Practice Exam Questions

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

ACCNS-N(Neonatal)

CNS Wellness through Acute Care

EXAMKILLER

Help Pass Your Exam At First Try

Total Question: 265 QAs

Question No: 1
Baby David's T98.6F after converting to Celsius. What is the correct answer?
A. 37 degrees.
B. 38 degrees.
C. 39 degrees.
D. 40 degrees.
Answer: A
Explanation: 37 degrees Celsius is the right temperature for T98.6F. This is obtained from the formula to convert Fahrenheit into Celsius using C = (F-32)5/9.

Question No: 2
After baby John's mom leaves you find a rattle in his isolette. What course of action should nurse Ellen take?
A. Remove the rattle and give it to his mom when she returns.
B. Leave it in the isolette.
C. Put it in his hand and let him play with it.
D. Shake it near his head hard and sing a lullabye.
Answer: A
Explanation: If the nurse finds a rattle of the baby's isolette, she must remove the rattle and give it to his mom when she returns. The baby cannot have that with him for safety reasons.

Question No: 3
Many nurses find it difficult in to get accurate information when making their assessment using the stethoscope and it can near impossible with a crying or irritable baby. What can the nurse do in order to make her job a little easier?
A. Rock the baby to sleep before attempting the assessment.
B. Give the baby a pacifier or bottle as a temporary aid to stop the crying
C. Wait to the nursery becomes quiet and the baby stops crying
D. Just do the best she can and get whatever she can from her examination
Answer: B
Explanation: Give the baby a pacifier or bottle as a temporary aid to stop the crying. The auscultation should not be delayed in the event there is something abnormal that may be occurring, especially if the baby is crying for what may seem like no apparent reason.

Question No: 4
Julia gave birth to a baby girl who is 2,930 grams in weight. The baby was admitted at the NICU due to a low APGAR score because her mother had a prolonged second stage of labor. As a result, the neonate had asphyxia. Which of the following would a nurse expect to find in a newborn with asphyxia?
A. Hypocapnia
B. Ketosis
C. Acidosis
D. Hyperoxemia

Answer: C
Explanation: A nurse would expect to find acidosis in a newborn with asphyxia. Asphyxia leads to acidosis, hypoxia, hypoxemia, and tissue anoxia. This results in hypercapnia (not hypocapnia) due to the increase in carbonic acid concentration in the fetal circulation because the carbon dioxide fails to get eliminated from the infant's lungs due to inadequate respiration. Ketosis is seen in diabetic ketoacidosis.

Question No: 5
Sixteen hours after birth, the nurse noticed that the neonate is jittery, hyperactive, sneezes frequently, produces a high-pitched cry, and is having difficulty sucking. Evaluation reveals that the neonate has increased deep tendon reflexes and a decreased Moro reflex. The nurse should suspect a case of:
A. Syphilis in the neonate
B. Cerebral palsy
C. Fetal alcohol syndrome
D. Opiod withdrawal
Answer: D
Explanation: The nurse should suspect a case of opiod drug withdrawal. The signs are indicative of opiod drug withdrawal in which typical changes occur in the central nervous system; it is a must to observe the neonate during the first 24-48 hours of life.

Question No: 6
Baby Boy Mcintosh was immediately transferred from the birthing center to the neonatal intensive care unit because of myelomeningocele. The nurse assigned at the unit should immediately:
A. Provide newborn care
B. Start the prophylaxis (antibiotic)
C. Apply a sterile saline dressing
D. Assess for any signs of paralysis
Answer: C
Explanation: The nurse at the unit should immediately apply a sterile saline dressing. This nursing intervention will help in the prevention of infection while keeping the membrane moist.

Question No: 7
During the assessment, the nurse noticed that one of the admitted neonates, who is small-for-gestational-age, is jittery, has a high-pitched cry, and has irregular respirations. The nurse must be aware that these signs could be an indication of:
A. Hypercalcemia
B. Hypovolemia
C. Hypoglycemia
D. Hypothyroidism
Answer: C
Explanation: The nurse must be aware that the signs presented are indicative of hypoglycemia. Neonates who are small-for-gestational-age may exhibit hypoglycemia (especially during the first 2 hours of life) due to depletion in glycogen storage, as well as inhibited gluconeogenesis.

Question No: 8

Nurse Dolores is caring for a fifteen-day-old neonate who has a necrotizing enterocolitis (NEC). What nursing care plan should be included for the neonate?
A. Measure abdominal girth at least every two hours
B. Dilute the milk formula as ordered
C. Hyperventilate the neonate before each feeding
D. Introduce formula feeding by lavage
Answer: A
Explanation: A nursing care plan should include measuring of the abdominal girth every two hours. Neonates who have NEC have prolonged gastric emptying; therefore, any increase in abdominal girth (>1 cm in 4 hours) is significant and it needs immediate intervention.

Question No: 9
A neonate was admitted at the hospital due to hydrocephalus. After the insertion of a shunt to treat the disease, the nurse should evaluate the function of the shunt by:
A. Palpation of the anterior fontanel
B. Notation of the frequency of voiding
C. Assessment of periorbital edema
D. Observation of symmetric Moro reflex
Answer: A
Explanation: After the insertion of a shunt to treat the disease, the nurse should evaluate the function of the shunt by palpation of the anterior fontanel. A bulging fontanel will be an indication of increased intracranial pressure. Other options are not significant indicators of increased intracranial pressure.

Question No: 10
A one-week-old infant was admitted at the neonatal intensive care unit after surgery to treat esophageal atresia. What would be an immediate postoperative nursing priority for this patient?
A. Administering oral milk feeding slowly
B. Observing for signs of infection at the incision site
C. Reporting episodes of vomiting to the physician
D. Checking for the patency of nasogastric tube
Answer: D
Explanation: An immediate postoperative nursing priority for this patient is checking for the patency of nasogastric tube. Postoperatively, the nasogastric tube is useful in decompression of the stomach and limits tension at the suture line.

Question No: 11
A nurse is caring for a pregnant patient and is assessing the fetal heart rate. The nurse notes that the fetal heart rate is abnormal for the third time; this is made known to the physician to order a fetal scalp pH sample. The nurse is aware that the fetus may be compromised if the fetal pH is:
A. 7.17
B. 7.22
C. 7.30
D. 7.34
Answer: A

Explanation: The nurse is aware that the fetus may be compromised if the fetal pH is 7.17. This value is indicative of fetal hypoxia; any reading that is less than 7.20 is dangerous and requires an emergency birth. Any reading higher than 7.2 is not life-threatening.

Question No: 12
The nurse is caring for several infants who are forty-eight hours old. Among the following infants, which should be given highest priority by the nurse?
A. A bottle-fed infant who takes 1-ounce of milk every three to five hours
B. A breastfed infant who lost 0.5 ounce of his weight
C. A bottle-fed infant who takes two to three ounces of milk every two to four hours
D. A breastfed infant who feeds every two to four hours
Answer: A
Explanation: The infant that should be given highest priority by the nurse is a bottle-fed infant who takes 1-ounce of milk every three to five hours. The patient exhibits poor feeding (1 ounce = 30 ml), which indicates specific problems. The infant normally loses weight during the first week of life and he/she usually gains weight in the second week.

Question No: 13
When caring for a neonate in acute respiratory distress from laryngotracheobronchitis who has a body temperature of 38.7 ºC, the nurse should give priority to:
A. Monitor the neonate's respiratory status continuously
B. Deliver 40% humidified oxygen
C. Provide support to decrease apprehension
D. Initiate measures to decrease fever
Answer: A
Explanation: When caring for a neonate in acute respiratory distress from laryngotracheobronchitis who has a body temperature of 38.7 ºC, the nurse should give priority to monitor the neonate's respiratory status continuously. In this case, patency of the airway is determined by continuous monitoring for signs of respiratory distress as laryngeal spasms can occur abruptly.

Question No: 14
The nurse is checking for cervical dilation of a patient who is in labor, when the nurse observes that the umbilical cord has prolapsed. The nurse's initial action would be to:
A. Obtain the fetal heart rate
B. Cover the cord with sterile saline soaks
C. Position the patient on her side
D. Place the patient in Trendelenburg's position
Answer: D
Explanation: The nurse's initial action would be to place the patient in Trendelenburg's position. Placing the patient in this position will prevent further prolapse and relieves pressure on the cord.

Question No: 15
A clinical nurse specialist is monitoring the blood glucose level of a neonate who was born to a diabetic mother. The nurse determined that the blood glucose level is 50 mg/dL. What would be the action of the

nurse?
A. Feed the baby orally with 10% dextrose in water
B. Monitor the neonate continuously for the next twenty-four hours
C. Alert the physician and request an order of glucose 50%
D. Assess the cord serum glucose level
Answer: B
Explanation: The action of the nurse should be to monitor the neonate continuously for the next twenty-four hours. The blood glucose level is within the normal range for neonates, so it doesn't require any measure aside from continuously monitoring the patient for the next twenty-four hours.

Question No: 16
A nurse is caring for a patient who is receiving magnesium sulfate therapy intravenously for preeclampsia. The patient gives birth to a baby weighing 4.2 pounds in the 36th week of gestation. The nurse is aware that a finding in the newborn that may indicate magnesium sulfate toxicity is:
A. Tachycardia
B. Pallor
C. Hypotonia
D. Tremors
Answer: C
Explanation: The nurse is aware that a finding in the newborn that may indicate magnesium sulfate toxicity is hypotonia. Hypotonia occurs with magnesium sulfate toxicity because of skeletal and smooth muscle relaxation.

Question No: 17
A clinical nurse specialist is caring for a neonate who develops hyperbilirubinemia. The physician ordered phototherapy BID. During the therapy, the nurse should include which plan of care:
A. Keep the eye shield on continuously
B. Cover the patient with a blanket made of light material
C. Take the vital signs every hour
D. Give fluids at least every two hours
Answer: D
Explanation: During the therapy, the nurse should include a plan of care to give fluids at least every two hours. During phototherapy, there is an increase in insensible and interstitial fluid losses, therefore extra fluids are needed to prevent dehydration.

Question No: 18
Prior to discharge from the newborn nursery at forty-eight hours old, the nurse knows that murmurs are frequently assessed and are most often due to which factor?
A. A ventricular septal defect
B. Transition from fetal to pulmonic circulation
C. Heart disease of the newborn period
D. Cyanotic heart disease
Answer: B
Explanation: The nurse knows that murmurs are frequently assessed and are most often due to transition from

fetal to pulmonic circulation. As the transition occurs, the murmurs may become loud and then resolve.

Question No: 19
A clinical nurse specialist is planning a nursing care for a pregnant patient who is admitted with a diagnosis of abruption placenta. The nurse should include a careful observation for signs and symptoms of:
A. Seizure
B. Jaundice
C. Hypovolemic shock
D. Hypertension
Answer: C
Explanation: The nurse should include a careful observation for signs and symptoms of hypovolemic shock. In this case, uterine bleeding can lead to a massive internal hemorrhage that can cause hypovolemic shock.

Question No: 20
A neonate with cardiac disease has been admitted to the nursery from the delivery room.
Which finding helps the nurse to differentiate between a cyanotic and an acyanotic defect?
A. Neonates with cyanotic heart disease feed poorly
B. The pulse oximeter does not read above 93%
C. Cyanotic heart disease causes high fevers
D. Neonates with cyanotic heart disease usually go directly to the operating room
Answer: B
Explanation: A finding that helps the nurse to differentiate between a cyanotic and an acyanotic defect is that the pulse oximeter does not read above 93%. Cyanotic heart diseases are unlikely to produce a reading above 93%.

Question No: 21
A child ingested twenty maximum strength acetaminophen tablets thirty minutes ago and is seen at the emergency department. The ER nurse calls one of the staff nurses at the NICU to identify which physician's order should be done first. The NICU nurse should state that it must be:
A. Gastric lavage PRN
B. Acetylcesteine for age per pharmacy
C. Activated charcoal per pharmacy
D. Start IV dextrose 5% with 0.33% normal saline KVO
Answer: A
Explanation: The ER nurse calls one of the staff nurses at the NICU to identify which physician's order should be done first. The NICU nurse should state that it must be gastric lavage PRN. The nurse must remove the drug as much as possible through a gastric lavage. The next would be the activated charcoal and lastly, the IV fluids.

Question No: 22
A newborn was admitted to the neonatal intensive care unit. His diagnosis is febrile seizures. In preparing for his admission, which of the following is the most important nursing action?
A. Request an order of a stat admission CBC
B. Place a urine collection bag and specimen cup at the bedside

C. Place a cooling mattress on his bed
D. Pad the side rails of his bed
Answer: D
Explanation: In preparing for his admission, the most important nursing action is to pad the side rails of his bed. The patient has a diagnosis of febrile seizures. Precautions to prevent injury and promote safety should take precedence.

Question No: 23
A nurse is caring for a neonate with a suspected diagnosis of rheumatic fever. The nurse reviews the laboratory results, knowing that which laboratory study would assist in confirming the diagnosis?
A. Immunoglobulin
B. RBC count
C. WBC count
D. Antistreptolysin O titer
Answer: D
Explanation: The nurse reviews the laboratory results, knowing that a laboratory study that would assist in confirming the diagnosis is antistreptolysin O titer. A diagnosis of rheumatic fever is confirmed by the presence of two major manifestations or one major and two minor manifestations from the Jones criteria. In addition, evidence of a recent streptococcal infection is confirmed by a positive antistreptolysin O titer, streptozyme assay, or an anti-DNase B assay.

Question No: 24
A nurse reviews the record of a newborn infant and notes that a diagnosis of esophageal atresia with tracheoesophageal fistula is suspected. The nurse expects to note which likely sign of this condition documented in the record?
A. Increased crying
B. Coughing at nighttime
C. Choking with feedings
D. Severe projectile vomiting
Answer: C
Explanation: The nurse expects to note choking with feedings. Any child who exhibits the “3 Cs”-coughing, choking with feedings, and unexplained cyanosis-should be suspected of tracheoesophageal fistula.

Question No: 25
A nurse admits a child to the hospital with a diagnosis of pyloric stenosis. On admission assessment, which data would the nurse expect to obtain when asking the mother about the child’s symptoms?
A. Diarrhea
B. Projectile vomiting
C. Increased urine output
D. Vomiting large amounts of bile
Answer: B
Explanation: On admission assessment, the data that the nurse would expect to obtain when asking the mother about the child's symptoms is projectile vomiting. Clinical manifestations of pyloric stenosis include projectile vomiting, irritability, hunger and crying, constipation, and signs of dehydration, including a decrease

in urine output.

Question No: 26
A nurse is preparing to care for an infant with a diagnosis of intussusception. The nurse reviews the child's record and expects to note which symptom of this disorder documented?
A. Diarrhea
B. Ribbon-like stools
C. Profuse projectile vomiting
D. Bright red blood and mucus in the stools
Answer: D
Explanation: The nurse reviews the child's record and expects to note the symptom of bright red blood and mucus in the stools. Intussusception is a telescoping of one portion of the bowel into another. The condition results in an obstruction to the passage of intestinal contents. The child with intussusception typically has severe abdominal pain that is crampy and intermittent, causing the child to draw in the knees to the chest. Vomiting may be present, but is not projectile. Bright red blood and mucus are passed through the rectum and commonly are described as currant jelly-like stools. Watery diarrhea and ribbon-like stools are not manifestations of this disorder.

Question No: 27
A sweat test is performed on an infant with a suspected diagnosis of cystic fibrosis. The nurse reviews the test results and determines that which of the following is a positive result for cystic fibrosis?
A. Chloride level of 20 mEq/L
B. Chloride level of 30 mEq/L
C. Chloride level of 40 mEq/L
D. Chloride level of 70 mEq/L
Answer: D
Explanation: The nurse reviews the test results and determines that a positive result for cystic fibrosis is a chloride level of 70 mEq/L. In a sweat test, sweating is stimulated on the child's forearm with pilocarpine, the sample is collected on absorbent material, and the amounts of sodium and chloride are measured. A sample of at least 50 mg of sweat is required for accurate results. A chloride level higher than 60 mEq/L is considered to be a positive test result. A chloride level of 40 mEq/L suggests cystic fibrosis and requires a repeat test. A chloride level of less than 40 mEq/L indicates no cystic fibrosis.

Question No: 28
A mother arrives in an emergency room with her infant and the mother states that the child fell off a bunk bed. A head injury is suspected and a nurse is assessing the child continuously for signs of increased intracranial pressure (ICP). Which of the following is a late sign of increased ICP in this child?
A. Nausea
B. Bradycardia
C. Bulging fontanel
D. Dilated scalp veins
Answer: B
Explanation: A late sign of increased ICP in this patient is bradycardia. Late signs of increased intracranial pressure (ICP) include a significant decrease in level of consciousness, bradycardia, and fixed and dilated pupils.

A bulging fontanel and dilated scalp veins are early signs of increased ICP and would be noted in an infant, not a 5-year-old child. Nausea is an early sign of increased ICP.

Question No: 29
A nurse is performing an admission assessment on a newborn infant with a diagnosis of spina bifida (myelomeningocele). A priority nursing assessment for this newborn is:
A. Pulse rate
B. Palpation of the abdomen
C. Specific gravity of the urine
D. Head circumference measurement
Answer: D
Explanation: A priority nursing assessment for this newborn is head circumference measurement. Newborn infants with spina bifida (myelomeningocele type) are at risk for hydrocephalus; therefore, the head circumference should be measured to obtain a baseline.

Question No: 30
A lumbar puncture is performed on an infant suspected of having bacterial meningitis and cerebrospinal fluid (CSF) is obtained for analysis. A nurse reviews the results of the CSF analysis and determines that which of the following results would verify the diagnosis?
A. Clear CSF, elevated protein, and deceased glucose level
B. Clear CSF, decreased pressure, and elevated protein level
C. Cloudy CSF, elevated protein, and decrease glucose level
D. Cloudy CSF, decreased protein, and decreased glucose level
Answer: C
Explanation: A nurse reviews the results of the CSF analysis and determines a result that would verify the diagnosis is a cloudy CSF, elevated protein, and decrease glucose level. Meningitis is diagnosed by testing cerebrospinal fluid obtained by lumbar puncture. In the case of bacterial meningitis, findings usually include an elevated pressure, turbid or cloudy cerebrospinal fluid, and elevated leukocyte, elevated protein, and decreased glucose levels

Question No: 31
A nurse is planning care for a newborn of a diabetic mother. A priority nursing diagnosis for this infant would be:
A. Hyperthermia related to excess fat and glycogen
B. Risk for injury related to low blood glucose levels
C. Risk for delayed development related to excessive size
D. Risk for aspiration related to impaired suck and swallow
Answer: B
Explanation: A priority nursing diagnosis for this infant is risk for injury related to low blood glucose levels. The neonate born to a diabetic mother is at risk for hypoglycemia, so risk for injury related to low blood glucose levels would be priority nursing diagnosis. The infant would also be at risk for hyperbilirubinemia, respiratory distress, hypocalcemia, and congenital anomalies. Hyperthermia, risk for delayed development, and risk of aspiration are not expected problems.

Question No: 32
A nurse in a newborn nursery is monitoring a preterm newborn infant for respiratory distress syndrome. Which assessment signs, if noted in the newborn infant, would alert the nurse to the possibility of this syndrome?
A. Tachypnea and retractions
B. Acrocyanosis and grunting
C. Hypotension and bradycardia
D. Presence of a barrel chest with acrocyanosis
Answer: A
Explanation: Assessment signs that would alert the nurse to the possibility of this syndrome if noted in a newborn infant are tachypnea and retractions. The newborn infant with respiratory distress syndrome may present with clinical signs of cyanosis, tachypnea or apnea, nasal flaring, chest wall retractions, or audible grunts. Acrocyanosis is the bluish discoloration of the hands and feet, is associated with immature peripheral circulation, and is not uncommon in the first few hours of life.

Question No: 33
A nurse in a newborn nursery is caring for a neonate. On assessment, the infant is exhibiting signs of cyanosis, tachypnea, nasal flaring, and grunting. Respiratory distress syndrome is diagnosed and the physician prescribes surfactant replacement therapy. The nurse prepares to administer this therapy by:
A. Intravenous
B. Subcutaneous
C. Intramuscular
D. Instillation of the preparation into the lung through an endotracheal tube
Answer: D
Explanation: The nurse prepares to administer this therapy by instillation of the preparation into the lung through an endotracheal tube. In this therapy, an exogenous surfactant preparation is instilled into the lungs through an endotracheal tube. The aim of therapy in respiratory distress syndrome is to support the disease until the disease runs its course, with the subsequent development of surfactant. The infant may benefit from surfactant replacement therapy.

Question No: 34
A nurse notes hypotonia, irritability, and a poor sucking reflex in a full-term newborn infant on admission to the nursery. The nurse suspects fetal alcohol syndrome and is aware that which additional sign would be consistent with fetal alcohol syndrome?
A. Length of nineteen inches
B. Abnormal palmar creases
C. Birth weight of 6 lb. 14 oz
D. Head circumference appropriate for gestational age
Answer: B
Explanation: The nurse suspects fetal alcohol syndrome and is aware that an additional sign that would be consistent with fetal alcohol syndrome is abnormal palmar creases. Features of newborn infants diagnosed with fetal alcohol syndrome include craniofacial abnormalities, intrauterine growth retardation, cardiac abnormalities, abnormal palmar creases, and respiratory distress.

Question No: 35

A ten-year-old patient who has been diagnosed with scoliosis is to be treated with a Milwaukee brace. To which of the following nursing diagnoses would a nurse give priority?
A. Self-care deficit
B. Sleep pattern disturbance
C. Skin integrity
D. Impaired gas exchange
Answer: C
Explanation: A nurse would give priority to a nursing diagnosis of skin integrity. Skin excoriation can occur if the leather and plastic pads of the brace touch the patient's skin. The brace can be worn over a tee shirt.

Question No: 36
A nurse is caring for an infant after corrective surgery for Tetralogy of Fallot. The mother reports that the child has suddenly begun seizing. The nurse recognizes this problem is probably due to:
A. A cerebral vascular accident
B. Postoperative meningitis
C. Medication reaction
D. Metabolic alkalosis
Answer: A
Explanation: The nurse recognizes this problem is probably due to a cerebral vascular accident. Polycythemia occurs as a physiological reaction to chronic hypoxemia, which commonly occurs in patients with Tetralogy of Fallot. Polycythemia and the resultant increased viscosity of the blood increase the risk of thromboembolic events. Cerebrovascular accidents may occur. Signs and symptoms include sudden paralysis, altered speech, extreme irritability or fatigue, and seizures.

Question No: 37
A preterm neonate, born at thirty-one weeks gestation, is receiving an intravenous electrolyte solution at a rate of 20-22 mL/hr via an umbilical arterial line. At the hourly intake measurement, the nurse determines that 45 mL have infused in the past hour. The most appropriate initial nursing action is to:
A. Check the physician's order
B. Set the infusion rate to 10-11 mL/hr on the next two hours
C. Take the vital signs
D. Compare the intake with the output
Answer: C
Explanation: The most appropriate initial nursing action is to take the vital signs. It is a priority to assess circulatory overload; changes in the vital signs would indicate a problem that must be addressed quickly.

Question No: 38
A physician offers a nurse to suture wounds of a neonate patient. The physician tells the nurse that minor wounds can be sutured by a nurse without any supervision. The nurse should:
A. Proceed with the procedure in the physician's presence
B. Refuse to suture the wound
C. Call the State Board of Nursing and report the situation
D. Follow the instructions given by the physician
Answer: B

Explanation: The nurse should refuse to suture the wound. A state's Nurse Practice Act is the ultimate source relative to a nurse's professional practice; a nurse may not function outside of the legal definition of nursing practice.

Question No: 39
After speaking with the parents of a child dying from acute lymphocytic leukemia, the physician gives a verbal order of DNR, but refuses to put it in writing. The nurse should:
A. Follow the instructions as given by the physician
B. Refuse to follow the order unless the nurse manager approves it
C. Ask the physician to put it in writing using a pencil before leaving
D. Determine whether the family is in accord with the physician while following hospital policy
Answer: D
Explanation: The nurse should determine whether the family is in accord with the physician while following hospital policy. This verifies family and physician agreement and uses policy developed by the ethics committee.

Question No: 40
Which of the following reasons, given by a mother who permits her baby girl to sleep in the same bed as the parents, requires further investigation by the nurse?
A. "I am too tired to get up at night to check on the baby in the other room."
B. "This promotes bonding between us and our child."
C. "I slept with my parents when I was a child."
D. I can be certain that my husband is not being inappropriate."
Answer: D
Explanation: A reason, given by a mother who permits her baby girl to sleep in the same bed as the parents, requiring further investigation by the nurse is, "I can be certain that my husband is not being inappropriate." This statement by the mother may indicate that she suspects her husband of child abuse and does not trust him to be alone with the baby.

Question No: 41
The best nursing approach to parents who are displaying anxiety and guilt when their baby is hospitalized is to:
A. Explain the dangers of excess anxiety and guilt
B. Distract their attention to something less painful
C. Anticipate their emotional responses and acknowledge them
D. Give personal examples that are similar to their situation
Answer: C
Explanation: The best nursing approach to parents who are displaying anxiety and guilt when their baby is hospitalized is to anticipate their emotional responses and acknowledge them. Parents may have a wide range of responses to their child's illness and hospitalization. The nurse should anticipate and recognize the responses and allow them to verbalize their feelings about the illness and hospitalization.

Question No: 42
A nurse notices the mother of a hospitalized twenty-five-day-old infant boy sitting and talking on the

telephone while the infant lies in the crib crying. Which of the following statements by the nurse would be most appropriate?
A. “Your son is crying and needs your attention now.”
B. “Let us check your son together to see what he needs.”
C. “Why do you think your son is crying right now?”
D. “When did you last feed your baby?”
Answer: B
Explanation: The statement by the nurse that would be most appropriate is, “let us check your son together to see what he needs.” The statement is nonjudgmental and directs the mother to recognize that she should respond to the patient’s cue.

Question No: 43
Jackie, an operating room nurse, calls her friend at the NICU because she was assigned to circulate for a pregnancy termination case. As her friend, you know that Jackie opposed to the abortion based on her moral principles. You should advise Jackie to:
A. Discuss her beliefs with the patient
B. Have her ask her supervisor to assign another nurse to the case
C. Have her request an ethics panel to be convened to review the case
D. Advise her to leave the room during the time the fetus is aborted
Answer: B
Explanation: You should advise Jackie to have her ask her supervisor to assign another nurse to the case. This is an ethical dilemma. The nurse has instituted the proper steps to process an ethical dilemma. The nurse has examined and identified her own values, verbalized the problem, and then considered alternatives.

Question No: 44
A family of a dying patient requests that the window remain open in the patient’s room. The most appropriate response by the nurse is:
A. “Open windows create a safety hazard.”
B. “You want the window open?”
C. “It’s too cold outside to do it.”
D. “Why would you want the window open?”
Answer: B
Explanation: The most appropriate response by the nurse is “You want the window open?” This is a clarifying statement. This is used to validate that the message was interpreted correctly.

Question No: 45
A nurse has received an order for Total Parenteral Nutrition for a patient admitted with severe malnutrition. Which of the following measures is essential?
A. A complete blood count has been obtained
B. A subclavian catheter is patent and a chest X-ray is done to confirm placement
C. Arm restraints should be in place during the catheter insertion
D. An antecubital IV catheter is started and a baseline chemistry profile has been done
Answer: B
Explanation: A measure that is essential is that a subclavian catheter is patent and a chest X-ray is done to

confirm placement. TPN administration requires central vascular access into a high-flow vein. Before initiation of the TPN solution, the placement of the catheter tip must be confirmed by a chest X-ray.

Question No: 46
Under the Good Samaritan Act, a nurse may be held liable for a patient abandonment at the scene of an emergency in which of the following cases?
A. The nurse does not stop to provide assistance
B. The nurse begins assistance and then abruptly stops
C. The nurse does not initiate care
D. The nurse does not perform under the direct order of a physician
Answer: B
Explanation: Under the Good Samaritan Act, a nurse may be held liable for patient abandonment at the scene of an emergency in cases when the nurse begins assistance and then abruptly stops. The nurse should give care that any reasonable, prudent person would consider first aid. Do not do what you don't know. Offer assistance; do not insist. Do not leave the scene until the injured victim leaves or another qualified person takes over.

Question No: 47
To communicate effectively with the parents of a hospitalized child, the nurse should:
A. Understand that non-verbal communication is meaningful
B. Have empathy with the parents, but realize that the nurse should be in control of the situation
C. Acknowledge positive comments and ignore negative comments
D. Present policy and procedures in detail upon admission
Answer: A
Explanation: To communicate effectively with the parents of a hospitalized child, the nurse should understand that non-verbal communication is meaningful. Observation of non-verbal behavior will assist the nurse in determining who the decision-maker is; enable the nurse to assess readiness to learn and provide guidelines to follow in communication of complex clinical information.

Question No: 48
An infant is admitted to the nursery for observation after a motor vehicle accident. Family members are unable to stay with the patient. To provide psychological comfort, the nurse would:
A. Assign the same nurse to care for the patient
B. Follow a routine to which the patient is accustomed
C. Ensure a staff member stays with the patient
D. Have the patient listen to the parent's voice over the phone
Answer: B
Explanation: To provide psychological comfort, the nurse would follow a routine to which the patient is accustomed. Very young patients gain security from having their needs consistently met.

Question No: 49
A nurse initiates preparation of a six-year-old boy for an infratentorial craniotomy. The nurse plans to:
A. Schedule role playing with another patient having the same surgery
B. Have the patient draw his concept of a brain and briefly clarify any misconceptions

C. Encourage a dummy play with simulated surgical equipment
D. Provide a thorough explanation of anatomy and the procedure to be performed
Answer: B
Explanation: The nurse plans to have the patient draw his concept of a brain and briefly clarify any misconceptions. This indicates the patient's level of understanding to the nurse and an explanation can then proceed at this level.

Question No: 50
While in the hospital, a male baby patient suddenly has a nosebleed that spreads blood on the play table. The nurse's initial action in this situation would be:
A. Take the patient back to his room for care
B. Call housekeeping to clean the area
C. Provide nursing care to stop his nosebleed
D. Notify the supervisor so that those in the area can be tested for HIV
Answer: C
Explanation: The nurse's initial action in this situation would be to provide nursing care to stop his nosebleed. The priority is to care for the patient; once the patient's problem has been resolved, the nurse can address the problem of the blood on the play table.

Question No: 51
A neonate, diagnosed with asthma, is admitted to the unit after an exacerbation at home. The patient is short of breath. To facilitate breathing and to promote respiratory drainage, the nurse would place the patient in a:
A. Supine position
B. Left lateral position
C. High Fowler's position
D. Trendelenburg position
Answer: C
Explanation: To facilitate breathing and to promote respiratory drainage, the nurse would place the patient in High Fowler's position. This position allows the lung more room to expand, thus affording more comfort.

Question No: 52
An abdominal surgery will be performed on a two-month-old infant. Recognizing the developmental level, on the day of the surgery, the nurse should provide the patient with a:
A. Pacifier to suck
B. Music box for listening
C. Rattle to shake
D. Mobile for watching
Answer: A
Explanation: Recognizing the developmental level, on the day of the surgery, the nurse should provide the patient with a pacifier to suck. The patient is NPO and satisfying the sucking need is the priority at this age.

Question No: 53
A two-week-old infant with hypertrophic pyloric stenosis is admitted for corrective surgery. The nurse recognizes that the primary objective of the preoperative period is to:

A. Correct fluid and electrolyte imbalances
B. Document the frequency and character of vomitus
C. Improve nutritional status
D. Stabilize vital signs
Answer: A
Explanation: The nurse recognizes that the primary objective of the preoperative period is to correct fluid and electrolyte imbalances. Preoperative restoration of fluid and electrolyte balance improves the likelihood of a successful outcome after the procedure.

Question No: 54
In which room must a nurse place an infant admitted with a diagnosis of meningitis?
A. Semi-private room in the middle of the unit
B. Corner of a four-bed room next to the nurse's station
C. Private room two doors away from the nurse's station
D. Isolation room away from the activity at the end of the hall
Answer: C
Explanation: A nurse must place an infant admitted with a diagnosis of meningitis in a private room two doors away from the nurse's station. A private room will provide isolation; being close to the nurse's station will facilitate frequent monitoring of neurologic status.

Question No: 55
An infant was admitted to the unit with a tentative diagnosis of bacterial meningitis. When preparing the child for a lumbar puncture, the nurse would first:
A. Obtain a pacifier for the patient to suck on during the procedure
B. Tell the parents they may stay with their child during the procedure
C. Use doll play to demonstrate the procedure
D. Ask the parents if the procedure has been explained to them
Answer: D
Explanation: When preparing the child for a lumbar puncture, the nurse would first ask the parents if the procedure has been explained to them. The procedure should be explained to the parents by the physician. An informed consent is required for the procedure. The nurse should confirm their comprehension and have them sign the consent.

Question No: 56
A nurse can best handle the answering of personal questions asked by the parents of an infant patient during the nurse-patient and family relationship by:
A. Providing brief, truthful answers and redirecting the focus of conversation
B. Offering an honest, brief expression of personal views on the subject
C. Reminding the parents gently that the nurse's feeling are not the parents' concern
D. Reviewing the positive and negative aspect of the subject
Answer: A
Explanation: A nurse can best handle the answering of personal questions asked by the parents of an infant patient during the nurse-patient and family relationship by providing brief, truthful answers and redirecting the focus of conversation. Unless the nurse answers the question, parents will continue to focus on the nurse

rather than on the self; the nurse can best redirect after a brief answer.

Question No: 57
A twenty-year-old patient who is at thirty-eight weeks gestation is being prepared for an emergency cesarean birth due to an abruption placenta and severe fetal compromise. The patient received nalbuphine 10 mg IV thirty minutes ago. Because the patient is too sedated to sign the consent form, the nurse would:
A. Have the attending physician and the surgeon sign the consent form
B. Sign the consent form and have the nurse manager countersign the form
C. Call the patient's parents or husband and request a verbal consent
D. Proceed with the preparation and forgo written consent
Answer: A
Explanation: Because the patient is too sedated to sign the consent form, the nurse would have the attending physician and the surgeon sign the consent form. The information indicates a life-threatening emergency and if the patient is unable to sign the informed consent, it is the legal responsibility of the attending physician and the surgeon to sign the consent so that further injury to the patient and her fetus may be prevented.

Question No: 58
When a nurse is carrying a newborn to the mother's room, a visitor asks to hold the baby. The visitor is sneezing and coughing. The nurse's first action should be to:
A. Give the baby to the mother
B. Ask the visitor if the coughing and sneezing are caused by a cold
C. Request that the visitor step outside the room
D. Check the baby's identification band with the mother
Answer: C
Explanation: The nurse's first action should be to request that the visitor step outside the room. The priority is to protect newborns from unnecessary exposure to microorganisms.

Question No: 59
Nurse Cassie is caring for a newborn female admitted to the nursery. The patient weighs ten pounds, two ounces, which is two pounds more than the birth weight of any of her siblings. Because of the patient's weight, the nurse will:
A. Perform serial glucose readings
B. Place the patient in a heated crib
C. Document the finding
D. Delay starting oral feedings
Answer: A
Explanation: Because of the patient's weight, the nurse will perform serial glucose readings. Large newborns may be the result of gestational diabetes; it is necessary to check the neonate for hypoglycemia because maternal glucose is no longer available.

Question No: 60
A mother expresses the desire to breastfeed her baby who is preterm and is admitted at the neonatal intensive care unit. The nurse should:
A. Discourage the mother because of the time and effort it will take to pump her breasts

B. Instruct the mother that breast milk is inadequate for a preterm infant because it does not contain all the necessary nutrients
C. Support the mother's decision and explain that even if her baby is able to breastfeed, the baby may easily be exhausted
D. Tell the patient that this is not permissible because the baby is being fed by gavage
Answer: C
Explanation: The nurse should support the mother's decision and explain that even if her baby is able to breastfeed, the baby may easily be exhausted. Exhaustion results from the extra sucking effort required to obtain milk flow from the breast.

Question No: 61
The clinical nurse specialist is caring for a preterm infant in the NICU. When assessing the patient, it is most important for the nurse to know the infant's gestational age and how it compares with the birth weight because:
A. This information must be documented on the admission record.
B. The patient will lose 12% of weight during the next few hours of life
C. The health insurance companies require evaluation and classification records
D. This data will help to identify potential problems
Answer: D
Explanation: When assessing the patient, it is most important for the nurse to know the infant's gestational age and how it compares with the birth weight because this data will help to identify potential problems. A preterm, small-for-gestational-age infant is at high risk for problems not seen in the term small-for-gestational-age infant because of immaturity; this information will help the nurse to anticipate problems and aim interventions at prevention.

Question No: 62
The clinical nurse specialist is caring for a ten-day-old preterm infant at the NICU. During the assessment, the nurse determines that the patient is experiencing hypothermia. The nurse would:
A. Rapidly warm the patient during the next hour until the temperature is stabilized
B. Assess the patient for signs and symptoms of hyperglycemia and begin temperature stabilization
C. Gradually warm the patient during the next several hours and monitor frequently
D. Record the infant's skin temperature every hour until the temperature is stable
Answer: C
Explanation: The nurse would gradually warm the patient during the next several hours and monitor frequently. Warming the patient in a gradual manner for a patient experiencing cold stress is important to prevent compromising the patient's cardiopulmonary status.

Question No: 63
A patient developed a rubella infection during the fifth month of pregnancy. At the time of the infant's birth, the nurse would place the newborn in the isolation nursery and observe:
A. Standard precautions
B. Enteric precautions
C. Droplet precautions
D. Body fluid precautions

Answer: C
Explanation: At the time of the infant's birth, the nurse would place the newborn in the isolation nursery and observe droplet precautions. The virus is found in the respiratory tract and the urine, so isolation is necessary; rubella is spread by droplets from the respiratory tract.

Question No: 64
A nurse confers with the nutritionist about the diet of a child with decreased mobility due to a fracture. In addition to being non-constipating, the diet should be:
A. Adequate in calories and calcium
B. Low in calories and high in protein
C. High in calories and in phosphorus
D. Moderate in calories and high in protein
Answer: A
Explanation: In addition to being non-constipating, the diet should be adequate in calories and calcium. Adequate calories support the growth and energy needs of the child, though intake should not exceed energy expenditure. In general, immobility results in deminenarilization. Extra calcium is not needed because it contributes to increased calcium levels in the blood.

Question No: 65
A baby returns to the unit after a cardiac catheterization. Two hours later, during the change of shifts, the statement about the child's progress that should be questioned by the incoming nurse is that the child:
A. Is on bed rest with bathroom privileges
B. Has voided 100 mL since the procedure
C. Has a pressure dressing over the entry site
D. Is to have blood pressure checked every two hours
Answer: A
Explanation: Two hours later, during the change of shifts, the statement about the child's progress that should be questioned by the incoming nurse is that the child is on bed rest with bathroom privileges. The patient is kept on bed rest without bathroom privileges to reduce the risk of bleeding or trauma to the insertion site.

Question No: 66
Dana is a nurse supervisor at the neonatal intensive care unit. She is reviewing different theories of leadership and management and she came across a theory that states that the effectiveness of leadership is dependent upon the unit's situation. Which of the following leadership styles best fits a situation where the followers are self-directed, experts, and are matured individuals?
A. Democratic
B. Authoritarian
C. Laissez faire
D. Bureaucratic
Answer: C
Explanation: A leadership style that best fits a situation where the followers are self-directed, experts, and are matured individuals is laissez faire. Laissez faire leadership is preferred when the followers know what to do and are experts in their field. This leadership style is relationship-oriented rather than task-centered.