvic Conditions Predisposing Cesarean Delivery
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

29. What are considered to be functions of the fallopian tubes? (Select all that apply.)

Chapter 03: Fetal Development

MULTIPLE CHOICE

1. What is the total number of chromosomes contained in a mature sperm or ovum?
a. 22
b. 23
c. 44
d. 46

ANS: B
Gametes (sex chromosomes) contain 23 chromosomes.

DIF: Cognitive Level: Knowledge REF: Page 31 OBJ: 2
TOP: Gametogenesis KEY: Nursing Process Step: N/A
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

2. A pregnant woman states, My husband hopes I will give him a boy because we have three girls. What will the nurse explain to this woman?
a. The sex chromosome of the fertilized ovum determines the gender of the child.
b. When the sperm and ovum are united, there is a 75% chance the child will be a girl.
c. When the pH of the female reproductive tract is acidic, the child will be a girl.
d. If a sperm carrying a Y chromosome fertilizes an ovum, then a boy is produced.

ANS: D
When a Y-bearing sperm fertilizes an ovum, a male child is produced.

DIF: Cognitive Level: Comprehension REF: Page 33 OBJ: 3
TOP: Sex Determination KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

3. What is the most common site for fertilization?
a. Lower segment of the uterus
b. Outer third of the fallopian tube near the ovary
c. Upper portion of the uterus
d. Area of the fallopian tube farthest from the ovary

ANS: B
Fertilization takes place in the outer third of the fallopian tube, which is closest to the ovary.

DIF: Cognitive Level: Knowledge REF: Page 33 OBJ: 3
TOP: Fertilization KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

4. The embryo is termed a fetus at which stage of prenatal development?
a. 2 weeks
b. 4 weeks
c. 9 weeks
d. 16 weeks

ANS: C
The fetus (third stage of prenatal development) begins at the ninth week and continues until the 40th week of gestation or until birth.

DIF: Cognitive Level: Knowledge REF: Page 36 OBJ: 4
TOP: Prenatal Developmental Milestones
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

ANS: C
The marked weight gain may be an indication of gestational hypertension. The blood pressure should be assessed before notifying the physician.

DIF: Cognitive Level: Application REF: Page 53 OBJ: 4
TOP: Gestational Hypertension KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

13. The patient remarks that she has heard some foods will enhance brain development of the fetus. The nurse replies that foods high in docosahexaenoic acid (DHA) are thought to enhance brain development. What food can the nurse recommend?
a. Fried fish
b. Olive oil
c. Red meat
d. Leafy green vegetables

ANS: C
Foods rich in DHA are red meat, flounder, halibut, and soybean and canola oil. Frying fish negatively alters the DHA.

DIF: Cognitive Level: Application REF: Page 55 OBJ: 8
TOP: Nutrition in Pregnancy KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

14. The nurse encourages adequate intake of folic acid for women of childbearing age before and during pregnancy. What is folic acid thought to decrease the incidence of in fetal development?
a. Structural heart defects
b. Craniofacial deformities
c. Limb deformities
d. Neural tube defects

ANS: D
Folic acid can reduce the incidence of neural tube defects such as spina bifida and anencephaly.

DIF: Cognitive Level: Knowledge REF: Page 45 | Page 61
OBJ: 8 TOP: Nutrition for Pregnancy
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Reduction of Risk

15. A woman tells the nurse that she is quite sure she is pregnant. The nurse recognizes which as a positive sign of pregnancy?
a. Amenorrhea
b. Uterine enlargement
c. HCG detected in the urine
d. Fetal heartbeat

ANS: D
Positive indications are caused only by the developing fetus and include fetal heart activity, visualization by ultrasound, and fetal movements felt by the examiner.

DIF: Cognitive Level: Knowledge REF: Page 50 OBJ: 6 | 7
TOP: Physiological Changes During Pregnancy
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

16. At her initial prenatal visit a woman asks, When can I hear the babys heartbeat? At what gestational age can the fetal heartbeat be auscultated with a specially adapted stethoscope or fetoscope?
a. 4 weeks

b. 12 weeks
c. 18 weeks
d. 24 weeks

ANS: C
The fetal heartbeat can be heard with a fetoscope between the 18th and 20th weeks of pregnancy.

DIF: Cognitive Level: Knowledge REF: Page 50 OBJ: 7
TOP: Physiological Changes During Pregnancy
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

17. A woman pregnant for the first time asks the nurse, When will I begin to feel the baby move? What is the nurses best response?
a. You may notice the baby moving around the 4th or 5th month.
b. Quickening varies with every woman.
c. Youll feel something by the end of the first trimester.
d. The baby will be big enough for you to feel in your 8th month.

ANS: A
Quickening, fetal movement felt by the mother, is first perceived at 16 to 20 weeks of gestation.

DIF: Cognitive Level: Knowledge REF: Page 49 OBJ: 7
TOP: Physiological Changes During Pregnancy
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

18. A pregnant woman inquires about exercising during pregnancy. What information should the nurse include when planning to educate this woman?
a. Exercise elevates the mothers temperature and improves fetal circulation.
b. Exercise increases catecholamines, which can prevent preterm labor.
c. A regular schedule of moderate exercise during pregnancy is beneficial.
d. Pregnant women should limit water intake during exercise.

ANS: C
In general, moderate exercise several times a week, from the 8th week through delivery, is advised during pregnancy.

DIF: Cognitive Level: Comprehension REF: Page 62 OBJ: 9 | 13
TOP: Exercise During Pregnancy KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

19. An ultrasound confirms that a 16-year-old girl is pregnant. How does the need for prenatal care and counseling for adolescents different from other age populations?
a. A pregnant adolescent is experiencing two major life transitions at the same time.
b. Adolescents who get pregnant are more likely to have other chronic health problems.
c. Adolescents are at greater risk for multifetal pregnancies.
d. At this age, a pregnant adolescent will accept the nurses advice.

ANS: A
The pregnant adolescent must cope with two of lifes most stress-laden transitions simultaneously: adolescence and parenthood.

DIF: Cognitive Level: Comprehension REF: Page 69 OBJ: 12
TOP: Psychological Adaptations to Pregnancy
KEY: Nursing Process Step: Planning
MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

20. At what age is a woman who becomes pregnant for the first time described as an elderly primip?

explain as the most likely cause of this symptom?
a. Supine hypotension syndrome
b. Gestational diabetes
c. Pregnancy-induced hypertension
d. Malnutrition

ANS: A
Supine hypotension syndrome, also called aortocaval compression or vena cava syndrome, may occur if the woman lies on her back. Symptoms of supine hypotension syndrome include faintness, lightheadedness, dizziness, and agitation.

DIF: Cognitive Level: Comprehension REF: Page 53 OBJ: 7
TOP: Physiological Changes KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Prenatal Care

MULTIPLE RESPONSE

25. A woman who is 36 weeks pregnant tells the nurse she plans to take a 12-hour flight to Hawaii. What would the nurse recommend that the patient do during the flight? (Select all that apply.)
a. Wear tight-fitting clothing to promote venous return.
b. Eat a large meal before boarding the flight.
c. Request a seat with greater leg room.
d. Drink at least 4 ounces of water every hour.
e. Get up and walk around the plane frequently.

ANS: C, D, E
Because of the increase in clotting potential, the pregnant patient is prone to a thromboembolism. Adequate hydration, frequent position changes, and movement decrease the risk.

DIF: Cognitive Level: Application REF: Page 64-65 OBJ: 10
TOP: Flight Precautions KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Reduction of Risk

26. The nurse cautions the patient that, because of hormonal changes in late pregnancy, the pelvic joints relax. What does this result in? (Select all that apply.)
a. Waddling gait
b. Joint instability
c. Urinary frequency
d. Back pain
e. Aching in cervical spine

ANS: A, B
A waddling gait and joint instability are the only signs that relate to joint changes. The other discomforts are related to the enlarging uterus with its attendant weight.

DIF: Cognitive Level: Comprehension REF: Page 55 OBJ: 7
TOP: Joint Changes KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

27. The nurse assesses the progress from the announcement stage of fatherhood to the acceptance stage when the patient reports which actions by the father? (Select all that apply.)
a. Goes fishing every afternoon
b. Has revised his financial plan
c. Spends leisure time with his friends
d. Traded his sports car for a sedan
e. Helped select a crib

ANS: B, D, E
Active planning for an infant is an indication of the acceptance stage. Concentration on a hobby and spending

DIF: Cognitive Level: Comprehension REF: Page 95 OBJ: 4
TOP: Rh Incompatibility KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

9. A woman seeking prenatal care relates a history of macrosomic infants, two stillbirths, and polyhydramnios with each pregnancy. What does the nurse recognize these factors highly suggest?
a. Toxoplasmosis
b. Abruptio placentae
c. Hydatidiform mole
d. Diabetes mellitus

ANS: D
Large (macrosomic) infants over 9 pounds are linked to gestational diabetes.

DIF: Cognitive Level: Comprehension REF: Page 96 OBJ: 5
TOP: Diabetes Mellitus KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

10. A nurse is providing prenatal education. The nurse will explain that pregnancy affects glucose metabolism in what way?
a. Placental hormones increase the resistance of cells to insulin.
b. Insulin cells cannot meet the bodys demands as the womans weight increases.
c. There is a decreased production of insulin during pregnancy.
d. The speed of insulin breakdown is decreased during pregnancy.

ANS: A
Hormones and enzymes produced by the placenta increase the resistance of cells to insulin.

DIF: Cognitive Level: Knowledge REF: Page 96 OBJ: 5
TOP: Diabetes Mellitus KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

11. Why does the woman taking oral hypoglycemic agents to control diabetes mellitus need to take insulin during pregnancy?
a. Insulin can cross the placental barrier to the fetus.
b. Insulin does not cross the placental barrier to the fetus.
c. Oral agents do not cross the placenta.
d. Oral agents are not sufficient to meet maternal insulin needs.

ANS: B
Oral hypoglycemic agents are not used during pregnancy because they can cross the placenta, possibly resulting in fetal birth defects or hypoglycemia.

DIF: Cognitive Level: Comprehension REF: Page 97 | Page 100
OBJ: 5 TOP: Diabetes Mellitus
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Pharmacological Therapies

12. A pregnant woman comes to the clinic stating that she has been exposed to hepatitis B. She is afraid that her infant will also contract hepatitis B. What will the nurse explain to this woman?
a. The infant will be given a single dose of hepatitis immune globulin after birth.
b. The infant will be able to use the antibodies from the immunizations given to the patient before delivery.
c. The infant will not have hepatitis B because the virus does not pass through the placental barrier.
d. The infant will be immune to hepatitis B because of the mothers infection.

ANS: A
The infant will be given immune globulin immediately after birth for temporary immunity followed by hepatitis B vaccine. Immunization is not recommended for women who are pregnant.

d. Frustration with activity restriction
e. Alteration in child care practices

ANS: A, B, D, E
High-risk pregnancies may produce problems such as disruption of family roles, financial pressures, delayed attachment to the infant, alteration in child care practices, and frustration with activity restriction.

DIF: Cognitive Level: Comprehension REF: Page 112 OBJ: 8
TOP: Impact of High-Risk Pregnancies KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity: Psychosocial Adaptation

29. A patient who is 30 weeks pregnant delivers a stillborn child in the emergency department (ED). What should the ED nurse offer the patient? (Select all that apply.)
a. Privacy
b. An opportunity to hold the infant
c. Materials about support groups
d. A memento (footprint or lock of hair)
e. A warm beverage

ANS: A, B, C, D
The patient should be offered privacy, an opportunity to hold the infant, support group information, and a memento. A warm beverage is not a priority at this time.

DIF: Cognitive Level: Application REF: Page 112 OBJ: 8
TOP: Stillborn Infant KEY: Nursing Process Step: Planning
MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

30. What would the nurse include in a teaching plan for the pregnant patient who has iron deficiency anemia and has been placed on iron supplements? (Select all that apply.)
a. Citrus fruits enhance absorption of iron.
b. Bran products support iron deficiency.
c. Milk will disguise the taste of the iron.
d. The iron therapy will continue for about 3 months.
e. Tea should be avoided while taking iron.

ANS: A, D, E
Calcium, bran, and milk interfere with the absorption of iron. Vitamin C helps with the absorption of iron, the therapy usually lasts 3 months, and the tannic acid in tea does interfere with the absorption of iron.

DIF: Cognitive Level: Application REF: Page 102 OBJ: 5
TOP: Iron Deficiency Anemia KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity: Pharmacological Therapies

31. The nurse takes into consideration that the patient with placenta previa is at risk for postpartum infection for what reasons? (Select all that apply.)
a. Vaginal organisms can invade the placenta.
b. The undernourished placenta becomes necrotic.
c. The amniotic fluid can become infected.
d. The placenta is an excellent growth medium.
e. The misplaced placenta weakens the uterine wall.

ANS: A, D
Vaginal organisms reach the placenta through the cervix. Once there, the organisms can multiply in the nutrient-rich environment of the placenta. The weak musculature of the lower segment of the uterus will cause postpartum hemorrhage rather than infection.

DIF: Cognitive Level: Comprehension REF: Page 88-89 OBJ: 3
TOP: Infection with Placenta Previa KEY: Nursing Process Step: Planning
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

Cerclage is the procedure that sutures the cervix closed to prevent its opening when the fetus presses against it.

DIF: Cognitive Level: Knowledge REF: Page 83 OBJ: 1
TOP: Cerclage KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Reduction of Risk

36. _____ _____ is the leading cause of perinatal infections that have a high mortality rate.

ANS:
Group B streptococcus (GBS)

Group B streptococcus (GBS) is a leading cause of perinatal infections that have a high neonatal mortality rate. The organism can be found in the womans rectum, vagina, cervix, throat, or skin.

DIF: Cognitive Level: Knowledge REF: Page 106 OBJ: 3 | 4
TOP: Perinatal Infections KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Antepartum and Newborn Care

37. A(n) _____ consists of a group of five fetal assessments: fetal heart rate and reactivity (the NST), fetal breathing movements, fetal body movements, fetal tone (closure of the hand), and volume of amniotic fluid.

ANS:
biophysical profile

A biophysical profile consists of a group of five fetal assessments: fetal heart rate and reactivity (the NST), fetal breathing movements, fetal body movements, fetal tone (closure of the hand), and volume of amniotic fluid.

DIF: Cognitive Level: Knowledge REF: Page 81, Table 5-1
OBJ: 2 TOP: Diagnostic tests
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Heath Promotion and Maintenance: Prenatal Care

Chapter 06: Nursing Care of Mother and Infant During Labor and Birth

MULTIPLE CHOICE

1. What does the nurse note when measuring the frequency of a laboring womans contractions?
a. How long the patient states the contractions last
b. The time between the end of one contraction and the beginning of the next
c. The time between the beginning and the end of one contraction
d. The time between the beginning of one contraction and the beginning of the next

ANS: D
The frequency of contractions is the elapsed time from the beginning of one contraction to the beginning of the next contraction.

DIF: Cognitive Level: Comprehension REF: Page 120 OBJ: 9
TOP: Frequency of Contractions KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

2. Why is the relaxation phase between contractions important?
a. The laboring woman needs to rest.
b. The uterine muscles fatigue without relaxation.
c. The contractions can interfere with fetal oxygenation.
d. The infant progresses toward delivery at these times.

ANS: C
Blood flow from the mother into the placenta gradually decreases during contractions. During the interval between contractions, the placenta refills with oxygenated blood for the fetus.

DIF: Cognitive Level: Comprehension REF: Page 121-122
OBJ: 6 TOP: Interval KEY: Nursing Process Step: N/A
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

3. What contraction duration and interval does the nurse recognize could result in fetal compromise?
a. Duration shorter than 30 seconds, interval longer than 75 seconds
b. Duration shorter than 90 seconds, interval longer than 120 seconds
c. Duration longer than 90 seconds, interval shorter than 60 seconds
d. Duration longer than 60 seconds, interval shorter than 90 seconds

ANS: C
Persistent contraction durations longer than 90 seconds or contraction intervals less than 60 seconds may reduce fetal oxygen supply.

DIF: Cognitive Level: Comprehension REF: Page 122, Safety Alert
OBJ: 9 TOP: Contraction/Fetal Compromise
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Reduction of Risk

4. Vaginal examination reveals the presenting part is the infants head, which is well flexed on the chest. What is this presentation?
a. Vertex
b. Military
c. Brow
d. Face

ANS: A
In the vertex presentation, the fetal head is the presenting part. The head is fully flexed on the chest.

DIF: Cognitive Level: Comprehension REF: Page 122-123
OBJ: 9 TOP: Fetal Position

TOP: Ice Pack/Bruising KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

21. At 1 and 5 minutes of life, a newborns Apgar score is 9. What does the nurse understand that a score of 9 indicates?
a. The newborn will require resuscitation.
b. The newborn may have physical disabilities.
c. The newborn will have above average intelligence.
d. The newborn is in stable condition.

ANS: D
Apgar scoring is a system for evaluating the infants need for resuscitation at birth. Five categories are evaluated on a scale from 0 to 2, with the highest score being 10. A score of 9 indicates that the newborn is stable.

DIF: Cognitive Level: Comprehension REF: Page 151-152, Table 6-7
OBJ: 10 TOP: Care of the Infant After Birth
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

22. The husband of a woman in labor asks, What does it mean when the baby is at minus 1 station? After giving an explanation, what statement by the husband indicates that teaching was effective?
a. Fetal head is above the ischial spines.
b. Fetal head is below the ischial spines.
c. Fetal head is engaged in the mothers pelvis.
d. Fetal head is visible at the perineum.

ANS: A
Station describes the level of the presenting part in the pelvis. It is estimated in centimeters from the level of the ischial spines. Minus stations are above the ischial spines.

DIF: Cognitive Level: Comprehension REF: Page 126 | Page 128, Figure 6-10
OBJ: 1 TOP: Mechanisms of Labor
KEY: Nursing Process Step: Evaluation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

23. The nurse formulates a nursing diagnosis for a woman in the fourth stage of labor. What is the most appropriate nursing diagnosis?
a. Pain related to increasing frequency and intensity of contractions.
b. Fear related to the probable need for cesarean delivery.
c. Dysuria related to prolonged labor and decreased intake.
d. Risk for injury related to hemorrhage.

ANS: D
In the fourth stage of labor, a priority nursing action is identifying and preventing hemorrhage.

DIF: Cognitive Level: Application REF: Page 147 OBJ: 6
TOP: Nursing Care Immediately After Birth
KEY: Nursing Process Step: Nursing Diagnosis
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

24. The nurse is caring for a patient who is not certain if she is in true labor. How might the nurse attempt to stimulate cervical effacement and intensify contractions in the patient?
a. By offering the patient warm fluids to drink
b. By helping the patient to ambulate in the room
c. By seating the patient upright in a straight-back chair
d. By positioning the patient on her right side

ANS: B

a. Anxiety related to the development of postpartum complications
b. Ineffective individual coping related to unfamiliarity with procedures
c. Risk for ineffective parenting related to emergency cesarean section
d. Grieving related to loss of expected birth experience

ANS: D
Women who have cesarean births usually need greater support than those who have vaginal births. They may feel grief, guilt, or anger because the expected course of birth did not occur.

DIF: Cognitive Level: Application REF: Page 183 OBJ: 8
TOP: Cesarean Section KEY: Nursing Process Step: Nursing Diagnosis
MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

17. A pregnant womans membranes ruptured prematurely at 34 weeks. She will be discharged to her home for the next few weeks. What would the nurse planning discharge instruction teach the woman to do?
a. Report any increase in fetal activity.
b. Notify her obstetrician if she has a temperature above 37.8 C (100 F).
c. Massage her breasts to promote uterine relaxation.
d. Rest in a side-lying Trendelenburg position with hips elevated.

ANS: B
For the woman with premature rupture of membranes (PROM) who is not having labor induced right away, teaching combines information about infection and preterm labor. The woman should monitor her temperature and report a temperature greater than 37.8 C (100 F).

DIF: Cognitive Level: Application REF: Page 192 OBJ: 6
TOP: Premature Rupture of Membranes KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity: Reduction of Risk

18. A woman who is 24 weeks pregnant is placed on an intravenous infusion of magnesium sulfate. What side effect should the nurse inform the patient that she might experience?
a. Nausea and vomiting
b. Headache
c. Warm flush
d. Urinary frequency

ANS: C
Magnesium sulfate is the drug of choice for initiating therapy to stop labor. The patient will notice a warm flush with the initiation of the drug.

DIF: Cognitive Level: Knowledge REF: Page 193 OBJ: 6
TOP: Preterm Labor KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

19. When a woman is admitted to the labor and delivery unit, she tells the nurse that she is anxious about delivery, the welfare of her infant, and how quickly she will recover. How can anxiety affect labor?
a. By decreasing a womans pain sensitivity
b. By reducing blood flow to the uterus
c. By increasing the ability to tolerate pain
d. By enhancing maternal pushing through greater muscle tension

ANS: B
Excessive anxiety reduces uterine blood flow, making uterine contractions less effective, and creates muscle tension that counteracts the expulsion powers of contractions.

DIF: Cognitive Level: Comprehension REF: Page 191 OBJ: 2
TOP: Factors That Influence Labor Pain KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance

emotional support and allowing patient to vent frustration are supportive to the patient but do not stimulate more effective labor.

DIF: Cognitive Level: Application REF: Page 177 OBJ: 3
TOP: Hypotonic Labor KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

28. What complications of overstimulation of uterine contractions may occur? (Select all that apply.)
a. Water intoxication
b. Impaired placental exchange of oxygen and nutrients
c. Increased blood pressure
d. Convulsions
e. Uterine rupture

ANS: A, B, E
The most common complications are impaired placental exchange and uterine rupture, but water intoxication can occur due to fluid retention.

DIF: Cognitive Level: Comprehension REF: Page 178 OBJ: 6
TOP: Complication of Oxytocin KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

29. How might the nurse instruct the patient to stimulate her nipples in an attempt to increase the quality of uterine contractions? (Select all that apply.)
a. Place a warm, moist washcloth over the breast.
b. Brush the nipples with a dry washcloth.
c. Gently pull on the nipples.
d. Apply suction to the nipples with a breast pump.
e. Press the palms of her hands down on her breasts.

ANS: B, C, D
Brushing nipples with a dry washcloth, gently pulling nipples, and applying suction with a breast pump are all effective methods of nipple stimulation, which will increase the quality of uterine contractions.

DIF: Cognitive Level: Application REF: Page 177 OBJ: 5
TOP: Nipple Stimulation KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

30. A woman is 37 weeks pregnant and questioning the nurse about possible induction of labor at term. What conditions would contraindicate labor induction? (Select all that apply.)
a. Maternal gynecoid pelvis
b. Placenta previa
c. Horizontal cesarean incision
d. Prolapsed cord
e. Gestational diabetes

ANS: B, D
Labor induction is contraindicated with placenta previa or a prolapsed umbilical cord. Gynecoid pelvis is the most favorable shape for vaginal delivery. Induction can be attempted as a VBAC after a horizontal cesarean incision but is contraindicated with a classic (vertical) incision. Gestational diabetes is not a contraindication for labor induction.

DIF: Cognitive Level: Comprehension REF: Page 175 OBJ: 2
TOP: Induction KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Reduction of Risk

31. A woman is preparing for administration of a cervical ripening agent. What nursing actions will the nurse anticipate implementing? (Select all that apply.)
a. Insert IV.

Chapter 09: The Family After Birth

MULTIPLE CHOICE

1. The nurse is assessing a newborn. What sign of hypoglycemia does the nurse record?
a. Increased nasal mucus
b. Increased temperature
c. Active muscle movements
d. High-pitched cry

ANS: D
There are many signs of hypoglycemia in the newborn. One is a high-pitched cry.

DIF: Cognitive Level: Comprehension REF: Page 219 OBJ: 9
TOP: Signs of Hypoglycemia KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Reduction of Risk

2. What would the nurse expect to find when assessing the fundus of the uterus immediately after delivery?
a. Well-contracted with its upper border at or just below the umbilicus
b. Well-contracted with its upper border three or four fingerbreadths above the umbilicus
c. Relaxed with its upper border level with the umbilicus
d. Relaxed with its upper border two or three fingerbreadths below the umbilicus

ANS: A
Immediately after the placenta is expelled, the uterine fundus can be felt as a firm mass, about the size of a grapefruit, at the level of the umbilicus.

DIF: Cognitive Level: Comprehension REF: Page 200 OBJ: 2
TOP: Fundus Assessment KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

3. What statement made by a new mother indicates she needs additional information about breastfeeding?
a. I let the baby nurse 10 to 15 minutes on the first breast and then switch to the other breast.
b. The baby needs to nurse at least 5 minutes on the breast to get the hindmilk.
c. The baby has been nursing every 2 to 3 hours.
d. If the baby gets fussy between feedings, I give her a bottle of water.

ANS: D
Supplemental feedings of formula or water should not be offered to a healthy newborn who is breastfeeding.

DIF: Cognitive Level: Comprehension REF: Page 223-227
OBJ: 14 TOP: BreastfeedingSupplemental Feedings
KEY: Nursing Process Step: Evaluation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

4. After delivery, the nurses assessment reveals a soft, boggy uterus located above the level of the umbilicus. What is the most appropriate nursing intervention?
a. Notify the physician.
b. Massage the fundus.
c. Initiate measures that encourage voiding.
d. Position the patient flat.

ANS: B
A poorly contracted uterus should be massaged until firm to prevent hemorrhage.

DIF: Cognitive Level: Application REF: Page 202 OBJ: 9
TOP: Boggy Uterus KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

ANS: C
Breastfeeding mothers may have more afterpains because infant suckling causes the posterior pituitary to release oxytocin, which is a hormone that contracts the uterus.

DIF: Cognitive Level: Application REF: Page 201 OBJ: 2
TOP: Afterpains with Breastfeeding KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

18. A new mother has decided not to breastfeed her newborn. What information will the nurse include when planning to teach the mother about formula feeding?
a. Positioning the bottle so that the nipple is full of formula during the entire feeding
b. Heating the infant formula in a microwave
c. Burping the infant after 4 ounces and again when the bottle is empty
d. Propping a bottle for a feeding

ANS: A
The nipple of the bottle should be kept full of formula to reduce the amount of air the infant swallows.

DIF: Cognitive Level: Comprehension REF: Page 232, Skill 9-7
OBJ: 17 TOP: Formula Feeding
KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity: Reduction of Risk

19. In the recovery room, the nurse checks the newly delivered womans fundus following a cesarean section. How would the nurse proceed with this assessment?
a. Palpate from the midline to the side of the body.
b. Palpate from the symphysis to the umbilicus.
c. Palpate from the side of the uterus to the midline.
d. Massage the abdomen in a circular motion.

ANS: C
The fundus is checked gently by walking the fingers from the side of the uterus to the midline.

DIF: Cognitive Level: Application REF: Page 209 OBJ: 5
TOP: Postpartum Cesarean Assessment KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

20. The nurse instructed a postpartum woman about storing and freezing breast milk. What statement by the woman leads the nurse to determine that the teaching was effective?
a. I can thaw frozen breast milk in the microwave.
b. Ill put enough breast milk for one day in a container.
c. Breast milk can be stored in glass containers.
d. Breast milk can be kept in the refrigerator for up to 3 months.

ANS: C
Breast milk can be safely stored in glass or clear hard plastic containers.

DIF: Cognitive Level: Comprehension REF: Page 229 OBJ: 14
TOP: Storing Breast Milk KEY: Nursing Process Step: Evaluation
MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

21. What should the nurse implement for security purposes when bringing the infant from the nursery to the mother?
a. Ask, Is this your band number?
b. Confirm room number of mother.
c. Ask the mother to identify herself verbally.
d. Check the band number of the infant with that of the mother.

ANS: D
The nurse should check the band number of the infant with that of the mother by asking the mother to verbally read the number.

DIF: Cognitive Level: Application REF: Page 216-217
OBJ: 8 TOP: Security Identification Procedure
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

22. Below what blood glucose level is the newborn considered hypoglycemic?
a. Below 70 mg/dL
b. Below 60 mg/dL
c. Below 50 mg/dL
d. Below 40 mg/dL

ANS: D
A blood glucose level of less than 40 mg/dL is considered hypoglycemic. If the screening sample is below 40 mg/dL, a venous sample will be drawn. After the blood has been drawn, the infant should be fed to prevent a further drop.

DIF: Cognitive Level: Comprehension REF: Page 219 OBJ: 8
TOP: Hypoglycemia KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity: Reduction of Risk

23. The nurse is caring for a woman of Middle Eastern descent on the first postpartum day. Education is provided regarding instruction on use of a sitz bath. What documentation best indicates that the woman has understood the provided instruction?
a. Patient correctly performed return demonstration.
b. Patient indicated understanding by nodding head with instruction.
c. Patient verbalizes I understand.
d. Family member indicates patient understands procedure.

ANS: A
The nurse may need an interpreter to understand and provide optimal care to the woman and her family. If possible, when discussing sensitive information the interpreter should not be a family member, who might interpret selectively. The interpreter should not be of a group that is in social or religious conflict with the patient and her family, an issue that might arise in many Middle Eastern cultures. It is also important to remember that an affirmative nod from the woman may be a sign of courtesy to the nurse rather than a sign of understanding or agreement.

DIF: Cognitive Level: Application REF: Page 200 OBJ: 3
TOP: Cultural Influences KEY: Nursing Process Step: Evaluation
MSC: NCLEX: Physiological Integrity: Cultural Awareness

24. A woman has given birth to an unresponsive newborn that NICU staff are attempting to revive. The patient and her husband are grief stricken and request the child be baptized immediately. What is the nurses most appropriate action?
a. Contact the hospital chaplain.
b. Request the couples clergy.
c. Baptize the newborn.
d. Ask the physician to baptize the newborn.

ANS: C
If the condition of a newborn is poor, the parents may wish to have a baptism performed. The minister or priest is notified. However this is an emergency, so the nurse may perform the baptism by pouring water on the infants forehead while saying, I baptize you in the name of the Father, and of the Son, and of the Holy Spirit. If there is any doubt as to whether the infant is alive, the baptism is given conditionally: If you are capable of receiving baptism, I baptize you in the name of the Father, and of the Son, and of the Holy Spirit. The physician is attending to the patients immediate health needs.

OBJ: 2 TOP: Estimating Lochia Discharge
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Reduction of Risk

32. The nurse explains that the three infections that are contraindications to breastfeeding are _____, _____, and _____.

ANS:
human immunodeficiency virus (HIV), hepatitis B, hepatitis C

Mothers who are HIV positive should not breastfeed because the virus can be transmitted through breast milk, as can the viruses that cause hepatitis B and C.

DIF: Cognitive Level: Comprehension REF: Page 222 OBJ: 13
TOP: Contraindication for Breastfeeding KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

33. The hormone responsible for milk production is _____.

ANS:
prolactin

During pregnancy, the woman secretes high levels of prolactin, the hormone that causes milk production. Following delivery, increased levels of prolactin lead to lactation.

DIF: Cognitive Level: Knowledge REF: Page 223 OBJ: 11
TOP: Prolactin KEY: Nursing Process Step: N/A
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

34. The hormone responsible for milk let-down or ejection from the breast is _____.

ANS:
oxytocin

The milk let-down reflex is caused by the hormone oxytocin.

DIF: Cognitive Level: Knowledge REF: Page 223 OBJ: 11
TOP: Oxytocin KEY: Nursing Process Step: N/A
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

35. _____ refers to changes that the reproductive organs, particularly the uterus, undergo after birth to return to their prepregnancy size and condition.

ANS:
Involution

Involution refers to changes that the reproductive organs, particularly the uterus, undergo after birth to return to their prepregnancy size and condition.

DIF: Cognitive Level: Knowledge REF: Page 200 OBJ: 1
TOP: Puerperium KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

TOP: Laceration KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Reduction of Risk

21. The nurse assesses a positive Homans sign when the patients leg is flexed and foot sharply dorsiflexed. Where does the patient report that the pain is felt?
a. Groin
b. Achilles tendon
c. Top of the foot
d. Calf of the leg

ANS: D
A pain in the calf of the leg when the leg is flexed and the foot is dorsiflexed is a positive Homans sign. Homans sign is suggestive of a deep vein thrombosis.

DIF: Cognitive Level: Comprehension REF: Page 243 OBJ: 2
TOP: Homans Sign KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

22. The new mother who had a vaginal delivery yesterday has a white blood cell count of 30,000 cells/dL. What action should the nurse implement?
a. Notify the charge nurse of a possible infection.
b. Prepare to put the patient in isolation.
c. Have the infant removed from the room and returned to the nursery.
d. Assess the patient further.

ANS: D
The patient should be assessed further for other signs of infection because a white blood cell (WBC) count of 20,000 to 30,000 cells/dL is normal in the early postpartum period.

DIF: Cognitive Level: Analysis REF: Page 244 OBJ: 6
TOP: Elevated WBC KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

23. A postpartum patient experiences anaphylactic shock. What is the most likely cause?
a. Pulmonary embolism
b. Hypertension
c. Allergy
d. Blood clotting disorder

ANS: C
Anaphylactic shock is caused by allergic responses to drugs administered. Cardiogenic shock may be caused by pulmonary embolism or hypertension. Hypovolemic shock could be caused by blood clotting disorders.

DIF: Cognitive Level: Comprehension REF: Page 237 OBJ: 3
TOP: Shock KEY: Nursing Process Step: Evaluation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

24. A woman is prescribed Coumadin (warfarin) to treat deep vein thrombosis. What will the nurse instruct this woman is the antidote for warfarin overdose?
a. Vitamin A
b. Vitamin B
c. Vitamin E
d. Vitamin K

ANS: D
The antidote for warfarin overdose is vitamin K.

DIF: Cognitive Level: Knowledge REF: Page 243 OBJ: 5
TOP: Warfarin KEY: Nursing Process Step: Implementation

Chapter 12: The Term Newborn

MULTIPLE CHOICE

1. While inspecting a newborns head, the nurse identifies a swelling of the scalp that does not cross the suture line. How would the nurse refer to this finding when documenting?
a. Molding
b. Caput succedaneum
c. Cephalohematoma
d. Enlarged fontanelle

ANS: C
A cephalohematoma is caused by a collection of blood beneath the periosteum of the cranial bone. It does not cross the suture line.

DIF: Cognitive Level: Comprehension REF: Page 283 OBJ: 1
TOP: Newborn AssessmentHead KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

2. What is the nurses best response to a mother who is voicing concern about the molding of her 2-day-old infant?
a. Molding doesnt cause any problems. Dont worry about it.
b. Did you deliver vaginally or by cesarean section?
c. The babys head conformed to the shape of the birth canal. It will go away soon.
d. A traumatic delivery can cause molding.

ANS: C
The newborns head may be out of shape from molding. This refers to the shaping of the fetal head to conform to the size and shape of the birth canal.

DIF: Cognitive Level: Application REF: Page 283 OBJ: 1
TOP: Newborn AssessmentHead KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

3. What symptom assessed in the newborn shortly after delivery should be reported?
a. Cyanosis of the hands and feet
b. Irregular heart rate
c. Mucus draining from the nose
d. Sternal or chest retractions

ANS: D
Sternal retractions are evidence that the newborn is in respiratory distress and should be reported immediately.

DIF: Cognitive Level: Analysis REF: Page 289 OBJ: 3
TOP: Newborn AssessmentRespiratory
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

4. When the newborns crib was moved suddenly, the nurse noticed that his legs flexed and arms fanned out, and then both came back toward the midline. How would the nurse interpret this behavior?
a. The Moro reflex
b. The grasp reflex
c. An abnormality of the musculoskeletal system
d. A neurological abnormality

ANS: A
The Moro reflex is a normal neonatal reflex. It is elicited when the infants crib is jarred. The infant responds by drawing the legs up, fanning the arms, and then bringing the arms to the midline in an embrace position.

Term infants over 4000 g (8.8 lb) may be classified as large for gestational age (LGA). For the preterm infant this is less than 38 weeks, for the term infant it is 38 to 42 weeks, and for the postterm infant it is beyond 42 weeks. A late preterm infant, also known as a near-term infant, is born between 34 and 36 weeks.

DIF: Cognitive Level: Analysis REF: Page 308-309
OBJ: 1 TOP: Gestational Age
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

26. An infant receives surfactant via endotracheal (ET) tube at birth for symptoms of respiratory distress syndrome (RDS). When will the nurse anticipate seeing improvement of lung function?
a. Immediately
b. Within 3 days
c. 1 to 2 weeks
d. At least 1 month

ANS: B
In preterm newborns, surfactant can be administered via ET tube at birth or when symptoms of RDS occur, with improvement of lung function seen within 72 hours.

DIF: Cognitive Level: Comprehension REF: Page 312 OBJ: 4
TOP: Respiratory Distress Syndrome KEY: Nursing Process Step: Evaluation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

MULTIPLE RESPONSE

27. The nurse knows that a postterm infant may experience which potential problems? (Select all that apply.)
a. Seizures
b. Asphyxia
c. Paralysis
d. Visual defects
e. Polycythemia

ANS: A, B, E
The postterm infant should be assessed closely for indication of asphyxia, seizures, and polycythemia.

DIF: Cognitive Level: Comprehension REF: Page 321 OBJ: 9
TOP: Potential Problems of the Postterm Infant
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

28. The nurse is caring for a woman who gave birth to a preterm infant. The nurse is aware that what are possible causes of preterm delivery? (Select all that apply.)
a. Placenta previa
b. Gestational diabetes
c. Pregnancy-induced hypertension
d. Hyperemesis gravidarum
e. Chloasma

ANS: A, B, C
The predisposing causes of preterm birth are numerous; in many instances the cause is unknown. Prematurity may be caused by multiple births, illness of the mother (e.g., malnutrition, heart disease, diabetes mellitus, or infectious conditions), or the hazards of pregnancy itself, such as gestational hypertension, placental abnormalities that may result in premature rupture of the membranes, placenta previa (in which the placenta lies over the cervix instead of higher in the uterus), and premature separation of the placenta. Studies also indicate the relationships between prematurity and poverty, smoking, alcohol consumption, and abuse of cocaine and other drugs. Hyperemesis gravidarum and chloasma are not risk factors for preterm birth.

DIF: Cognitive Level: Comprehension REF: Page 309 OBJ: 3

The childs position must be changed frequently to relieve pressure and promote circulation.

DIF: Cognitive Level: Application REF: Page 335 OBJ: 8
TOP: Developmental Hip Dysplasia KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

17. The nurse is caring for an Rh-negative mother on the postpartum unit. What scenario indicates the need to administer RhoGAM to this patient?
a. She has had one Rh-negative child and is pregnant with an Rh-negative child.
b. She has had an Rh-positive infant and is pregnant with an Rh-positive fetus.
c. She has had an O-negative child and is pregnant with a B-negative child.
d. She is a primipara with an O-negative child.

ANS: B
The only woman with antibodies against the Rh-positive infant is the Rh-negative woman who has had one Rh-positive child and is now pregnant with another.

DIF: Cognitive Level: Analysis REF: Page 340 OBJ: 11
TOP: Rh Concerns KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Reduction of Risk

18. Parents ask the nursery staff what the light does for their jaundiced infant. What is the nurses best response?
a. The light increases the infants metabolism.
b. The light stimulates liver function.
c. The light dilates blood vessels.
d. The light breaks down bilirubin.

ANS: D
Severe jaundice can cause kernicterus, an accumulation of bilirubin in the brain tissue, which can lead to serious brain damage. The light breaks down excess bilirubin so that it can be excreted.

DIF: Cognitive Level: Application REF: Page 342 OBJ: 11
TOP: Hemolytic Disease of the Newborn
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

19. Parents of a newborn with a unilateral cleft lip are concerned about having the defect repaired. The nurse explains that a child with a cleft lip usually undergoes surgical repair at which time?
a. Immediately after birth
b. By 3 months of age
c. After 12 months of age
d. Varies in every case

ANS: B
A cleft lip is repaired by 3 months of age when weight gain is established and the infant is free of infection.

DIF: Cognitive Level: Comprehension REF: Page 331 OBJ: 7
TOP: Cleft Lip KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

20. Phototherapy is instituted for an infant. What is the most appropriate nursing action for the infant having phototherapy?
a. Cover the infants head with a hat.
b. Dress the infant lightly in a T-shirt.
c. Keep the infants eyes covered.
d. Reposition the infant at least every 4 to 8 hours.

ANS: C

The infants eyes are protected with patches to prevent damage from the high-intensity lights.

DIF: Cognitive Level: Application
REF: Page 342, Figure 14-14 | Page 343, NCP 14-2 | Page 345 Box 14-4
OBJ: 12 TOP: Phototherapy
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Reduction of Risk

21. The nurse is caring for a macrosomic newborn whose mother has diabetes. What should the nurse assess for with this neonate?
a. Hypoglycemia
b. Erythroblastosis fetalis
c. Intracranial hemorrhage
d. Pancreatic failure

ANS: A
The newborn of a mother with diabetes is prone to hypoglycemia.

DIF: Cognitive Level: Application REF: Page 347 OBJ: 15
TOP: Infant of a Diabetic Mother KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Reduction of Risk

22. What assessment made by the nurse would lead the nurse to suspect hip dysplasia?
a. Asymmetrical gluteal folds
b. Limited adduction of the affected side
c. Foot turned inward
d. Deep inguinal creases

ANS: A
The gluteal folds are asymmetrical because the head of the femur has slipped out of the acetabulum. There is also limited abduction of the affected side, and when the legs are flexed the affected leg seems to be shorter.

DIF: Cognitive Level: Comprehension REF: Page 333-334, Figure 14-9
OBJ: 8 TOP: Hip Dysplasia
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

23. The nurse is providing care to a child with Down syndrome. What body system has the highest risk of congenital anomaly in a child with Down syndrome?
a. Reproductive system
b. Genitourinary system
c. Cardiovascular system
d. Gastrointestinal system

ANS: C
Down syndrome children are prone to deformities of the cardiovascular system.

DIF: Cognitive Level: Knowledge REF: Page 339 OBJ: 10
TOP: Down Syndrome KEY: Nursing Process Step: Planning
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

24. The parents of a child diagnosed with cystic fibrosis ask the nurse what caused this disorder. What is the most appropriate response?
a. Cystic fibrosis is a chromosomal defect.
b. Cystic fibrosis is a metabolic defect.
c. Cystic fibrosis is a malformation present at birth.
d. Cystic fibrosis is a blood disorder.

ANS: B

MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

COMPLETION

32. The nurse explains that the second process of self-mobility an infant learns is seen at the age of 9 months, when the infant begins to _____.

ANS:
creep

At 7 months the infant begins to crawl, using arms and dragging trunk and legs. At 9 months the infant begins to creep, holding his or her trunk above the floor. The next self-mobility activity is cruising, where the child walks from one piece of furniture to the next before it begins to walk independently.

DIF: Cognitive Level: Application REF: Page 389, Figure 16-3
OBJ: 3 TOP: Creeping KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

33. The nurse cautions parents to place their infant in the _____ position, rather than on his or her stomach, to reduce the risk of sudden infant death syndrome (SIDS).

ANS:
supine

The supine or side-lying position has been found to reduce possible aspiration and is believed to reduce the risk of SIDS.

DIF: Cognitive Level: Application REF: Page 395 OBJ: 16
TOP: Positions for Sleep KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Reduction of Risk

34. _____ is characterized by periods of unexplained irritability and crying in a healthy, well-fed infant.

ANS:
Colic

Colic is characterized by periods of unexplained irritability and crying in a healthy, well-fed infant.

DIF: Cognitive Level: Knowledge REF: Page 395 OBJ: 1
TOP: Colic KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

35. The nurse explains that an infants prehensile development is progressive and logical. Arrange the development in the order from the simplest to the most complex. Put a comma and space between each answer choice (a, b, c, d, etc.)

a. Hands held open most of the time
b. Grasps with thumb on one side and three fingers on the other
c. Picks up toy with squeeze action
d. Thumb and forefinger hold object
e. Hands held closed most of the time

ANS:
E, A, C, B, D

The development advances from the newborns closed hands to the open star hands of the older infant, to the squeeze action, to a grasp with thumb and fingers, to the pincher movement of thumb and forefinger.

DIF: Cognitive Level: Analysis REF: Page 388-389, Figure 16-3

a. Temperature of 37.1 C (98.8 F)
b. Pulse at 100 beats/min
c. Respirations of 36 breaths/min
d. Blood pressure of 90/60 mm Hg

ANS: C
In the toddler period, the respiratory rate decreases to 25 breaths/min.

DIF: Cognitive Level: Analysis REF: Page 408 OBJ: 2
TOP: Vital Signs KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

14. What would be an expected finding when assessing language development in a 2-year-old?
a. A 900-word vocabulary
b. Use of two-word sentences
c. Use of pronouns and prepositions
d. 100% of speech is understandable

ANS: B
The 2-year-old should be using two-word sentences.

DIF: Cognitive Level: Analysis REF: Page 409, Table 17-2
OBJ: 5 TOP: Speech Development
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

15. The nurse is planning to explain the use of time-outs to the parent of a 3-year-old. How many minutes will the nurse indicate is appropriate for a child of this age?
a. 3
b. 6
c. 10
d. 15

ANS: A
Timing for time-out is usually based on 1 minute per year of age.

DIF: Cognitive Level: Comprehension REF: Page 410 OBJ: 6
TOP: Guidance and Discipline KEY: Nursing Process Step: Evaluation
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

16. The parent of a toddler tells the nurse, My daughters appetite has decreased. Thank goodness she loves to drink milk. What is the most appropriate response by the nurse?
a. Has your daughter been sick recently?
b. How much milk does she drink in a day?
c. Has she become a fussy eater, too?
d. Have you tried offering her finger foods?

ANS: B
Milk should be limited to 24 ounces a day. Too few solid foods can lead to dietary deficiencies of iron.

DIF: Cognitive Level: Application REF: Page 413 OBJ: 9
TOP: Nutrition Counseling KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity

17. How many hours should toddlers be able to stay dry for the nurse to suggest they are ready to begin bladder training?
a. 1
b. 2
c. 3

e. Understands no

ANS:
C, D, E, A, B

Social smile: 2 months
Babbles: 3 months
Understands no: 9 months
Jumps with both feet: 24 months
Holds a cup by the handle: 36 months

DIF: Cognitive Level: Analysis REF: Page 407, Table 17-1
OBJ: 3 TOP: Physical Development
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

Chapter 18: The Preschool Child

MULTIPLE CHOICE

1. Which statement best describes the 3-year-old child?
a. Boisterous, tattles on others
b. Aggressive, shows off
c. Helpful, wants to assist with chores
d. Talkative, inquisitive about the environment

ANS: C
Three-year-old children are helpful and can assist in simple household chores.

DIF: Cognitive Level: Comprehension REF: Page 424 OBJ: 3
TOP: Development KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

2. The parents of a 4-year-old boy are concerned because they have noticed him frequently touching his penis. What knowledge would act as the basis for the nurses response?
a. This behavior indicates a normal curiosity about sexuality.
b. Masturbation suggests the boy has an excessive fear of castration.
c. It is usually a result of discomfort from a penile rash or irritation.
d. The behavior is abnormal and the child should be referred for counseling.

ANS: A
Masturbation at this age is common and indicates that the preschooler has a normal curiosity about sexuality.

DIF: Cognitive Level: Comprehension REF: Page 424 OBJ: 9
TOP: Masturbation KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

3. A preschool-age child is asked, Why do trees have leaves? Which response would be an example of animism?
a. So I can have shade over my sandbox.
b. Because God made them that way.
c. To hide behind when they are scared.
d. For the squirrels to play in.

ANS: C
Animism describes the tendency of preschool children to attribute human characteristics to nonhuman objects.

DIF: Cognitive Level: Application REF: Page 421 OBJ: 1
TOP: Cognitive Development KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

4. What tasks would be appropriate to expect of a 5-year-old?
a. Setting the table with paper plates
b. Washing the dirty knives
c. Carrying glasses from the table to the sink
d. Scrubbing out the sink with cleanser

ANS: A
Parents must consider developmental level and safety when asking the 5-year-old child to help with chores.

DIF: Cognitive Level: Application REF: Page 430 OBJ: 3
TOP: DevelopmentSafety KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

5. A 3-year-old child, while playing with his favorite toy in the playroom of the pediatric unit, is approached

9. A parent asked the nurse, At what age are children capable of assuming more responsibility for personal belongings? What is the nurses best response based on knowledge of growth and development?
a. 6 years
b. 7 years
c. 9 years
d. 12 years

ANS: C
The 9-year-old is dependable and assumes more responsibility for personal belongings.

DIF: Cognitive Level: Comprehension REF: Page 440 OBJ: 3
TOP: Nine-Year-Old KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

10. The school nurse is preserving a tooth that was knocked out on the school playground. What will the nurse be especially careful to do?
a. Wrap the tooth loosely in a clean cloth.
b. Rinse the tooth with alcohol.
c. Handle the tooth only by the crown.
d. Place the tooth in a warm environment.

ANS: C
When a permanent tooth is avulsed, the tooth should be picked up by the crown to prevent any further damage to the root and placed in milk until the child can be examined by a dentist.

DIF: Cognitive Level: Application REF: Page 439, Nursing Tip
OBJ: 7 TOP: Safety KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Reduction of Risk

11. A parent states, My 7-year-old really wants a dog. His 10-year-old brother has allergies to animal dander. I dont know what to do. What type of pet should the nurse suggest as the best choice?
a. A small breed of dog because the large dogs produce more allergens
b. An older unneutered dog that produces fewer allergens than a younger one
c. A cat because it requires less care and is less allergenic
d. A poodle, which does not shed, making it a good choice for people with allergies

ANS: D
The poodle does not have a shed cycle and so it may be the least offensive pet for the allergic child.

DIF: Cognitive Level: Analysis REF: Page 448 OBJ: 8
TOP: Pet Ownership KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

12. When asked about her activities, a 10-year-old girl responded, I like school. I play the flute in the school band, and I take tennis lessons. What does the nurse know these activities will help this child develop?
a. Initiative
b. Industry
c. Identity
d. Intimacy

ANS: B
The school-age period is referred to by Erikson as the stage of industry. Successful participation in activities facilitates the childs sense of industry.

DIF: Cognitive Level: Application REF: Page 434 OBJ: 3
TOP: Psychosocial Development KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

13. A mother reports that she has a new job and her 12-year-old child is home alone for a time after school.

DIF: Cognitive Level: Knowledge REF: Page 435 OBJ: 3
TOP: Eruption of Permanent Teeth KEY: Nursing Process Step: Planning
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

33. The _____maintains that every sex education program should present the topic from six aspects: biological, social, health, personal adjustment and attitudes, interpersonal associations, and establishment of values.

ANS: Sexuality Information and Education Council of the United States (SIECUS)

DIF: Cognitive Level: Knowledge REF: Page 436 OBJ: 1
TOP: Sex Education KEY: Nursing Process Step: Planning
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

ANS: A
This is the only statement that associates the parents feelings about the adolescent behavior that is not aggressive or accusatory.

DIF: Cognitive Level: Analysis REF: Page 462, Health Promotion box
OBJ: 14 TOP: I Statements
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

21. A 13-year-old girl tells the nurse she is concerned because she has not had her first menstrual period. What is the best initial response from the nurse?
a. Your hormone levels may be irregular.
b. Could you be pregnant?
c. Age of first menstrual cycle varies.
d. Do not worry about it.

ANS: C
Puberty is easily recognized in girls by the onset of menstruation. The first menstrual period is called the menarche. It commonly occurs about age 12 or 13 years, but this varies. It may occur as early as age 10 years or as late as age 15 years.

DIF: Cognitive Level: Application REF: Page 455 OBJ: 6
TOP: Menstrual Cycle KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

22. The nurse is documenting the pediatricians assessment of a female patient. When assessing Tanners stages of breast development there is elevation of papilla only. What stage of development will the nurse document?
a. Stage 1
b. Stage 2
c. Stage 3
d. Stage 4

ANS: A
According to Tanners Stages of Sexual Maturity, Stage 1 (Preadolescent) is elevation of papilla only.

DIF: Cognitive Level: Application REF: Page 454, Figure 20-4
OBJ: 7 TOP: Breast Development
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

23. The school nurse is educating high school students about guidelines to be followed when participating in sports. Which statement by a student alerts the nurse of the need for further information?
a. I will eat carbohydrates before practice.
b. I drink large amounts of fluid when working out.
c. I wear protective gear every time I play sports.
d. I avoid caffeine when participating in sports.

ANS: B
Fluids lost by sweat must be replaced by drinking small amounts of fluid during a workout. Thirst is one guide for intake. Caffeine and alcohol deplete body water and are to be avoided. Carbohydrates that provide both energy and other nutrients are best for athletes. Protective gear should be worn by all team players in any contact sport.

DIF: Cognitive Level: Application REF: Page 463 OBJ: 13
TOP: Sport Guidelines KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

MULTIPLE RESPONSE

20. The nurse explains to the parents of a hospitalized child that their child will receive fentanyl for an upcoming procedure. What advantage of fentanyl will the nurse explain?
a. It is specifically designed for children.
b. It has a rapid onset.
c. It is nonaddicting.
d. It has a long duration.

ANS: B
Fentanyl is a drug useful for all ages because of its rapid onset and brief duration.

DIF: Cognitive Level: Knowledge REF: Page 474 OBJ: 4
TOP: Fentanyl KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Pharmacological Therapies

21. The nurse shares the information and timelines recorded on the interdisciplinary outline of care for a child. What is this document?
a. Clinical pathway
b. Comprehensive nursing care plan
c. Holistic care approach
d. Incorporated cost analysis

ANS: A
This document is the clinical pathway, which is a broad outline of interdisciplinary plan of care with specific timelines.

DIF: Cognitive Level: Comprehension REF: Page 478 OBJ: 8
TOP: Clinical Pathway KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe, Effective Care Environment: Coordinated Care

22. The anxious parent asks if there is a danger of her 2-year-old child becoming addicted to the opioid pain reliever. What is the nurses most helpful response?
a. Although this drug is addictive, the doctor monitors the dose very carefully.
b. Dont worry. Addicted children are very easy to wean off the drug.
c. Addiction is rare in children when opiates are given for pain.
d. Addictive behaviors are easy to assess. The drug will be stopped if that happens.

ANS: C
Addiction is rare in children.

DIF: Cognitive Level: Comprehension REF: Page 474 OBJ: 4
TOP: Pain Relief KEY: Nursing Process Step: Intervention
MSC: NCLEX: Physiological Integrity: Pharmacological Therapies

23. The nurse is preparing to start an IV on an infant admitted to the pediatric unit. What intervention is appropriate for the nurse to implement?
a. Involve the parents.
b. Provide a simple explanation to the child.
c. Let the child examine the equipment.
d. Suggest coping techniques.

ANS: A
It is appropriate to involve the parents when performing a procedure on an infant. Providng a simple explanation, letting the child examine the equipment, and suggesting coping techniques are not appropriate interventions for an infant.

DIF: Cognitive Level: Application REF: Page 470 | Page 478
OBJ: 7 TOP: Age-Appropriate Interventions
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

24. The pediatric nurse is caring for child that weighs 15 kilograms and calls the physician for an order for Acetaminophen for pain control. What is the maximum amount of medication per dose the nurse anticipates ordering?
a. 100 mg
b. 150 mg
c. 225 mg
d. 250 mg

ANS: C
Acetaminophen is commonly used for the relief of mild to moderate pain in infants and children. The maximum dose is 15 mg/kg/dose for infants and children, with a maximum of 5 doses in 24 hours.

DIF: Cognitive Level: Analysis REF: Page 474 OBJ: 4
TOP: Age-Appropriate Interventions KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity: Pharmacological Therapies

MULTIPLE RESPONSE

25. What will the nurse include when documenting the discharge of a pediatric patient? (Select all that apply.)
a. Time of discharge
b. Adult(s) accompanying the child and the relationship to the child
c. Condition of the child
d. Method of transportation
e. Instructions that were given to physician

ANS: A, B, C, D
Information that should be included in the discharge note include time of discharge, adults accompanying the child and relationship to child, condition of the child, and method of transportation. It should also be documented that instructions were given to parents.

DIF: Cognitive Level: Application REF: Page 484 Legal and Ethical Considerations box
OBJ: 12 TOP: Discharge Documentation
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe, Effective Care Environment: Coordinated Care

26. The nurse suggests to parents that they use the outpatient surgical center for their childs upcoming surgery. What advantage(s) does this type of facility have to offer? (Select all that apply.)
a. Lower cost
b. Less incidence of health careassociated infections
c. Reduction of parent-child separation
d. Ample time for recuperation at the facility
e. Decreased emotional impact of illness

ANS: A, B, C, E
All options listed are advantages of outpatient services with the exception of recuperating at the facility.

DIF: Cognitive Level: Comprehension REF: Page 469-470
OBJ: 2 TOP: Outpatient Facilities
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity: Psychosocial Adaptation

27. What are the basic fears of a young child being hospitalized? (Select all that apply.)
a. Separation
b. Permanent scarring
c. Pain
d. Cost
e. Body intrusion

ANS: A, C, E

DIF: Cognitive Level: Comprehension REF: Page 560 OBJ: 6
TOP: Russell Traction KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

9. The nurse is checking for capillary refill on a child in Bryants traction. How long does it take for the toe to regain color if adequate perfusion is assessed?
a. 3 seconds
b. 4 seconds
c. 5 seconds
d. 6 seconds

ANS: A
Capillary refill in 3 seconds or less is determined to be indicative of adequate perfusion.

DIF: Cognitive Level: Comprehension REF: Page 563, Skill 24-1
OBJ: 8 TOP: Fracture KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

10. The parent of a child with osteomyelitis asks why his child is in so much pain. What will the nurse respond causes the pain experienced with osteomyelitis?
a. Pressure of inelastic bone
b. Purulent drainage in the bone marrow
c. The cast applied on the extremity
d. Circulatory congestion of the skin

ANS: B
Osteomyelitis is an infection of the bone. Inflammation produces an exudate that collects under the marrow and cortex of the bone. The vessels are compressed and thrombosis occurs, producing ischemia and pain.

DIF: Cognitive Level: Comprehension REF: Page 566-567
OBJ: N/A TOP: Osteomyelitis
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

11. A child hospitalized for treatment of osteomyelitis complains that he is tired of being sick and wants to know when the antibiotic protocol will end. How long will the nurse indicate that antibiotic therapy will probably last?
a. 2 weeks
b. 6 weeks
c. 2 months
d. 3 months

ANS: B
Because osteomyelitis is an infection in the bone, antibiotics are given intravenously for 4 to 6 weeks.

DIF: Cognitive Level: Application REF: Page 566-567
OBJ: 1 TOP: Osteomyelitis
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Pharmacological Therapies

12. What finding would the nurse assessing the neurovascular status of a child in Russell traction report immediately?
a. Skin thats warm to the touch
b. Capillary refill less than 3 seconds
c. Ability to wiggle toes
d. Bluish coloration of skin

ANS: D
Cyanosis or pallor noted in an extremity is an indication of circulatory impairment.

DIF: Cognitive Level: Application REF: Page 563, Safety Alert
OBJ: 7 | 8 TOP: Neurovascular Assessment
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

13. A 13-year-old girl is diagnosed with functional scoliosis. What does the nurse explain as the cause of this spinal curvature defect?
a. Juvenile rheumatoid arthritis
b. Poor posture
c. Heredity
d. Myelomeningocele

ANS: B
Functional scoliosis usually is caused by poor posture, and it is not a spinal disease.

DIF: Cognitive Level: Comprehension REF: Page 570-571
OBJ: 13 TOP: Scoliosis KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

14. What intervention is appropriate for a nurse assessing a preadolescent child for scoliosis?
a. Ask the child to bend forward at the waist and observe the childs back for asymmetry.
b. Observe the gait while the child is walking forward heel to toe.
c. Have the child flex the knees and look for uneven knee height.
d. Look at the childs shoulders and hips while fully clothed.

ANS: A
The nurse looks at the back as the child bends forward for general body alignment and asymmetry.

DIF: Cognitive Level: Application REF: Page 570-571
OBJ: 13 TOP: Scoliosis KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

15. What nursing action will significantly decrease the risk of serious complications for a child in Bryants traction?
a. Neurovascular checks are done frequently.
b. Bandages are wrapped tightly.
c. The child is restrained from rolling over.
d. The childs buttocks are resting on the bed.

ANS: A
The nurse caring for a child in traction must be alert for Volkmanns ischemia, which occurs when circulation is obstructed.

DIF: Cognitive Level: Application REF: Page 562 OBJ: 7
TOP: Traction: Volkmanns Ischemia KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

16. Which intervention would be helpful in relieving morning discomfort associated with juvenile rheumatoid arthritis?
a. Wearing splints at night to prevent extension contractures
b. Applying moist heat packs upon awakening
c. Taking a warm tub bath the evening before
d. Sleeping with two pillows under the head

ANS: B
Application of moist heat, with a compress or by tub bath upon awakening, will help to lessen stiffness.

DIF: Cognitive Level: Application REF: Page 569 OBJ: 12
TOP: Juvenile Rheumatoid Arthritis KEY: Nursing Process Step: Implementation

ANS:
9

After a protocol of antiviral medications, the routine immunizations should be delayed because the antiviral medications affect the integrity of the immunizations.

DIF: Cognitive Level: Knowledge REF: Page 584 OBJ: 5 | 9
TOP: Respiratory Syncytial Virus (RSV)
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

32. The nurse reviews Accolate and Zyflo, which are _____ _____; they are capable of blocking the inflammatory response as well as providing bronchodilation.

ANS:
leukotriene modifiers

The leukotriene modifiers are capable of blocking the inflammatory response and can also provide bronchodilation.

DIF: Cognitive Level: Knowledge REF: Page 591, Table 25-2
OBJ: 12 TOP: Leukotriene Modifiers
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Pharmacological Therapies

33. Place the three stages of smoke inhalation injury in the correct order (first to last). Put a comma and space between each answer choice (a, b, c, d, etc.)

a. Bronchopneumonia
b. Pulmonary insufficiency
c. Pulmonary edema

ANS:
B, C, A
Smoke inhalation injury may cause carbon monoxide poisoning. Poisonous substances inhaled from burning material may also cause pathological disturbance. There are three stages of inhalation injury:

1. Pulmonary insufficiency in the first 6 hours
2. Pulmonary edema from 6 to 72 hours
3. Bronchopneumonia after 72 hours, which may cause atelectasis

DIF: Cognitive Level: Knowledge REF: Page 585 OBJ: 7
TOP: Smoke Inhalation KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

MSC: NCLEX: Physiological Integrity: Physiological Adaptation

5. An infant is experiencing dyspnea related to patent ductus arteriosus (PDA). What does the nurse understand regarding why dyspnea occurs?
a. Blood is circulated through the lungs again, causing pulmonary circulatory congestion.
b. Blood is shunted past the pulmonary circulation, causing pulmonary hypoxia.
c. Blood is shunted past cardiac arteries, causing myocardial hypoxia.
d. Blood is circulated through the ductus from the pulmonary artery to the aorta, bypassing the left side of the heart.

ANS: A
When PDA is present, oxygenated blood recycles through the lungs, overburdening the pulmonary circulation.

DIF: Cognitive Level: Comprehension REF: Page 608-609
OBJ: 4 TOP: Congenital Heart Disease
KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

6. Which is the most appropriate nursing action related to the administration of digoxin (Lanoxin) to an infant?
a. Counting the apical rate for 30 seconds before administering the medication
b. Withholding a dose if the apical heart rate is less than 100 beats/min
c. Repeating a dose if the child vomits within 30 minutes of the previous dose
d. Checking respiratory rate and blood pressure before each dose

ANS: B
As a rule, if the pulse rate of an infant is below 100 beats/min, the medication is withheld and the physician is notified.

DIF: Cognitive Level: Application REF: Page 612 OBJ: 5
TOP: Congestive Heart Failure KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Pharmacological Therapies

7. A child develops carditis from rheumatic fever. Which areas of the heart are affected by carditis?
a. Coronary arteries
b. Heart muscle and the mitral valve
c. Aortic and pulmonic valves
d. Contractility of the ventricles

ANS: B
The tissues that cover the heart and heart valves are affected. The heart muscle may be involved and the mitral valve is frequently involved.

DIF: Cognitive Level: Knowledge REF: Page 614 OBJ: 6
TOP: Rheumatic Fever KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

8. Which comment made by a parent of a 1-month-old would alert the nurse about the presence of a congenital heart defect?
a. He is always hungry.
b. He tires out during feedings.
c. He is fussy for several hours every day.
d. He sleeps all the time.

ANS: B
Fatigue during feeding or activity is common to most infants with congenital cardiac problems.

DIF: Cognitive Level: Application REF: Page 611-612
OBJ: 3 TOP: Congenital Heart Disease
KEY: Nursing Process Step: Data Collection

MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

9. The nurse is caring for a child with a diagnosis of Kawasaki disease. The childs parent asks the nurse, How does Kawasaki disease affect my childs heart and blood vessels? On what understanding is the nurses response based?
a. Inflammation weakens blood vessels, leading to aneurysm.
b. Increased lipid levels lead to the development of atherosclerosis.
c. Untreated disease causes mitral valve stenosis.
d. Altered blood flow increases cardiac workload with resulting heart failure.

ANS: A
Inflammation of vessels weakens the walls of the vessels and often results in aneurysm.

DIF: Cognitive Level: Comprehension REF: Page 617 OBJ: 12
TOP: Kawasaki Disease KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

10. The nurse explained how to position an infant with tetralogy of Fallot if the infant suddenly becomes cyanotic. Which statement by the father leads the nurse to determine he understood the instructions?
a. If the baby turns blue, I will hold him against my shoulder with his knees bent up toward his chest.
b. If the baby turns blue, I will lay him down on a firm surface with his head lower than the rest of his body.
c. If the baby turns blue, I will immediately put the baby upright in an infant seat.
d. If the baby turns blue, I will put the baby in supine position with his head elevated.

ANS: A
In the event of a paroxysmal hypercyanotic or tet spell, the infant should be placed in a knee-chest position.

DIF: Cognitive Level: Application REF: Page 610, Figure 26-3
OBJ: 4 TOP: Tetralogy of Fallot
KEY: Nursing Process Step: Evaluation
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

11. The parent of a 1-year-old child with tetralogy of Fallot asks the nurse, Why do my childs fingertips look like that? On what understanding does the nurse base a response?
a. Clubbing occurs as a result of untreated congestive heart failure.
b. Clubbing occurs as a result of left-to-right shunting of blood.
c. Clubbing occurs as a result of decreased cardiac output.
d. Clubbing occurs as a result of chronic hypoxia.

ANS: D
Clubbing of the fingers develops in response to chronic hypoxia.

DIF: Cognitive Level: Comprehension REF: Page 609-610
OBJ: 4 TOP: Tetralogy of Fallot
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

12. A child has an elevated antistreptolysin O (ASO) titer. Which combination of symptoms, in conjunction with this finding, would confirm a diagnosis of rheumatic fever?
a. Subcutaneous nodules and fever
b. Painful, tender joints and carditis
c. Erythema marginatum and arthralgia
d. Chorea and elevated sedimentation rate

ANS: B
The presence of two major Jones criteria would indicate a high probability of rheumatic fever.

DIF: Cognitive Level: Application REF: Page 614, Box 26-1
OBJ: 6 TOP: Rheumatic Fever

formula for making the diagnosis of rheumatic fever is to identify two major criteria in the patient, or one major and two minor criteria.

DIF: Cognitive Level: Knowledge REF: Page 609 OBJ: 6
TOP: Jones Criteria KEY: Nursing Process Step: N/A
MSC: NCLEX: N/A

29. _____is designed to serve the metabolic needs during intrauterine life and also to permit safe transition to life outside the womb.

ANS:
Fetal circulation

Fetal circulation is designed to serve the metabolic needs during intrauterine life and also to permit safe transition to life outside the womb.

DIF: Cognitive Level: Knowledge REF: Page 614 OBJ: 2
TOP: Fetal Circulation KEY: Nursing Process Step: N/A
MSC: NCLEX: N/A

30. Systemic blood pressure increases with age and is correlated with _____ and _____throughout childhood and adolescence.

ANS:
height; weight

Systemic blood pressure increases with age and is correlated with height and weight throughout childhood and adolescence. Significant hypertension is considered when measurements are persistently at or above the 95th percentile for the patients age and sex.

DIF: Cognitive Level: Knowledge REF: Page 615 OBJ: 3
TOP: Hypertension KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Health Promotion/Disease Prevention

31. _____ is a systemic disease involving the joints, heart, central nervous system (CNS), skin, and subcutaneous tissues. It belongs to a group of disorders known as collagen diseases.

ANS:
Rheumatic fever (RF)

Rheumatic fever (RF) is a systemic disease involving the joints, heart, central nervous system (CNS), skin, and subcutaneous tissues. It belongs to a group of disorders known as collagen diseases

DIF: Cognitive Level: Knowledge REF: Page 613 OBJ: 1
TOP: Rheumatic Fever KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

electrophoresis

The hemoglobin electrophoresis is a blood test to check for different types of hemoglobin in the blood. Hemoglobin is the substance in red blood cells that carries oxygen. Electrophoresis uses an electrical current to separate normal and abnormal types of hemoglobin in the blood. Hemoglobin types have different electrical charges and move at different speeds. The amount of each hemoglobin type in the current is measured. An abnormal amount of normal hemoglobin or an abnormal type of hemoglobin in the blood may mean that a disease is present. A person with sickle cell disease has abnormal hemoglobin S cells.

DIF: Cognitive Level: Knowledge REF: Page 624 OBJ: 3
TOP: Electrophoresis KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

36. To prevent _____ _____, the nurse warms the blood that is to be given as a transfusion through a central line.

ANS:
cardiac arrhythmias

Cold blood entering the heart via a central line can trigger an irregular heartbeat.

DIF: Cognitive Level: Comprehension REF: Page 632-633
OBJ: 16 TOP: Blood Transfusion
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

37. The rate of RBC production is regulated by _____.

ANS:
erythropoietin

Erythropoietin is a glycoprotein hormone that controls erythropoiesis or red blood cell production.

DIF: Cognitive Level: Knowledge REF: Page 620 OBJ: 12
TOP: Components of Blood KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Reduction of Risk Potential

38. Place the stages of dying in the usual order as detailed by Kbler-Ross (1975). Put a comma and space between each answer choice (a, b, c, d, etc.)

a. Bargaining
b. Acceptance
c. Denial
d. Anger
e. Reaching out to help others
f. Depression

ANS:
C, D, A, F, B, E

The stages of dying as detailed by Kbler-Ross (1975)denial, anger, bargaining, depression, acceptance, and reaching out to help otherscan be applied to parents and siblings as well as to the sick child. (Nurses may also respond with similar feelings.) It is important to accept and support each participant at whatever stage has been reached and to refrain from directing progress.

DIF: Cognitive Level: Comprehension REF: Page 638 OBJ: 20
TOP: Stages of Dying KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Psychosocial Integrity: End of Life Concepts

MSC: NCLEX: Physiological Integrity: Physiological Adaptation

5. Which is the most appropriate intervention for a 3-month-old infant who has gastroesophageal reflux?
a. Position the infant in the crib on his or her abdomen, with the head elevated.
b. Administer medication as ordered to stimulate the pyloric sphincter.
c. Give thin rice cereal with formula before feeding solid foods.
d. Place the infant in an infant seat after feedings.

ANS: A
After feedings, the infant is placed in a prone position to avoid increased intraabdominal pressure.

DIF: Cognitive Level: Application REF: Page 651 OBJ: 7
TOP: Gastroesophageal Reflux KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

6. The nurse is interviewing parents of an infant with pyloric stenosis. What would the nurse expect the parents to report?
a. Diarrhea
b. Projectile vomiting
c. Poor appetite
d. Constipation

ANS: B
Vomiting is the outstanding symptom of pyloric stenosis. Food is ejected with considerable force, which is described as projectile vomiting.

DIF: Cognitive Level: Comprehension REF: Page 645 OBJ: 3
TOP: Pyloric Stenosis KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

7. A mother reports that her child has been scratching the anal area and complaining of itching. What does the nurse suspect based on this information?
a. Pinworms
b. Giardiasis
c. Ringworm
d. Roundworm

ANS: A
With pinworms, the nurse or parent may notice that the child scratches the anal area and complains of itchiness. The other choices do not cause this reaction.

DIF: Cognitive Level: Application REF: Page 662 OBJ: 12
TOP: Worms KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

8. The nurse is teaching a parent about pyrvinium (Povan). What would be included in regard to potential side effects?
a. Diarrhea
b. Skin rash
c. Red stool
d. Metallic taste

ANS: C
The nurse should advise parents that pyrvinium stains clothing and turns stools red.

DIF: Cognitive Level: Knowledge REF: Page 662 OBJ: 12
TOP: Worms KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Pharmacological Therapies

9. What instruction will the nurse give to parents about preventing the spread and reinfection of pinworms?
a. Keep childrens nails short.
b. Dress child in loose-fitting underwear.
c. Clean the bathroom with bleach solution.
d. Wash bed linens in cold water.

ANS: A
One intervention to prevent the further spread of pinworms is to keep the childs fingernails short. Pinworms are not spread from person to person.

DIF: Cognitive Level: Comprehension REF: Page 662 OBJ: 12
TOP: Worms KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

10. A mother reports that her 2-year-old child experiences constipation frequently. Which food would the nurse recommend to include in the childs diet?
a. Cooked vegetables
b. Pretzels
c. Whole-grain cereal
d. Yogurt

ANS: C
Dietary modifications for constipation include eating more high-roughage foods such as whole-grain breads and cereals.

DIF: Cognitive Level: Comprehension REF: Page 654 OBJ: N/A
TOP: Constipation KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

11. What description of a childs stool characteristic leads the nurse to suspect intussusception?
a. Currant jelly
b. Black and tarry
c. Green liquid
d. Greasy and foul-smelling

ANS: A
Bowel movements of blood and mucus that contain no feces (currant jelly stools) are common about 12 hours after the onset of the obstruction.

DIF: Cognitive Level: Comprehension REF: Page 649 OBJ: 6
TOP: Intussusception KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

12. What is the treatment of choice for a child with intussusception?
a. A barium enema
b. Immediate surgery
c. IV fluids until the spasms subside
d. Gastric lavage

ANS: A
A barium enema is the treatment of choice for intussusception because the passage of the barium frequently un-telescopes the bowel. Surgery is scheduled only if reduction is not achieved.

DIF: Cognitive Level: Knowledge REF: Page 649 OBJ: 6
TOP: Intussusception KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

13. Parents ask the nurse how their infant developed a Meckels diverticulum. What condition, will the nurse explain, is present causing this diagnosis?

ANS: A
The priority goal of care in gastroenteritis is preventing fluid and electrolyte imbalance.

DIF: Cognitive Level: Application REF: Page 650 OBJ: N/A
TOP: Gastroenteritis KEY: Nursing Process Step: Planning
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

22. The nurse is speaking to the parent of a 3-year-old child who has mild diarrhea. What dietary modification would the nurse advise?
a. Soft foods with rice, bananas, toast, and applesauce
b. Small amounts of clear fluids such as gelatin
c. An oral rehydrating solution, such as Pedialyte
d. Chicken soup because it is high in sodium

ANS: C
An oral rehydrating solution is recommended to replace fluids and electrolytes lost from frequent bowel movements.

DIF: Cognitive Level: Application REF: Page 652 OBJ: 9
TOP: Diarrhea KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

23. What would the nurse expect to find in a child admitted to the hospital for nonorganic failure to thrive?
a. Cry to be picked up
b. Be limp like a rag doll
c. Be responsive to cuddling
d. Weigh in the 10th percentile for age

ANS: B
Some children with failure to thrive have rag-doll limpness (hypotonia) and appear wary of their caregivers.

DIF: Cognitive Level: Comprehension REF: Page 659 OBJ: N/A
TOP: Failure to Thrive KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

24. Which nursing interventions will be implemented for the mother of a 10-month-old infant with nonorganic failure to thrive?
a. Pointing out errors that the nurse observes when the mother is caring for the infant
b. Discussing negative characteristics of the infant with the mother
c. Having the nurse provide as much of the infants care as possible
d. Teaching the mother about the developmental milestones to expect in the next few months

ANS: D
The nurse can increase parents knowledge of growth and development by providing anticipatory guidance about normal developmental milestones.

DIF: Cognitive Level: Application REF: Page 659-660
OBJ: N/A TOP: Failure to Thrive
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

25. Which statement by a mother may indicate a cause of her sons vitamin C deficiency?
a. We get our fruits from homemade preserves.
b. We use milk from our own goats.
c. We grow all our own vegetables.
d. Were not big meat eaters.

ANS: A
Vitamin C is destroyed by heat.

MSC: NCLEX: Physiological Integrity

5. During a physical assessment of a hospitalized 5-year-old, the nurse notes that the foreskin has been retracted and is very tight on the shaft of the penis; the nurse is unable to return it over the head of the penis. What action should the nurse implement?
a. Forcibly push the foreskin down over the head of the penis.
b. Place a warm compress on the penis.
c. Notify the charge nurse.
d. Wait a few hours and try again.

ANS: C
Notify the charge nurse of this occurrence of paraphimosis. The tight foreskin can impede blood flow to the penis; this should be remedied immediately.

DIF: Cognitive Level: Application REF: Page 672 OBJ: 1
TOP: Paraphimosis KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Reduction of Risk

6. A 7-year-old child with acute glomerulonephritis has gross hematuria and has been confined to bed. What is the most appropriate nursing intervention for this child?
a. Providing activities for the child on restricted activity
b. Feeding the child a protein-restricted diet
c. Carefully handling edematous extremities
d. Observing the child for evidence of hypotension

ANS: A
Although children may feel well, activity is limited until hematuria resolves.

DIF: Cognitive Level: Application REF: Page 678 OBJ: 7
TOP: Acute Glomerulonephritis KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity: Reduction of Risk

7. Which urinary diversion procedure is the least damaging to the body image of the adolescent?
a. Urostomy
b. Ileal conduit
c. Nephrostomy
d. Suprapubic placement

ANS: B
The ileal conduit diverts urine to the colon, and the urine is excreted with the feces. There is no external appliance, as is needed with the other diversion methods.

DIF: Cognitive Level: Comprehension REF: Page 674, Table 29-2
OBJ: 10 TOP: Obstructive UropathyUrinary Diversions
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

8. The mother of a 5-year-old child taking prednisone for nephrotic syndrome tells the nurse he needs to get immunizations to enter kindergarten. What does the nurse clarify about receiving immunizations while on prednisone?
a. Can interfere with the treatment for nephrosis
b. Require that the child have antibiotic coverage
c. Can be given in smaller, divided doses
d. Should be delayed

ANS: D
No vaccinations or immunizations should be administered while the disease is active and during immunosuppressive therapy.

a. 6
b. 7
c. 12
d. 20
e. 21

ANS: A, B, C, D
Defects in chromosomes 6, 7, 12, and 20 and other genetic disorders are associated with diabetes mellitus syndrome.

DIF: Cognitive Level: Knowledge REF: Page 707 OBJ: N/A
TOP: Diabetes Mellitus KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

25. Which food sources are high in soluble fiber? (Select all that apply.)
a. Raw fruits
b. Cooked vegetables
c. Beans
d. Lean meat
e. Bran cereal

ANS: A, C, E
Foods high in soluble fiber include raw fruits, beans, and bran cereal.

DIF: Cognitive Level: Comprehension REF: Page 712 OBJ: 9
TOP: Dietary Fiber Sources KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

26. What does the nurse remind the adolescent with diabetes that soluble fiber in the diet can reduce? (Select all that apply.)
a. Blood glucose
b. Serum cholesterol
c. Incidence of infections
d. Absorption of sugar
e. Insulin requirements

ANS: A, B, D, E
Soluble fiber can reduce blood glucose, serum cholesterol, absorption of sugar, and insulin requirements. It has no effect on infections.

DIF: Cognitive Level: Comprehension REF: Page 712 OBJ: 9
TOP: Fiber in Diet KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

27. Which process(es) does the nurse explain the endocrine system is primarily responsible for controlling? (Select all that apply.)
a. Maturation
b. Reproduction
c. Stress response
d. Sexual identity
e. Growth

ANS: A, B, C, E
The endocrine system governs maturation, reproduction, stress response, and sexual maturity. Sexual identity is a psychosocial response.

DIF: Cognitive Level: Comprehension REF: Page 703 OBJ: 2
TOP: Endocrine System KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

28. The home health nurse is monitoring an 8-month-old child with hypothyroidism taking levothyroxine (Synthroid). Which symptoms does the nurse recognize as signs of overdose? (Select all that apply.)
a. Tachycardia
b. Irritability
c. Vomiting
d. Weight gain
e. Diaphoresis

ANS: A, B, E
All the options with the exception of weight gain and vomiting are indications of overdose of Synthroid. Weight loss is a symptom of overdose, however.

DIF: Cognitive Level: Comprehension REF: Page 706 OBJ: 3
TOP: Levothyroxine (Synthroid) Overdose
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Pharmacological Therapies

29. What makes keeping diabetes in control in an adolescent difficult? (Select all that apply.)
a. Hormonal changes
b. Developmental conflicts
c. Preference for fast food
d. Growth spurts
e. Knowledge of disease

ANS: A, B, C, D
The adolescent who is in a growth spurt and filled with raging hormones resents and denies the need to be dependent on a medication. Medication schedules and diet restrictions do not correlate well with the adolescents lifestyle of eating fast foods. Denial of disease is prevalent in the adolescent.

DIF: Cognitive Level: Comprehension REF: Page 717, Table 31-7
OBJ: 8 TOP: Diabetic Adolescent
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Growth and Development

30. A child with diabetes mellitus is observed to have cold symptoms. What signs and symptoms will alert parents of the possibility of ketoacidosis? (Select all that apply.)
a. Chest congestion
b. Ear pain
c. Fruity breath
d. Hyperactivity
e. Nausea

ANS: C, E
Symptoms of ketoacidosis are compared with those of hypoglycemia. Signs and symptoms include a fruity odor to the breath, nausea, decreased level of consciousness and dehydration. Lab values include ketonuria, decreased serum bicarbonate concentration (decreased CO2 levels) and low pH, and hypertonic dehydration.

DIF: Cognitive Level: Comprehension REF: Page 709 OBJ: 6
TOP: Ketoacidosis KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

31. The nurse is discussing insulin shock with parents of a child recently diagnosed with diabetes mellitus. What will the nurse respond when the parents ask why children are more prone to insulin reactions? (Select all that apply.)
a. The condition is more unstable in children.
b. Parents are often noncompliant.
c. The activities are irregular.
d. They are still growing.
e. Sleep patterns are not established.

ANS: A, C, D
Children are more prone to insulin reactions than adults because of the following: the condition itself is more unstable in young people; they are growing; their activities are more irregular.

DIF: Cognitive Level: Comprehension REF: Page 716 OBJ: 11
TOP: Insulin Shock KEY: Nursing Process Step: Planning
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

COMPLETION

32. The nurse reminds the parents of a diabetic with an insulin pump that the tubing of the pump should be changed aseptically every _____ hours.

ANS:
48

The tubing of the insulin pump should be changed every 48 hours.

DIF: Cognitive Level: Knowledge REF: Page 714 OBJ: 9
TOP: Insulin Pump KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

33. The nurse explains that the diagnosis of diabetes is made when the fasting blood glucose level is _____ mg/dL on two separate occasions, and the history is positive for indication of the disease.

ANS:
126

An elevated blood glucose level of 126 mg/dL on two separate occasions is grounds for the diagnosis of diabetes mellitus when the history is positive for the disease.

DIF: Cognitive Level: Comprehension REF: Page 707 OBJ: 9
TOP: Diagnosis of DM KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

34. The nurse assessing a glycosylated hemoglobin (HbA1c) test is aware that this test can evaluate average glucose levels over a period of _____ to _____ months.

ANS:
3; 4

Glucose attaches to the red cells over the life span of the cell and can be read as percentages. An HbA1c reading of 6% to 9% is normal; a reading of 12% or higher is indicative of DM.

DIF: Cognitive Level: Knowledge REF: Page 709 OBJ: 9
TOP: Glycosylated Hemoglobin KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

35. Long-acting types of insulin are seldom given to children because of the danger of _____ during sleep.

ANS:
hypoglycemia

Long-acting types of insulin are seldom given to children because of the danger of hypoglycemia during sleep.

DIF: Cognitive Level: Comprehension REF: Page 715 OBJ: 1 | 11
TOP: Insulin administration/Hypoglycemia
KEY: Nursing Process Step: Implementation

MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

5. What type of precautions are necessary when caring for a toddler with varicella?
a. Contact
b. Protective
c. Airborne infection
d. Large droplet infection

ANS: C
Airborne-infection precautions are used for patients with conditions such as tuberculosis, varicella, and rubella. Small airborne particles caught on floating dust in the room can be inhaled from anywhere in the room.

DIF: Cognitive Level: Application REF: Page 722, Health Promotion box
OBJ: 4 TOP: Medical Asepsis and Standard Precautions
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

6. Which statement assures the nurse that parents understand how long a child who has varicella is contagious?
a. My child should stay home from school for 6 days after the pox appear.
b. My child can return to school when the rash fades.
c. My child must stay away from other children until all of the lesions have healed.
d. My child is contagious as long as he has a fever.

ANS: A
The child with varicella is contagious for 6 days after the appearance of the rash.

DIF: Cognitive Level: Comprehension REF: Page 722, Health Promotion box
OBJ: 2 TOP: Common Varicella
KEY: Nursing Process Step: Evaluation
MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

7. Which statement made by a sexually active adolescent girl indicates an understanding of the prevention of sexually transmitted diseases?
a. I always douche after intercourse.
b. I think you can get a vaccination for STDs now.
c. I insist that my partner wear a condom.
d. I am protected because I take the pill.

ANS: C
The use of condoms to prevent STDs is not considered 100% effective but is recommended for sexual intercourse.

DIF: Cognitive Level: Comprehension REF: Page 739, Nursing Tip
OBJ: 9 TOP: Sexually Transmitted Diseases
KEY: Nursing Process Step: Evaluation
MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

8. What is the priority nursing diagnosis for a hospitalized infant who is HIV positive?
a. Risk for injury
b. Altered nutrition
c. Impaired skin integrity
d. Risk for infection

ANS: D
The infant who is HIV positive has impaired immunologic functioning and is at high risk for infection.

DIF: Cognitive Level: Application REF: Page 742-743, NCP 32-1
OBJ: 10 TOP: Human Immunodeficiency Virus
KEY: Nursing Process Step: Nursing Diagnosis

DIF: Cognitive Level: Application REF: Page 727 OBJ: 3
TOP: Protective Isolation KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

13. The nurse is planning to administer immunizations at a well-child visit when a parent reports the 18-month-old child is allergic to eggs. Which vaccine would be contraindicated?
a. Influenza
b. Inactivated polio vaccine
c. Diphtheria, tetanus, acellular pertussis
d. Hepatitis B

ANS: A
The influenza vaccine should not be given to children who are allergic to eggs.

DIF: Cognitive Level: Knowledge REF: Page 729 OBJ: 6
TOP: Nurses Role in ImmunizationsAllergy
KEY: Nursing Process Step: Planning
MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

14. The nurse is preparing to administer immunizations at a well-child clinic. Which method of administration will the nurse implement?
a. DTaP subcutaneously
b. Hib vaccine prepared in a separate syringe
c. Varicella intramuscularly
d. Varicella 1 week after the MMR vaccine

ANS: B
Hib vaccine must be given in a separate syringe from other vaccines administered at the same time.

DIF: Cognitive Level: Knowledge REF: Page 733, Figure 32-6
OBJ: 6 TOP: Hib KEY: Nursing Process Step: Evaluation
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

15. A child was sent to the school nurse because of a rash. The nurse noted the rash was present on the trunk, extremities, and face. The childs cheeks were bright red. With what is the nurse aware this type of rash is consistent?
a. Measles
b. Roseola
c. Varicella
d. Fifth disease

ANS: D
In fifth disease, the child has a generalized rash and the cheeks have a slapped-cheek appearance.

DIF: Cognitive Level: Comprehension REF: Page 722, Health Promotion box
OBJ: 2 TOP: Fifth Disease
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

16. What statement leads the nurse to determine that a childs parent understands information related to tick bites?
a. Ill have my son wear dark clothing on his hike.
b. We should all get the Lyme disease vaccine before our trip.
c. Ill get a prescription for amoxicillin to take with us.
d. We will wear long pants and long-sleeved shirts in the woods.

ANS: D
People should keep skin covered by wearing protective clothing in wooded areas to prevent tick bites.

24. The nurse is explaining to a family about disaster preparedness. What will the nurse instruct the family to prepare in a disaster kit in case of emergency? (Select all that apply.)
a. Small television
b. Vital documents
c. Nonperishable food
d. Pet food
e. Blankets

ANS: B, C, D, E
The nurse can assist families to prepare for natural disasters, such as hurricanes or floods, or manmade disasters, such as bioterrorist attacks or bombings. The American Medical Association (AMA) office guidelines for preparing a family and community disaster plan state that the family should keep several days supply of food, water, pet food, warm clothing, blankets, copies of vital documents, and toiletries on hand. A battery-powered radio and extra medications, eyeglasses, and basic first aid supplies are also essential.

DIF: Cognitive Level: Knowledge REF: Page 738-739
OBJ: 8 TOP: Disaster Preparedness
KEY: Nursing Process Step: Planning
MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

25. The nurse is assisting with an admission assessment of a child with scarlet fever. Which actions will the nurse expect to implement? (Select all that apply.)
a. Obtain a throat culture.
b. Encourage ambulation.
c. Assess for desquamation.
d. Initiate droplet precautions.
e. Administer isoniazid.

ANS: A, C
A diagnosis of scarlet fever would indicate throat culture and assessment for desquamation. Bed rest with quiet activity is indicated. Droplet precautions would not be implemented for scarlet fever. Isoniazid is administered for tuberculosis.

DIF: Cognitive Level: Application REF: Page 724, Health Promotion box
OBJ: 2 TOP: Scarlet Fever
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

COMPLETION

26. The nurse explains that the _____ test determines the childs susceptibility to tuberculosis.

ANS:
Mantoux

The Mantoux test is a screening test for the susceptibility to TB. An intradermal injection is given and read 3 days later. An erythema and induration of more than 5 mm is considered a positive reading.

DIF: Cognitive Level: Knowledge REF: Page 726 OBJ: 4
TOP: Mantoux KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

27. The nurse uses a diagram showing how the wood tick acts as a(n) _____ in the transmission of Lyme disease.

ANS:
vector

A vector is an insect or animal that carries a communicable disease.

Chapter 33: The Child with an Emotional or Behavioral Condition

MULTIPLE CHOICE

1. A parent asks the nurse to describe what is meant by a learning disability. Which is the nurses most helpful response?
a. A child may have difficulty with perception, language, comprehension, or memory.
b. It is characterized by inattention, impulsiveness, and hyperactivity.
c. The childs intellectual ability limits his learning.
d. The child has difficulty learning because of brain damage.

ANS: A
Learning disability is an educational term. Children with learning disabilities may have average to above-average intelligence, but they may experience difficulties in perception, language, comprehension, and conceptualization.

DIF: Cognitive Level: Comprehension REF: Page 749 OBJ: N/A
TOP: Learning Disability KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

2. What would be the appropriate response to an adolescent who states, This has been the worst day of my life?
a. You should focus your mind on positive thoughts.
b. Everybody has a bad day now and then.
c. Youre young. What could be so terrible?
d. Tell me about the worst day of your life.

ANS: D
The nurse establishes a rapport with the adolescent by acknowledging his or her feelings and giving the adolescent full attention.

DIF: Cognitive Level: Application REF: Page 754, Nursing Tip
OBJ: 6 TOP: Suicide KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity: Psychosocial Adaptation

3. The nurse asks, Do your parents drink every day? The adolescent suddenly shouts, Im not going to talk about that! Its none of your business, anyway! Leave me alone! How does the nurse interpret the adolescents behavior?
a. The adolescent is acting out and needs to be brought under control so the conference can continue.
b. The adolescent is trying to shift the focus of the conference away from himself, and the nurse needs to refocus.
c. The adolescent is demonstrating that this problem requires the assistance of a psychiatrist.
d. The adolescent is responding to the discrediting of his parents, which causes anxiety.

ANS: D
Discrediting parents threatens the childs security and creates anxiety.

DIF: Cognitive Level: Analysis REF: Page 757-758
OBJ: 10 TOP: Children of Alcoholics
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

4. The nurse is answering phone calls at a local suicide prevention hotline. Which statement would be recognized as the greatest risk of suicide?
a. I just needed to talk to someone to keep myself from thinking silly thoughts about killing myself.
b. My parents arent home and wont be back for 4 hours. That should be enough time for the pills to work. Ive got a hundred of them.
c. My dad will be home first, so hell find me. So I think Ill use his gun. I hope he didnt lock the cabinet.
d. My girlfriend is here with me. She told me to call because I was talking crazy about killing myself.

Chapter 34: Complementary and Alternative Therapies in Maternity and Pediatric Nursing

MULTIPLE CHOICE

1. A pregnant woman tells the nurse that she got relief from nausea when she had a therapy that involves pressure and massage on meridian sites. What type of therapy does this describe?
a. Acupuncture
b. Acupressure
c. Aromatherapy
d. Ayurveda

ANS: B
Acupressure uses finger pressure and massage on the meridian sites. It can be used during pregnancy to control nausea, backache, and pain. It has been useful for minor postpartum problems such as constipation.

DIF: Cognitive Level: Knowledge REF: Page 764-765
OBJ: 2 TOP: Acupressure KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

2. Which child should not receive massage therapy?
a. 15-year-old with a fractured femur
b. 12-year-old with diabetes mellitus
c. 8-year-old with Down syndrome
d. 17-year-old with an eating disorder

ANS: C
Children with Down syndrome are prone particularly to cervical spine anomalies and may be injured by massage therapy.

DIF: Cognitive Level: Comprehension REF: Page 763 OBJ: 3
TOP: Massage KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

3. A 12-year-old with rheumatoid arthritis finds aromatherapy helpful for relieving her joint discomfort. Which essential oil is useful for children with chronic pain?
a. Lavender
b. Ephedra
c. Ginseng
d. Kava-kava

ANS: A
Lavender, chamomile, and sandalwood essential oils are useful in aromatherapy for children with chronic pain.

DIF: Cognitive Level: Knowledge REF: Page 765, Nursing Tip
OBJ: 2 TOP: Alternative Health PracticesAromatherapy
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

4. A pregnant woman wishes to use aromatherapy during her labor and delivery. What is the most appropriate essential oil for the nurse to recommend?
a. Juniper
b. Wintergreen
c. Thyme
d. Citrus

ANS: D
Citrus is one essential oil that has been shown to be useful during labor and delivery.

DIF: Cognitive Level: Comprehension REF: Page 760 OBJ: 3 | 9
TOP: Guided Imagery KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

9. What is the difference between complementary therapy and alternative therapy?
a. Complementary therapy must be administered by a medical doctor.
b. Complementary therapy is administered with conventional therapy.
c. Complementary therapy replaces conventional therapy.
d. Complementary therapy is administered to a group of patients at the same time.

ANS: B
Complementary therapy is administered with conventional therapy, such as massage with muscle relaxants for low back pain.

DIF: Cognitive Level: Comprehension REF: Page 760 OBJ: 2
TOP: CAM KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

10. The nurse uses a diagram to show the location of meridians. How will the nurse explain the definition of meridians?
a. They are lymph nodes.
b. They are invisible pathways for energy.
c. They are lines that divide the body into 10 zones.
d. They are areas of skin that are specifically innervated.

ANS: B
Meridians are invisible pathways through which energy travels to effect acupuncture treatment.

DIF: Cognitive Level: Knowledge REF: Page 764, Figure 34-4
OBJ: 8 TOP: Herbal Remedies: CAM
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

11. Which herbal remedy used by a patient taking warfarin should the nurse report to the physician?
a. Angelica (dong quai)
b. Chamomile
c. Ginseng
d. Kava-kava

ANS: A
Angelica prolongs prothrombin time and will synergize the effect of the warfarin.

DIF: Cognitive Level: Application REF: Page 766, Table 34-3
OBJ: 4 TOP: Herbal Remedies
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Reduction of Risk

12. What should the nurse remind a parent who is considering homeopathic remedies for treatment of her childs asthma?
a. Should be drunk with large amounts of fluid
b. Can be taken with traditional Western medications
c. Can be enhanced by drinking hot tea
d. May contain mercury, alcohol, or arsenic

ANS: D
Homeopathic remedies often contain mercury, alcohol, or arsenic and are taken sublingually. All Western medications should be stopped when the homeopathic therapy is begun. Caffeine drinks are to be avoided during homeopathic treatment.

DIF: Cognitive Level: Comprehension REF: Page 765 OBJ: 9
TOP: CAM Therapies KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity: Reduction of Risk

MULTIPLE RESPONSE

17. What conditions would a nurse expect to see treated with hyperbaric oxygen therapy (HBOT)? (Select all that apply.)
a. Wounds
b. Carbon monoxide poisoning
c. Hyperemesis gravidarum
d. Decompression illness
e. Pneumonia

ANS: A, B, D
Hyperbaric oxygen therapy (HBOT) uses an airtight enclosure to provide compressed air or oxygen under increased pressure. HBOT is used to revive children with carbon monoxide poisoning, to aid wound healing, and to treat the diving syndrome known as decompression illness. HBOT is contraindicated during pregnancy, because the increased oxygen saturation can cause the ductus arteriosus to close, resulting in fetal death.

DIF: Cognitive Level: Knowledge REF: Page 769 OBJ: 13
TOP: HBOT KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Reduction of Risk

18. The mother of a pediatric patient asks the nurse about safety concerns with using herbal supplements with children. Which herbal products would the nurse educate this mother are safe to use in most of the pediatric population? (Select all that apply.)
a. Ephedra
b. Ginger
c. Fish oil
d. Chamomile
e. Aloe vera

ANS: B, C, D, E
Ginger, fish oil, chamomile and aloe vera are safe herbal products for children. However, some herbs, such as ephedra, can be fatal to children.

DIF: Cognitive Level: Knowledge REF: Page 767-768, Table 34-3
OBJ: 11 TOP: Herbal Therapies
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Reduction of Risk

19. The nurse points out that light therapy is used in the treatment of patients with which disorder(s)? (Select all that apply.)
a. Digestive disorders
b. Seasonal affective disorder
c. Inflammatory diseases
d. Stress disorders
e. Jaundice

ANS: B, E
Light therapy has proven effective in the treatment of persons with seasonal affective disorders. Light therapy is also used in the treatment of jaundiced babies.

DIF: Cognitive Level: Comprehension REF: Page 763 OBJ: 9
TOP: Light Therapy KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

20. What advantage(s) of alternative health care should the nurse outline when providing information to