Practice Exam Questions

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

# CCRN-Neonatal

## Acute/Critical Care Nursing

EXAMKILLER

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**Total Question: 364 QAs**

Question No: 1
A nurse is educating a new mother about infant care. The mother asks when her baby should be seen for check up. The nurse informs the mother that the schedule of well-baby visits is done:
A. Every month until the 12th month
B. At 1, 2 and 6 months
C. At 1, 2, 4, 6, and 9 months
D. At 1, 2, 4, 6, 9, and 18 months
Answer: C
Explanation: The recommended schedule of visits is set at 1, 2, 4, 6, and 9 months. This schedule follows the timing of the recommended immunizations.

Question No: 2
A 25-year-old mother with a 6-month-old baby asks the nurse if her son should receive the Hepatitis A vaccine. What is the best response of the nurse?
A. “No. The Hepatitis A vaccine is given to those who are sexually active.”
B. “No. Hepatitis A is given to those who work with contaminated blood specimens.”
C. “Yes. Children who are 6 months of age must receive the vaccine.”
D. “No. The Hepatitis A vaccine is recommended at ages 12 months or 24 months.”
Answer: D
Explanation: The Hepatitis A vaccine is recommended at 12 months of age or 24 months of age. It is also recommended for individuals who are travelling outside the country. The Hepatitis B vaccine is given to newborn babies during birth and to individuals who are working with contaminated specimens. Children receive the DTaP at 18 months.

Question No: 3
A 39 year old mom, named Sophia, arrives to the Emergency Department with her 2 month old girl, however, she only speaks French. What is the best method of communicating with her?
A. use sign language
B. use a translation service
C. have a bilingual staff member translate
D. both B and C
Answer: B
Explanation: The best method to communicate with a French speaking 39 year old mom who arrives to the Emergency Department with her 2 month old baby would be to use a translation service. This is outlined in many hospitals and nursing professional associations as this is a legal matter and translation services are readily available and should be utilized.

Question No: 4
Baby Christopher is rushed to the Emergency Department with a nose bleed that is ceasing to stop, upon history the nurse finds that Christopher's parents are of Ashkenozic descent. What type hemophilia is baby Christopher most likely to have?

A. Hemophilia A
B. Hemophilia C
C. Hemophilia B
D. Hemophilia A/B
Answer: B
Explanation: Baby Christopher is most likely to have Hemophilia C since his parents are of Ashkenozic descent. This is an X-linked genetic disorder common in those of Ashkenozic descent.

Question No: 5
David's mom demonstrates understanding of his proper care of bathing when she states which of the following as taught by nurse Ellen prior to her discharging them?
A. Use mild baby soap except on face
B. Give him a tub bath
C. Give him a sponge bath until the umbilical cord falls off
D. Both A and C
Answer: D
Explanation: David's mom demonstrates understanding of his proper care of bathing when she states that she should use mild baby soap except on face and give him a sponge bath until the umbilical cord falls off. This is the safest for proper hygiene and prevention of infection.

Question No: 6
Nurse Lilian is teaching her students about post circumcision care of baby Steven. Which of the following show(s) they have understood?
A. Inspecting the penis immediately after circumcision
B. Observe the first void after circumcision.
C. Record the first void post circumcision.
D. Both B and C
Answer: D
Explanation: Observing and recording the first void after circumcision shows that the students have understood about post circumcision care of baby. While inspecting the penis immediately after circumcision is important it does not show an understanding of the more important need to ensure the infant can properly urinate post-circumcision. The inspecting the penis is usually done by the physician for signs of bleeding and is not as critical for examining functioning post circumcision.

Question No: 7
What are important sign for the students to recognize as a positive Ortoloni's sign on baby George?
A. Hip subluxation.
B. Clicking sound.
C. Clunking sound.
D. All of the above.
Answer: D
Explanation: For the students to recognize as a positive Ortoloni's sign on baby George, they should observe all of the above including hip subluxation, clicking and clunking sounds. Ortoloni's test spund be performed within a few hours of birth especially to detect any congenital dysplasia of the hip which can be a life

debilitating condition if not recognized immediately.

Question No: 8
Baby Allan has just been born and Nurse Wayne is checking him for appropriate sensory behavior. Which finding is true about baby Allan's sensory behaviors at birth?
A. Nurse Wayne should stand between 30" and 33" away and wave.
B. Nurse Wayne should stand between 7" to 12" away and wave.
C. Nurse Wayne should stand between 38" to 40" away and wave.
D. Nurse Wayne should stand between 3" to 6" away and wave.
Answer: B
Explanation: In order to check baby Allan's sensory behaviors at birth, Nurse Wayne should stand between 7" to 12" away and wave. This is to ensure that baby Allan can utilize his sense of vision, including visual acuity and fields as well, his sense of detecting a being or object in his vicinity.

Question No: 9
A baby Darcy has just been born to mother Helen. A nurse is teaching Helen how to elicit an appropriate palmer reflex in baby Darcy. How should the nurse teach baby Darcy's mother Helen to elicit a good palmer reflex?
A. Place a finger in each of Darcy's hands to stimulate the grasp.
B. Run a finger down his arm.
C. Stroke the bottom of his feet.
D. None of the above.
Answer: A
Explanation: The nurse should teach baby Darcy's mother Helen to elicit a good palmer reflex by placing a finger in each of Darcy's hands to stimulate the grasp. This is vitally important to detect in the first few hours after birth as a defect could lead to a long term disability if not detected early for intervention.

Question No: 10
Nicole, a 29 year old mom, brings baby Andrew to the Emergency Department because she finds some bluish black marks on his back and sacrum that appear like bruises. What should the triage nurse do in this situation?
A. Call the abuse hotline.
B. Explain these are not ordinary.
C. Find out when they appeared.
D. Explain these are Mongolian spots.
Answer: D
Explanation: In this case, Nicole, the 29 year old mom brings baby Andrew to the Emergency Department because she finds some bluish black marks on his back and sacrum that appear like bruises, the triage should explain that these are Mongolian spots. Mongolian spots are common in neonates and infants and do not have any pathological basis and should not be a cause for alarm.

Question No: 11
Sylvia is a 30 year old pregnant mother with a known history of drug abuse including cocaine. During her prenatal visits, she is constantly reminded by the nursing staff not to use cocaine or any drugs during her pregnancy; however she doesn't listen and her baby is born with which possible complication(s)?

A. Vomiting.
B. Irritability.
C. High pitched cry.
D. All of the above.
Answer: D
Explanation: The pre-natal nursing staff instructed Sylvia not to use cocaine or any drugs during her pregnancy however she did not listen and her baby is born with complication like vomiting, irritability and high pitched cry. This is unfortunate as these are just initial symptoms and longer term outcomes of Slyvia's baby are still to be revealed including not meeting developmental milestones in speech and language.

Question No: 12
A very anxious primigravida mother is being seen in the pre-natal clinic at 39 weeks and has indicated that she read that she was not to change the cat box filler but she did early in her pregnancy. She is worried about the possible consequences to her baby. Which of the following is the most common infectious disease for a child being born with whom a mother changed the cat filler box?
A. Rubella.
B. Toxoplasmosis.
C. Herpes virus type 2.
D. Cytomegalovirus.
Answer: B
Explanation: For a mother who changed the cat filler box, Toxoplasmosis is the most common infectious disease. Toxoplasmosis is found in the feces of cats and pregnant mothers are particular susceptible to passing the disease onto their child and so are readily advised during pre-natal visits not to change the cat box filler while pregnant.

Question No: 13
Baby Dwayne was born at 35 weeks premature and is the neonatal intensive care unit, the nurse taking care of him walks over to baby Dwayne's bassinet and finds him bradycardic and blue. What course of action should be taken take?
A. Provide respiratory support
B. Provide immediate suction
C. Tactile stimulation
D. All of the above
Answer: D
Explanation: The course of action that should be taken when the neonatal intensive care until nurse notices baby Dwayne bradycardic and blue should provide respiratory support, tactile simulation and suction him. This can be an emergency but often times the neonate is just sleeping and is having an apnea episode which can often be resolved with the above maneuvers. If this becomes a frequent occurrence the attending physician should be notified.

Question No: 14
Nicole has just given birth to baby Alex and you are the neonatal nurse teaching proper breast feeding technique. Which positions should Nicole NOT use to breast feed baby Alex?
A. Cradle

B. Side-lying
C. Football
D. Front-lying
Answer: D
Explanation: The position Nicole should not use to breast feed baby Alex is front lying. This is dangerous as regurgitation as well as improper nutrition delivery can be consequences of this position.

Question No: 15
Nurse Diane has explained to baby Michael's parents the tips for ensuring safety and preventing possible illness. Which demonstrates comprehension of this?
A. Expose him to everyone who wants to visit
B. Use of a proper car seat
C. Ensure little or no clothing in the beginning
D. Both B and C.
Answer: B
Explanation: The demonstration of comprehension by baby Michael's parents for ensuring safety and preventing possible illness for baby Michael include use of a proper care seat. This is important as many infants are not put in proper car seats and thus risk injury in the event of a motor vehicle collision. Infants should not be exposed to anyone with an illness and should be properly dressed and insulated to provide protection from cold weather and other possible pathogens while their immune system develops.

Question No: 16
The neonatal nurse assigned to baby Keith notices that his mother has left baby Keith alone with a bottle propped in his mouth. Why should the neonatal nurse be concerned about leaving baby Keith alone with his bottle propped in his mouth?
A. He may aspirate formula
B. He may swallow air
C. He may be at increase risk for otitis media
D. All of the above.
Answer: D
Explanation: The neonatal nurse should be concerned about leaving baby Keith alone with his bottle propped in his mouth because he may aspirate formula or swallow air as well it is an increased risk for otitis media. This is a dangerous practice and neonatal nurses should be on the constant look out for this as well as instructing the parents not to do this.

Question No: 17
Baby Tyrone was just born at term and has been given to the neonatal nursing for APGAR scoring and initial management. What initial injection should Baby Tyrone receive?
A. Vitamin K 0.5-1mg IM
B. VitaminK 0.5-1mg SC
C. Vitamin B 0.5-1mg IM
D. Vitamin B 0.5-1mg SC
Answer: A
Explanation: The initial injection baby Tyrone should receive is Vitamin K 0.5-1 mg IM. Vitamin K is a coagulant

made in the body into platelets that protects the neonate from bleeding.

Question No: 18
After being born and receiving initial care, the neonatal nurse is determining and infants physical maturity. Which tool is most appropriate to utilize?
A. Ballard assessment tool
B. Glascow Coma Scale
C. FAACS scale
D. All of the above
Answer: A
Explanation: The most appropriate tool to utilize in this situation is the Ballard gestational age assessment tool. This tool measures the physical maturity of the neonate by assessing different domains in gross motor function.

Question No: 19
Upon birth Baby Richard is noticed by his mother Lorraine to have beautiful blue eyes. Lorraine asks the nurse on duty in the nursery when will baby Richard's permanent eye be established?
A. 3 to 12 months
B. 12 to 24 months
C. 24 to 36 months
D. 36 to 48 months
Answer: A
Explanation: The nurse on duty should inform Lorraine that permanent eye color will be established in 3 to 12 months from birth. The range is due many factors and is dependent heavily upon genetics.

Question No: 20
Baby Amelia is admitted into the neonatal intensive care unit after being born prematurely. When the neonatal nurse rounds on baby Amelia, her mother is quite frightened because baby Amelia is having Doll's eye. How long can this usually go on for?
A. 5 days
B. 10 days
C. 30 days
D. Permanently
Answer: B
Explanation: Doll's eye usually go on for 10 days and although may be frightening to the parents, are on no pathological or serious concern.

Question No: 21
The neonatal nurse on duty is examining baby Mark. Why should the neonatal nurse be very gentle with baby Mark's neck?
A. He can't support his neck
B. He can't rotate his head freely
C. His neck is weak
D. All of the above

Answer: D
Explanation: The neonatal nurse should be very gentle with baby Mark's neck because baby Mark's neck is weak, he can't support his neck and he can't rotate his head freely. This is very common for neonates as the neonatal nurse can cause permanent damage to the neck if they are not careful and gentle.

Question No: 22
The neonatal nurse is called to baby Jack's incubator by his mother because baby Jack is acting 'funny'. The neonatal nurse finds baby Jack to be jittery and having a high pitched cry. What is the most crucial immediate action the neonatal nurse needs to take?
A. Check blood glucose.
B. Give him a pacifier to suck on.
C. Change his diaper.
D. Cuddle and soothe him.
Answer: A
Explanation: In the case of finding a neonate jittery with a high pitched cry, the most crucial immediate action the neonatal nurse needs to take is to check baby Jack's blood glucose level. Being jittery and having a high pitched cry for a baby could indicate a hypoglycemic episode in which case immediate intervention needs to be initiated with glucose.

Question No: 23
On initial morning rounds, the neonatal nurse discovers baby Sean has blood glucose of 35 mg/dl. What immediate course of action should be taken?
A. Feed him immediately
B. Give him water
C. Give him insulin
D. All of the above
Answer: A
Explanation: The immediate course of action that should be taken when the neonatal nurse discovers baby Sean has a blood glucose level of 35 mg/dl should be to feed him immediately. This will increase the blood glucose level, and his blood glucose level should be checked in 1 hour time after feeding to ensure it is within the normal range.

Question No: 24
In the neonatal intensive care Nurse George is teaching baby Derek's mother about his taste behaviors. Which statement of the following should Nurse George teach to baby Derek's mother?
A. He prefers sweet tastes
B. He prefers sour tastes
C. He prefers bitter tastes
D. He prefers spicy tastes
Answer: A
Explanation: The statement which Nurse George should teach to baby Derek's mother when teaching about taste behaviors is "He prefers sweet tastes". This is because as a newborn sweet taste is the first learned taste sensation.

Question No: 25
Baby Devon is in the neonatal intensive care until after being delivered prematurely. He is about to be discharged and on discharge planning Nurse Bill is taking the opportunity to teach some nursing students about neonates tactile behaviors. Of the following which are correct?
A. The neonate's lips are hypersensitive.
B. The neonate is especially sensitive to being cuddled and touched.
C. The neonate's skin on his thighs, forearms, and trunk are hyposensitive.
D. All of the above.
Answer: D
Explanation: When Nurse Bill teaches his students about baby Devon's tactile behaviors, all of the above are correct. As the neonate's lips are hypersensitive, the neonate is especially sensitive to being cuddled and touched, and the neonate's skin on his thighs, forearms, and trunk are hyposensitive. These are initial tactile responses in a neonate that will change.

Question No: 26
You are training to be a neonatal nurse practitioner, which of the following nurseries are you permitted to work in as a Neonatal Nurse Practitioner?
A. Levels 1
B. Levels 1 and 2
C. Levels 1, 2 and 3
D. Level 3 only
Answer: C
Explanation: As a Neonatal Nurse Practitioner, you can work in nurseries at level 1, 2 and 3. This is in accordance with state and regulatory guidelines.

Question No: 27
The neonatal intensive care unit nurse is teaching baby Kevin's mother how not to startle him. Which of the following actions should be avoided?
A. Loud noises.
B. Hand clapping.
C. Both A and B
D. Only A
Answer: C
Explanation: The following actions loud noises and hand clapping should be avoided when teaching baby Kevin's mother how not to startle him. Startling a baby can cause distress upon not only the neonate but also upon others within the neonatal intensive care unit as well as the parents.

Question No: 28
A 25 year old mother just gave birth to baby Louise 2 hour ago, however, now baby Louise is requiring immediate intervention because she is displaying which of the following sign(s)?
A. Blue feet.
B. Blue hands.
C. Nasal flaring
D. Apical heart of 150

Answer: C
Explanation: Baby Louise requires immediate attention 2 hours post delivery because she is demonstrating nasal flaring. This is an ominous sign of pulmonary difficulties and can also have signs of subcostal indrawing and retractions.

Question No: 29
The attending neonatologist has ordered intravenous fluid for baby Joseph. The neonatal nurse has appropriately decided to use an umbilical venous line. What should the neonatal nurse assess for before beginning the intravenous fluid?
A. Blanching on the lower extremities.
B. Blanching on the buttocks.
C. Blue discoloration.
D. All of the above.
Answer: D
Explanation: The neonatal nurse should assess for blanching on the lower extremities, blanching on the buttocks and blue discoloration before administering the intravenous fluid. Since the intravenous fluid is being administered through an umbilical venous line it is important to note these signs before intravenous fluid administration to document any changes within these areas.

Question No: 30
Nurse Ellen finds baby Alexandre with which of the following findings that indicates he is in respiratory distress?
A. PCO2 > 60mg/hg expiratory grunting
B. Nasal flaring
C. Tachypnea
D. All of the above
Answer: D
Explanation: Nurse Ellen can conclude that the baby is in respiratory distress by observing all of the above including a PCO2 greater than 60mg/hg, expiratory grunting, nasal flaring and Tachypnea.

Question No: 31
Nurse David receives baby Gil and is informed that the parents have to go home to care for their other children. What is the best gift she can give them for bonding?
A. His picture.
B. His blanket.
C. His pacifier.
D. His baby bottle.
Answer: A
Explanation: The best gift Nurse David can give the parents is a picture of baby Gil to develop bonding between them. A picture is a constant reminder of their newborn child and is shown to increase bonding and caring for parents and their new born.

Question No: 32
Which assessment findings should Nurse Ursala find on baby Linda indicating Erb-Duchenne paralysis?
A. Grasp reflex missing.

B. Grasp reflex intact.
C. Flaccid arm with elbow extended and hand rotated inward.
D. Both B and C.
Answer: D
Explanation: Nurse Ursula should find both grasp reflexes intact and flaccid arm with elbow extended and hand rotated inward to conclude Erb-Duchenne paralysis. This is a common complication of delivery when the fetuses arm is Hyperextended during delivery.

Question No: 33
A baby is just born at term to a G1P1 mother with an uneventful spontaneous vaginal delivery. Which of the following findings are expected when the neonatal nurse performs her newborn assessment?
A. Epstein pearls
B. Tonic neck reflex
C. Caput succedenum
D. Both A and B
Answer: C
Explanation: The finding that should be expected when the neonatal nurse performs her newborn assessment is caput succedenum. Caput succedenum is used to check for swelling of soft tissue under the scalp.

Question No: 34
Baby Christopher is born at term to a 25 year old mother. What are the normal ranges of vitals when the neonatal nurse performs her new born assessment?
A. T97.5 to 98.6 F, HR 120-160, resps 30-60
B. T 96.5 to 98.6, HR 60-100, resps 12-20.
C. T 96.5 to 98.6, HR 120-160, resps 30-60
D. T 97.5 to 98.6 F, HR 60-100, resps 12-20
Answer: A
Explanation: The normal ranges of vital signs when the neonatal nurse performs her newborn assessment is temperature 97.5 to 98.6 Fahrenheit, Heart Rate of 120-160 beats per minute and Respirations of 30-60 per minute.

Question No: 35
Baby Daniel us 36 hours old and has been brought into the Emergency Department with a temperature of 97.0 F. What immediate action should triage nurse?
A. Recheck his temperature in 2 hours.
B. Wrap him up in 3 warm blankets and cuddle him.
C. Give him a warm bottle of milk.
D. Wrap him up in 3 warm blankets and place a cap on his head
Answer: D
Explanation: The immediate action the triage nurse should do for baby Daniel, who is 36 hours old with a temperature of 97.0 F, is to wrap him up in 3 warm blankets and place a cap on his head. This is to prevent hypothermia which is a severe consequence of a low temperature in newborns. A cap on the head is necessary as much thermal heat is lost from the head more than any other body part.

Question No: 36
A newborn mother urgent alerts the neonatal intensive care nurse that her neonate is grunting, nasal flaring and subcostal indrawing. The neonatalologist on call is called and diagnosis the neonate as in respiratory distress and orders blood gases to be obtained every 30 minutes. What type of access line should be inserted into this neonate in this situation?
A. Arterial line
B. Venous line
C. Central venous pressure line
D. Swan Ganz catheter
Answer: A
Explanation: The access line that needs to be inserted into this neonate in this situation is an arterial line. For the most accurate measurement of saturation of oxygen, arterial blood is required and thus an arterial line is required to be inserted for constant monitoring of arterial blood gases.

Question No: 37
A newborn is born in respiratory distress and requires an arterial line placed. Where the arterial oxygen saturation sensor should be placed?
A. Sole of foot
B. Around the finger
C. Palm of the hand
D. All of the above
Answer: A
Explanation: The arterial oxygen sensor should be placed on the sole of the foot. This is because this is the most likely place for the sensor to stay on while still providing an accurate oxygen saturation reading.

Question No: 38
A baby Irfran is admitted to the neonatal intensive care unit with respiratory depression after a difficult labour and delivery. How often should the neonatal intensive care nurse rotate the oxygen sensor site on baby Irfran?
A. Every 2 hours.
B. Every 4 hours.
C. Every 12 hours.
D. Every 24 hours.
Answer: C
Explanation: The neonatal intensive care nurse should rotate the oxygen sensor site on baby Irfran every 12 hours. This is the time frame designated according to hospital and nursing protocol to ensure the oxygen sensor is correct and accurate.

Question No: 39
A baby is born to as mother who is a smoker and has suffered intrauterine growth restriction with a birth weight of 3.7 lbs. When a neonate has a low birth weight what are some of the finding(s)?
A. High pitched cry
B. Hypoglycemia
C. Little scalp hair
D. Both B and C

Answer: D
Explanation: When a neonate has a low birth weight common findings include hypoglycemia and little scalp hair. These finding are in line with disproportional growth and indicative on low birth weight.

Question No: 40
After baby Dawn's mother visits, the neonatal nurse finds her in animal print cotton blanket and cyanotic. What should she do?
A. Check her airway
B. Check the umbilical stump for bleeding
C. Check her temperature
D. Check her heart rate
Answer: C
Explanation: The neonatal nurse finding baby Dawn wrapped in an animal print cotton blanket and cyanotic should immediately check baby Dawn's temperature. The reason for this is neonates are highly susceptible to hypothermia and a cotton blanket is likely insufficient to keep baby Dawn appropriately heated this early in life.

Question No: 41
The neonatal nurse on duty finds that Baby Donald is demonstrating seesaw movements while resting. The neonatal nurse recognizes this as a sign of what?
A. Respiratory distress
B. Cardiac compromise
C. Hunger
D. All of the above
Answer: A
Explanation: The neonatal recognizes the seesaw movements while resting that baby Donald is doing is a sign of respiratory distress. This is an important sign for neonatal nurses to watch for as the seesaw movements indicate the neonate is struggling to breathe and is going to into respiratory distress.

Question No: 42
The neonatal nurse is examining baby Michael's mouth during a new born assessment and notices white patches on his tongue. In this situation what should the neonatal nurse do?
A. Use a toothbrush and clean his tongue
B. Obtain an order for nystatin
C. Feed milk
D. All of the above
Answer: B
Explanation: In this situation, when a neonatal nurse finds that baby Michael has white patches on his tongue they should obtain an order for an antifungal medication such as Nystatin. Nystatin can be applied with a eye dropper directly onto the tongue, additionally, sterile water can be used to rinse out the milk the neonate is drinking and likely causing the fungus Canadia Albacains on baby Michael's tongue.

Question No: 43
A neonate, Timothy, is just admitted to the neonatal intensive care unit, and upon initial assessment by the

neonatal nurse on duty, she find bay Tim with red brick dust and immediately informs the attending neonatologist. What is the finding of red brick dust in this neonate?
A. Uric acid crystals in the urine
B. Blood in the stool
C. Blood vessel dilation
D. Elevated blood glucose
Answer: A
Explanation: The finding of red brick dust in this neonate is uric acid crystals in the urine. This is usually found because of a build up on uric acid and a failure to excrete it appropriately.

Question No: 44
The assigned neonatal nurse to baby Latisha, Nurse Linda should care for baby Latisha by performing which of the following task(s)?
A. Organizing care
B. Minimizing interruptions
C. Monitoring for stress
D. All of the above
Answer: D
Explanation: The assigned neonatal nurse Linda should care for baby Latisha by performing organizing care, minimizing interruptions and monitoring for stress. This is very important for a neonate as their immune system as well as stress response system is not fully developed these are ways to reduce stress on baby Latisha, reducing any chance of her not developing fully.

Question No: 45
Upon delivery the neonatal nurse on duty examines baby Erin and detects a heart murmur and informs the neonatologist who agrees with the finding and orders an urgent echocardiogram. Baby Erin is diagnosed with Tetralogy of Fallot. What are some of the clinical symptoms of Tetralogy of Fallot?
A. Cyanosis
B. Rapid breathing
C. Deep breathing
D. All of the above
Answer: D
Explanation: The clinical symptoms of Teralogy of Fallot in a neonate are cyanosis, rapid breathing and deep breathing (sometime referred to as tet spells). These symptoms occur because of right to left shunting of blood in the heart that causes an increase in systemic vascular resistance therefore decreasing pulmonary resistance.

Question No: 46
Baby Ryan after being admitted to the neonatal intensive care unit for prematurity is discharged 1 week later. However, he returns to the neonatal intensive care unit and is diagnosed with inborn metabolism. What are some of the clinical symptom(s) of inborn metabolism?
A. Vomiting small amounts of formula
B. Voiding small amounts of urine
C. High blood glucose

D. All of the above
Answer: A
Explanation: The clinical symptom of inborn metabolism is vomiting of small amounts of formula.

Question No: 47
While teaching baby Michelle's amount human development, neonatal nurse Slyvia, instructs baby Michelle's mother that baby Michelle will begin to acknowledge human voices at what age?
A. 0-2 months
B. 2-4 months
C. 4-6 months
D. 6-8 months
Answer: A
Explanation: Neonatal nurse Slyvia instructs baby Michelle's mother that baby Michelle will begin to acknowledge human voices at the age of 0-2 months. This is a developmental milestone that is critically monitored for in the neonatal intensive care unit as it can be one of the first signs of developmental delay and an underlying pathological process.

Question No: 48
A nurse in a delivery room is assisting with the delivery of newborn infant. After the delivery, the nurse prepares to prevent heat loss in the newborn infant resulting from evaporation by:
A. Warming the crib
B. Turning on the overhead radiant warmer
C. Closing the doors to the room
D. Drying the infant with a warm blanket
Answer: D
Explanation: Evaporation of moisture from a wet body dissipates heat along with moisture. Keeping the newborn infants dry by drying the wet newborn infant at birth will prevent hypothermia via evaporation.

Question No: 49
A nurse is assessing a newborn infant following circumcision and notes that the circumcised area is reed with a small amount of bloody drainage. Which of the following nursing actions would be most appropriate?
A. Document findings
B. Contact the physician
C. Circle the amount of bloody drainage on the dressing and reassess in 30 minutes
D. Reinforce the dressing
Answer: A
Explanation: The penis is normally red during the healing process. Yellow exudates may be noted in 24 hours, and this is part of normal healing. The nurse would expect that the area would be red with a small amount of bloody drainage.

Question No: 50
A nurse in a newborn nursery is monitoring a preterm newborn infant for respiratory distress syndrome (RDS). Which assessment signs if noted in the newborn infant would alert the nurse to the possibility of this syndrome?
A. Hypotension and bradycardia

B. Tachypnea and retractions
C. Acrocyanosis and grunting
D. The presence of a barrel chest with acrocyanosis
Answer: B
Explanation: 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.

Question No: 51
A postpartum nurse is providing instructions to the mother of a newborn infant with hyperbilirubinemia who is being breastfed. Which of the following instructions would the nurse provide to the mother?
A. Switch to bottle feeding the baby during the period of high bilirubin levels and to feed less frequently
B. Stop the breast feedings and switch to bottle feeding permanently
C. Provide bottled water feedings between the breastfeeding sessions
D. Continue to breastfeed every 2 to 4 hours
Answer: D
Explanation: Breastfeeding should be initiated within two hours after birth and every 2 to 4 hours thereafter. The infant should not be feed less frequently. It is not necessary to stop breast feeding for permanently.

Question No: 52
A nurse is assessing a newborn infant who was born to a mother who is addicted to drugs. Which of the following assessment findings would the nurse not expect to note during the assessment of this newborn?
A. Irritability
B. Difficulty in consoling the newborn
C. Lethargy
D. Incessant crying
Answer: C
Explanation: A newborn infant born to a woman using drugs is irritable. The infant is easily overloaded by sensory stimulation. The infant may cry incessantly and be difficult to console. The infant would hyperextend and posture rather than cuddle when being held.

Question No: 53
A 4-day-old newborn infant is receiving phototherapy at home for a bilirubin level of 14 mg/dL. The nurse should plan to include which of the following in the plan of care during the home visit to the mother of the newborn infant?
A. Having minimal contact with the newborn infant to prevent stimulation
B. Advising the mother to limit newborn infant oral intake during phototherapy
C. Applying lotions to exposed newborn infant's skin
D. Assessing skin integrity and fluid and electrolyte status of the newborn infant
Answer: D
Explanation: Assessing skin integrity and fluid and electrolyte status of the newborn infant is an essential component of phototherapy. Contact with the newborn infant is important.

Question No: 54
A nurse notes hypotonia, irritability, and a poor sucking reflex in a full-term newborn infant upon admission

to the nursery. The nurse suspects fetal alcohol syndrome (FAS) and is aware that which of the following additional sign(s) would be consistent with FAS?
A. Head circumference appropriate for gestational age
B. Birth weight of 6 pounds 14 ounces
C. Length of 19 inches
D. Abnormal palmar creases
Answer: D
Explanation: Features of newborn infants diagnosed with FAS include craniofacial abnormalities, intrauterine growth retardation (IUGR), cardiac abnormalities, abnormal palmar creases, and respiratory distress.

Question No: 55
The mother of a newborn infant calls a clinic and reports to a nurse that when cleansing the umbilical cord, the mother noticed that the cord was moist and that discharge was present. The most appropriate nursing instruction to the mother is which of the following?
A. To increase the number of times that the cord is cleansed per day
B. To monitor the cord for another 24 to 48 hours and to call the clinic if the discharge continues
C. To bring the infant to the clinic
D. That this is normal occurrence
Answer: C
Explanation: Symptoms of infection are moistness, oozing, discharge, a reddened base around the cord. If symptoms of infection occur, the mother should be instructed to notify a health care provider. If these symptoms occur, antibiotics are necessary.

Question No: 56
A nurse develops a plan of care for a human immunodeficiency virus (HIV)-infected mother and her newborn infant. The nurse includes which intervention in the plan of care?
A. Instruct the breastfeeding mother regarding the treatment of the nipples with nystatin ointment
B. Monitor the newborn infant's vital signs routinely
C. Maintain standard (universal) precautions at all times while caring for the newborn
D. Initiate referral to evaluate for blindness, deafness, learning, or behavioral problems
Answer: C
Explanation: The newborn infant born of an HIV-infected mother must be cared for with strict attention to standard (universal) precautions. This prevents the transmission of HIV from the newborn infant, if infected, to others, and prevents transmission of other infectious agents to the possibly immunocompromised newborn infant, HIV infected mothers should not breastfeed.

Question No: 57
In a newborn nursery, a nurse receives a telephone call to prepare for the prepare for the admission of a 43-week-gestation newborn infant with Apgar scores of 1 nurse's highest priority should be to:
A. Connect the resuscitation bag to the oxygen outlet
B. Turn on the apnea and cardiorespiratory monitors
C. Set up the intravenous line with 5% dextrose in water
D. Set the radiant warmer control temperature at 36.5° C (97.6° F)
Answer: A

Explanation: The highest priority on admission to the nursery for a newborn with low Apgar scores is airway, which would involve preparing respiratory resuscitation equipment. The remaining options are also important, although they are of somewhat lower priority.

Question No: 58
A nurse educates a mother in how to bathe a newborn infant. The nurse tells the mother to:
A. Start with the dirtiest area first
B. Begin with the eyes and face
C. Begin with the feet and work upward
D. Only wash the diaper area, since this is the only part of the infant that gets soiled.
Answer: B
Explanation: Bathing should start at the eyes and face, usually the cleanest area.

Question No: 59
A nurse has provided directions to a mother of a male newborn infant who is not circumcised about measures to clean the penis. Which statement if made by the mother indicates an understanding of how to clean the newborn infant's penis?
A. "I need to retract the foreskin and clean the penis every time I give my infant a bath."
B. "I should gently retract the foreskin as far as it will go on the penis and then pull the skin back over the penis after cleaning."
C. "I should retract the foreskin and clean the penis every time I changed the diaper."
D. "I need to avoid pulling back the foreskin to clean the penis because this may cause adhesions."
Answer: D
Explanation: In male newborn infants, prepuce is continuous with the epidermis of the glans and is not retractable. If retraction is forced, this may cause adhesions to develop. The mother should be told to allow separation to occur naturally, which usually occurs between 3 years and puberty. Most foreskins are retractable by 3 years of age and should be pushed back gently at this time of cleaning once a week.

Question No: 60
A nurse is performing an admission assessment on 6-month-old infant with a diagnosis of hydrocephalus. The nurse assesses for the major sign associated with hydrocephalus when the nurse:
A. Tests the urine for protein
B. Takes the apical pulse
C. Palpates the anterior fontanel
D. Tales the blood pressure
Answer: C
Explanation: In infants with hydrocephalus, the head at an abnormal rate, and the first sign of the disorder may be bulging fontanels without head enlargement. A bulging, tense, and nonpulsatile anterior fontanel indicates an increase in cerebrospinal fluid collection in the cerebral ventricle. A method of assessing fluid collection in the cranial cavity is to palpate the anterior fontanel.

Question No: 61
A nurse is performing an admission assessment on a newborn infant with a diagnosis of spina bifida (meningomyelocele). The nurse assesses for a major symptom associated with this type of spina bifida when

the nurse:
A. Checks the capillary refill of the nailbeds of the upper extremities
B. Tests the urine for blood
C. Palpates the abdomen for masses
D. Checks for responses to painful stimuli from the torso downward
Answer: D
Explanation: Newborn infants with spina bifida (meningomyelocele) demonstrate lack of innervation from below the site of the sac that contains the meninges and spinal cord and excess cerebrospinal fluid. They therefore show diminished or no responses to painful in these areas below the sac.

Question No: 62
A child diagnose with Reye's syndrome. A nurse develops a nursing care plan for the child and includes which intervention in the plan?
A. Providing a quiet atmosphere with dimmed lighting
B. Assessing hearing loss
C. Monitoring urine output
D. Changing body position every 2 hours
Answer: A
Explanation: In Reye's syndrome, supportive care is directed toward monitoring and managing cerebral edema. Decreasing stimuli in the environment by providing a quiet environment with dimmed lighting would decrease the stress on the cerebral tissue and neuron responses.

Question No: 63
A nurse develops a plan of care for a child at risk for generalized tonic-clonic seizures. In the plan of care, the nurse initiates seizure precautions and documents that which items need to be placed at child's bedside?
A. Suctioning equipment and an airway
B. Oxygen with a tracheostomy set
C. Emergency cart
D. Airway and a tracheostomy set
Answer: A
Explanation: Generalized tonic-clonic seizures cause rigidity of all body muscles, followed by intense jerking movements. Since airway obstruction and increased oral secretions can occur during and after the seizure, an airway and suctioning equipment are placed at the bedside.

Question No: 64
A nurse is caring for a child newly diagnosed with cerebral palsy. The parents of the child ask the nurse about the disorder. The nurse bases her answer on the understanding that cerebral palsy is:
A. A chronic disability characterized by impaired muscle movement and posture
B. An infectious disease of the central nervous system
C. In inflammation of the brain as a result of a viral illness
D. A congenital condition that results in moderate to severe retardation
Answer: A
Explanation: Cerebral palsy is a chronic disability characterized by impaired movement and posture resulting from an abnormality in the extrapyramidal or pyramidal motor nervous system.

Question No: 65
A child diagnosed with Down syndrome is cared for by a nurse. In describing the disorder to the parents, the nurse bases the explanation on the fact that Down syndrome is a condition characterized by:
A. Above average intellectual functioning with deficits in adaptive behavior
B. Average intellectual functioning and the absence of deficits in adaptive behavior
C. Moderate to severe retardation, congenital nature, and linkage to an extra chromosome 21, group G
D. Subaverage intellectual functioning with the absence of deficits in adaptive behavior
Answer: C
Explanation: Down syndrome is a form of mental retardation. It is a congenital condition that results in moderate to severe mental retardation. A high percentage of cases are attributable to an extra chromosome (Group G); hence the name trisomy 21.

Question No: 66
A maternity nurse working in a newborn nursery accepted a telephone call from the delivery room and is told that a newborn with spina bifida (meningomyelocele) will be transported to the nursery. The maternity nurse prepares for the arrival of the newborn and places which of the following priority items at the newborn's bedside?
A. A blood pressure cuff
B. A rectal thermometer
C. A specific gravity urinometer
D. A bottle of sterile normal saline
Answer: D
Explanation: The newborn with spina bifida is at risk for infection before the closure of the sac. A sterile normal saline dressing is placed over the sac to maintain moisture of the sac and its contents. This prevents tearing or breakdown of the skin integrity at the site.

Question No: 67
The mother of a newborn diagnosed with strabismus was told by the physician that surgery will be necessary to realign the weakened eye muscles. The nurse was asked by the mother if when the surgery might be performed. The most appropriate response is to tell the mother that surgery will be performed:
A. Immediately
B. Shortly before the child starts school
C. Before the child is 2 years old
D. Before the child begins to read
Answer: C
Explanation: In a child diagnosed with strabismus, surgery may be indicated to realign the weakened eye muscles. It is most often indicated when amblyopia (decrease vision in the deviated eye) is present. The surgery should be performed before the child is 2 years old.

Question No: 68
A senior staff nurse takes the pulse of 6 months old sleeping child during her routine monitoring of vitals, what is the normal range of pulse rate/minute of 6 months old healthy sleeping child?
A. 70-120