Practice Exam Questions

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

CCRN-Pediatric

Acute/Critical Care Nursing

EXAMKILLER

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Total Question: 357 QAs

Question No: 1
Stuttering among pre-schoolers is:
A. a symptomatic delay in neural development
B. a common characteristic.
C. an indication of a speech problem.
D. a possible result of an emotional problem.
Answer: B
Explanation: Stuttering among pre-schoolers is a common characteristic. It is normal and common for preschoolers to stutter and it is not to be considered as a problem. This happens as the child's advancing mental ability and level of comprehension exceed the vocabulary acquisitions.

Question No: 2
A 5-week-old infant tightly grasps a little toy placed in his hands. The mother was impressed with this ability. The nurse on duty should explain that this is:
A. a behavior that is usually observed in an older infant.
B. a palmar grasp reflex that is expected at this age group.
C. an unusual behavior that needs further evaluation.
D. a pincer grasp reflex which will disappear in about 3-4 months of life.
Answer: B
Explanation: In a case when the infant tightly grasps a toy in his hands, the nurse should explain to the mother that this is an involuntary behavior termed as the palmar grasp reflex is at its peak at 4 weeks of age and normally disappears at 3-4 months of age. Pincer grasp is a fine motor behavior which begins at 8 month of age.

Question No: 3
A primary school age boy was diagnosed with Myelogenous Leukemia. He is about to begin Chemotherapy and tells the nurse "I'm already 12 years old and I think I have the right to refuse the treatment". The nurse's most therapeutic response is:
A. "You are old enough. You're also old enough to understand that you need the Chemotherapy.
B. "You seem afraid. Let me talk to you about it".
C. Your father already gave his consent so we need to go on with the treatment".
D. Because you're under 18 years old, it means you don't have the capacity to refuse.
Answer: B
Explanation: In a case, the nurse finds out the boy is disinterested, "You seem afraid. Let me talk to you about it" is the best response because it permits exploration of the child's feelings. If the child starts to discuss feelings, there may not be a need to inform him that he is too young to refuse the treatment.

Question No: 4
Jessica, a 29-year-old mother, tells the nurse that her youngest son who is just 7-months-old can already sit without any support. The nurse should tell the mother that this:
A. could be a developmental delay which needs further evaluation.

B. is an activity that shows the upper 10% of physical development.
C. is a developmental milestone that is just expected at his age.
D. is a behavior which indicates that he is going to walk in the next 3 months.
Answer: C
Explanation: Sitting without support is an expected developmental milestone that is expected of a 7-month-old infant. It is done by extending the legs to the side and leaning forward on the hands. After a month, an infant is expected to sit steadily without the use of his hands or mother's support. Sitting alone cannot be a predictor of when the baby will start to walk.

Question No: 5
A nurse teaches a mother of a 2-month-old infant to be sure that the floor is free of small objects when her child is crawling. The reason for this is that:
A. sharp objects can easily injure the infant's skin.
B. the infant could hide small objects making them harder to find.
C. the infant can easily pick up small objects
D. it is very hazardous for them to pick up things from the floor.
Answer: C
Explanation: A 2-month-old infant already has the ability to use its fingers and thumbs in opposition (known as pincer grasp); this therefore enables it to pick up small objects and put them into its mouth which could lead to aspiration.

Question No: 6
What is the most appropriate toy that a nurse should give to a 12-week-old infant?
A. Colorful stuffed toy
B. Metallic mirror
C. Rattle
D. Balls made of safe plastic
Answer: B
Explanation: Metallic mirror is the best among the choices because a 3-month-old infant is more interested in self-recognition and playing with the "baby" in the mirror. The infant is old enough for a rattle and still too young for stuffed toys and plastic balls.

Question No: 7
An infant who weighed 6 pounds at birth now weighs 12 pounds at 1 year. The nurse at the clinic recognizes that this infant:
A. has the expected weight at 1 year of age.
B. has probably been neglected
C. has low weight compared to what is expected.
D. has not been offered adequate nourishment
Answer: C
Explanation: The baby should have a weight of 18 pounds according to the weight charts of the national center for health statistics. The weight at birth is expected to be doubled at 6 months and be tripled at 1 year. We cannot say that the infant was neglected or offered inadequate nourishment because it is a judgmental conclusion.

Question No: 8
A 2 year old boy was scheduled for an emergency surgery. It as noted that the mother is 16 year old and the father is 17 year old. The child's father and paternal grandfather, who care for the baby, are at the bedside. Informed consent should be signed by:
A. the 17 year old father
B. the 16 year old mother
C. Paternal grandfather
D. Surgeon and attending physician
Answer: A
Explanation: The child's father should be the one to sign the consent regardless of his age. In this case, parenthood confers the rights of an adult to the teenager. Informed consent can also signed by the mother if she is present. Option D is valid only if there's no relative that is present or if there's not enough time to obtain consent considering the condition of the patient.

Question No: 9
A 2 year old was brought to the pediatric clinic for a routine check up. When assessing the child's relationship with other children, the nurse would expect to observe.
A. cooperative play
B. team play
C. parallel play
D. initiative play
Answer: C
Explanation: Parallel play is typical of the toddler age group. They have not yet learned to interact with other toddler in a social situation. Initiative play does not identify any age group; moreover, it is not a recognized term for social play.

Question No: 10
Which of the following is the correct way of instilling eardrops among children below 3 years old:
A. Apply medicated ear wicks, then instill the eardrops
B. Cleanse the ear canal trough pulling the pinna outward
C. Pull the pinna up and back to straighten the ear canal
D. Pull the pinna down and back to straighten the ear canal
Answer: D
Explanation: Canal should be straighten by pulling it down and back so that the eardrops will reach the eardrum. This approach is applicable to children below 3 years old because their ear canal curves upward.

Question No: 11
When is the best time to do a corrective surgery for an infant with hypospadias:
A. Anytime during pre school age
B. 72 hours after birth
C. Within few months after birth
D. 6-18 months of age.
Answer: D

Explanation: 6-18 months is the preferred age to do a corrective surgery for an infant with hypospadias because fear of castration and body image is not yet developed. It can't be performed shortly after birth because the phallus is not developed enough. Fear of bodily mutilation is present during pre school age.

Question No: 12
A pre-schooler is being prepared for an ear surgery in an ambulatory care facility. When the child is called to go to the operating room, the nurse should:
A. Allow the child to walk from the unit.
B. Remove the child's toy.
C. Allow the parents to accompany the child until he is sedated.
D. Ask the parents to leave the room and wait outside.
Answer: C
Explanation: Most health institutions allow the parents accompany the child until he is sedated and to stay with the child as long as possible. This minimizes the stress related to fearful events. Also, current theory is consistent that parents should remain during the induction of anesthesia due to parent's positive feedback.

Question No: 13
Measles vaccine should be given among infant between:
A. 1 and 3 months
B. 6 and 9 months
C. 9 and 11 months
D. 12 and 15 months
Answer: D
Explanation: Measles vaccine should be given immediately after the first birthday between 12 and 15 months. Maternal antibodies to measles are no longer present to block the formation of the Child's own antibodies. Other options has questionable efficacy of the vaccine because maternal antibodies are still present at those times.

Question No: 14
A school age girl with rubella should be isolated from an unimmunized:
A. 18 year old sister who has recently married.
B. 4 year old child who lives next door.
C. 14 year old brother who had rubella as a child.
D. 21 year old brother living at home.
Answer: A
Explanation: An unimmunized woman like 18 year old sister who has recently got married and is exposed to rubella virus is at a higher risk. If she contracts the disease it may be transmitted to her fetus once she got pregnant. Option b has a lesser effect as it would probably be mild and confer immunity.

Question No: 15
Which of the following would a nurse expect to observe in a pediatric client who has a tentative diagnosis of Acute lymphocytic Leukemia:
A. Alopecia and swollen gums
B. Alopecia and Petechiae

C. Anorexia and Insomnia
D. Anorexia and Petechiae
Answer: D
Explanation: Anorexia and Petechiae are indicative of catabolism and Bone marrow depression which are expected in a child with ALL. Alopecia would occur only until Chemotherapy in instituted. It is also expected that a child will be lethargic and sleep excessively due to Bone marrow depression.

Question No: 16
A nurse is aware that the most common site for bleeding to develop in a child with hemophilia is:
A. Gums
B. Stomach
C. Joints
D. Nose and ears
Answer: C
Explanation: The most common sites for bleeding to develop in a child with hemophilia are the joints. It is probably related to weight bearing and their continuous movement.

Question No: 17
One goal of therapy for sickle cell anemia is prevention of sickling phenomenon, which is responsible for the pathologic sequelae. Which of the following plan of care is directed toward the prevention of a crisis:
A. Giving iron-rich formula as nourishment.
B. Promoting oxygenation and hemodilution
C. Techniques in decreasing tissue oxygen requirements and maintaining hemoconcentration
D. Enforcing periods of bed rest to minimize energy expenditures.
Answer: B
Explanation: Because low oxygen tension precipitates sickling, therefore adequate oxygenation is desirable. Hemodilution prevents increased viscosity, which can cause sickling and thrombus formation. Bed rest is desirable during a pain episode, but not routinely employed in preventing crisis.

Question No: 18
A father of a 16 year old who has sickle cell anemia tells a nurse that his family is scheduled to go camping this summer. He asks what activity would be appropriate for his child. The nurse would suggest:
A. Collecting logs to be use for campfire
B. Biking around the lake
C. Fresh water swimming
D. Motorboat ride around the lake.
Answer: D
Explanation: The activity doesn't require high amount of oxygen. The goal is to prevent sickling, therefore activities which may lead to increased cellular metabolism and increased tissue hypoxia should be avoided.

Question No: 19
A nurse is aware that a child with AIDS is more prone to infection than an adult with AIDS because:
A. child with AIDS is exposed to more pathogen than an adult with AIDS.
B. the immune system of a child is incapable of producing antibodies.

C. the AIDS virus attacks child's immune systems through a different mechanisms
D. a child has fewer circulating antibodies resulting from a lack of previous exposure to pathogens.
Answer: D
Explanation: Adults have higher levels of antibodies than children because over time they have been exposed to more pathogens. Other options are incorrect because in comparison, they do not differ.

Question No: 20
Victor, a 4 year old child, is at the clinic for a routine clinic visit. In assessing Victor's growth and development, the nurse is guided by principles of growth and development. Which is not included:
A. Different parts of the body grows at different rate
B. All individual follow standard growth rate
C. Rate and pattern of growth can be modified
D. All individuals follow cephalo-caudal and proximo-distal
Answer: C
Explanation: Growth and development occurs in cephalo-caudal meaning development occurs through out the body's axis. Ex: the child must be able to lift the head before he is able to lift his chest. Proximo-distal is development that progresses from center of the body to the extremities. Ex: a child first develops arm movement before fine-finger movement. Different parts of the body grows at different range because some body tissue mature faster than the other such as the neurologic tissues peaks its growth during the first years of life while the genital tissue doesn't till puberty. Also G&D is predictable in the sequence which a child normally precedes such as motor skills and behavior. G&D can never be modified.

Question No: 21
What type of play is most appropriate for a 6 year old child:
A. make believe
B. hide and seek
C. building blocks
D. peek-a-boo
Answer: A
Explanation: Make believe is most appropriate because it enhances the imitative play and imagination of the preschooler. Peek-a-boo and building blocks are appropriate for infants, while hide and seek is applicable to school age children.

Question No: 22
Which of the following information would indicate that a pre-school has normal growth and development:
A. Determines own sense self
B. Develops sense of whether he can trust the world
C. Has the ability to try new things
D. Learns basic skills within his culture
Answer: C
Explanation: Because Erik Erickson defines the developmental task of a preschool as learning Initiative vs. Guilt. Children can initiate motor activities of various sorts on their own and no longer responds to or imitate the actions of other children or of their parents.

Question No: 23
Which of the following is true about Mongolian Spots?
A. Are linked to pathologic conditions
B. Are managed by tropical steroids
C. Disappears in about a year
D. Are indicative of parental abuse
Answer: C
Explanation: Mongolian spots are stale grey or bluish patches of discoloration commonly seen across the sacrum or buttocks due to accumulation of melanocytes and they disappear in 1 year. They are not linked to steroid use and pathologic conditions.

Question No: 24
Signs of cold stress that the nurse must be alert when caring for a Newborn is:
A. Hypothermia
B. Increased Respirations
C. Shaking
D. Decreased activity level
Answer: B
Explanation: A newborn will increase its respirations because the newborn will need more oxygen because of too much activity. Hypothermia is inaccurate because normally, temperature of a newborn drop, also a child under cold stress will kick and cry to increase the metabolic rate thereby increasing heat so B isn't a good choice. A newborn doesn't have the ability to shiver.

Question No: 25
What would cause the closure of the Foramen ovale after the baby had been delivered?
A. Decreased blood flow
B. Shifting of pressures from right side to the left side of the heart
C. Increased in oxygen saturation
D. Increased PO2
Answer: B
Explanation: During feto-placental circulation, the pressure in the heart is much higher in the right side, but once breathing/crying is established, the pressure will shift from the R to the L side, and will facilitate the closure of Foramen Ovale.

Question No: 26
Failure of the Foramen Ovale to close will cause what Congenital Heart Disease?
A. Transposition of great arteries
B. Atrial Septal defect
C. Pulmunary Stenosis
D. Total anomalous Pulmunary Artery
Answer: B
Explanation: Foramen ovale is the opening between two Atria so, if its will not close Atrial Septal defect can occur.

Question No: 27
A mother brought her child to the clinic with nose bleeding. The nurse showed the mother the most appropriate position for the child which is:
A. low back rest
B. moderate back rest
C. Lying semi flat
D. Sitting up
Answer: D
Explanation: This position will minimize the amount of blood pressure in nasal vessels and keep blood moving forward not back into the nasopharynx, which will have the choking sensation and increase risk of aspiration. Other options are inappropriate because they can cause blood to enter the nasopharynx.

Question No: 28
For acute otitis media, the treatment is prompt antibiotic therapy. Delayed treatment may result in complications of:
A. Eardrum Problems
B. Diabetes mellitus
C. Brain damage
D. Tonsillitis
Answer: C
Explanation: One of the complications of recurring acute otitis media is risk for having Meningitis, thereby causing possible brain damage. That is why patient must follow a complete treatment regimen and follow up care.

Question No: 29
Which of the following statements would the nurse expect a 5-year old boy to say whose pet gerbil just died:
A. “He’s just a bit dead”
B. “I’ll be good from now own so I won’t die like my gerbil”
C. “Did you hear the joke about…”
D. “Joker got him”
Answer: A
Explanation: A 5 y/o views death in “degrees”, so the child most likely will say that “he is just a bit dead”. Personification of death occurs in ages 7 to 9 as well as denying death can if they will be good. Denying death using jokes and attributing life qualities to death occurs during age 3-5.

Question No: 30
When assessing the fluid and electrolyte balance in an infant, which of the following would be important to remember:
A. Infant has greater body surface area than adults
B. Infants have more intracellular water that adult do
C. The metabolic rate of an infant is slower than in adults
D. Infant can concentrate urine at an adult level
Answer: A
Explanation: Infants have greater body surface area than adult, increasing their risk to F&E imbalances. Also

infants can't concentrate a urine at an adult level and their metabolic rate, also called water turnover, is 2 to 3 times higher than adult. Plus more fluids of the infants are at the ECF spaces not in the ICF spaces.

Question No: 31
A nurse must be aware that infants with heart failure require immediate scheduling of:
A. operations during childhood.
B. same medications as that of an adult.
C. different treatment as that of an adult.
D. meticulous heart surgery.
Answer: B
Explanation: For a reason that mechanism of heart failure is exactly the same in pediatrics and geriatrics. Same medications like cardiac glycosides and furosemide are utilized, although the dosage will be different. Other options are uncertain because there are other treatments which are successful other than surgeries.

Question No: 32
A mother tells the nurse "the doctor said that my child has pulmonic stenosis. What does it mean?" The nurse's best response should be:
A. "What else did the doctor say about the disease"
B. "It means that the baby has a heart failure"
C. "Let me call your doctor so that your questions will be answered correctly"
D. "You seemed very concerned. Your baby has a great doctor anyway"
Answer: A
Explanation: The nurse needs to know how much information the mother has before giving any information. We know that the disease is narrowing at the entrance to the pulmonary artery and may vary in severity and treatment. Calling the doctor at this point abdicates the role of the nurse.

Question No: 33
An infant was diagnosed of Tetralogy of Fallot. The nurse assessed that the infant is underweight. What could be the reason behind this problem:
A. recurrent respiratory infections due to pulmonary hypertension.
B. Polycythemia brought by a decreased in the level of arterial PO2.
C. deficient caloric intake due to activity intolerance.
D. Cerebral changes due to cyanosis.
Answer: C
Explanation: Inadequate weight gain happens because the infant tires very easily, sufficient calories cannot be ingested to meet the nutritional needs. Other options do occur but they are indirectly related to weight gain.

Question No: 34
An infant with tetralogy of fallot was admitted at the unit. Which of the following is indicative of physiologic adaptation of a client with tetralogy of fallot:
A. shallow and irregular respirations.
B. decrease platelet count
C. ecchymoses
D. digital clubbing

Answer: D
Explanation: There will be a poor peripheral circulation due to Hypoxia. Clubbing of fingers occur as a result of capillary development and tissue hypertrophy of the fingertips. There will be a rapid breathing.

Question No: 35
Dietary restriction in a child who has Hemocystenuria will include which of the following amino acid:
A. Lysine
B. Methionine
C. Isolensine tryptophase
D. Valine
Answer: B
Explanation: Hemocystenuria is the elevated excretion of the amino acid hemocystiene, and there is inability to convert the amino acid methionine or cystiene. Therefore dietary restriction of these amino acids is advised.

Question No: 36
Which of the following would be a diagnostic test for Phenylketonuria which uses fresh urine mixed with ferric chloride:
A. Guthrie Test
B. Phenestix test
C. Beutler's test
D. Coomb's test
Answer: B
Explanation: Phenestix test is a diagnostic test for Phenylketonuria which uses a fresh urine sample (diapers) and mixed with ferric chloride. If positive, there will be a presence of green spots at the diapers. Guthrie test is another test for PKU and is the one that mostly used. The specimen used is the blood and it tests if CHON is converted to amino acid.

Question No: 37
An inborn error of metabolism that causes premature destruction of RBC:
A. G6PD
B. Hemocystinuria
C. Phenylketonuria
D. Celiac Disease
Answer: A
Explanation: G6PD is the premature destruction of RBC when the blood is exposed to antioxidants, legumes and flava beans.

Question No: 38
For a child with recurring nephrotic syndrome, which of the following areas of potential disturbances should be a prime consideration when planning ongoing nursing care:
A. Muscle coordination
B. Sexual maturation
C. Intellectual development
D. Body image

Answer: D
Explanation: Because of edema, associated with nephrotic syndrome, potential self concept and body image disturbance related to changes in appearance and social isolation should be considered.

Question No: 39
When assessing a newborn with cleft lip, the nurse would be alert which of the following will most likely be compromised:
A. Sucking ability
B. Respiratory status
C. Locomotion
D. GI function
Answer: A
Explanation: Because of the defect, the child will be unable to form the mouth adequately around the nipple thereby requiring special devices to allow feeding and sucking gratification. Respiratory status may be compromised when the child is fed improperly or during post op period.

Question No: 40
While assessing a male neonate whose mother desires him to be circumcised, the nurse observes that the neonate's urinary meatus appears to be located on the ventral surface of the penis. The physician is notified because the nurse would suspect which of the following:
A. Phimosis
B. Hydrocele
C. Epispadias
D. Hypospadias
Answer: D
Explanation: Hypospadias is a condition in which the urethral opening is located below the glans penis or anywhere along the ventral surface of the penile shaft. Epispadias, the urethral meatus is located at the dorsal surface of the penile shaft.

Question No: 41
When assessing a newborn for developmental dysplasia of the hip, the nurse would expect to assess which of the following:
A. Symmetrical gluteal folds
B. Trendelemburg sign
C. Ortolani's sign
D. Characteristic limp
Answer: C
Explanation: It is the abnormal clicking sound when the hips are abducted. The sound is produced when the femoral head enters the acetabulum. Letter A is wrong because it should be "asymmetrical gluteal fold". Letter B and C are not applicable for newborns because they are seen in older children.

Question No: 42
Which of the following immunizations would the nurse expect to administer to a child who is HIV (+) and severely immunocompromised:

A. DTaP
B. Rotavirus
C. MMR
D. IPV
Answer: D
Explanation: IPV or Inactivated polio vaccine does not contain live micro organisms which can be harmful to an immunocompromised child. Unlike OPV, IPV is administered via IM route.

Question No: 43
A mother asks the nurse about Vitamin A supplementation. The best response is that giving Vitamin A starts when the infant reaches 6 months and the first dose is:
A. 200,000 "IU"
B. 100,000 "IU"
C. 20,000 "IU"
D. 10,000 "IU"
Answer: B
Explanation: An infant aging 6-11 months will be given Vitamin supplementation of 100, 000 IU and for Preschoolers ages 12-83 months 200,000 "IU" will be given.

Question No: 44
Which of the following would require careful monitoring in the child with ADHD who is receiving Methylphenidate (Ritalin):
A. Dental health
B. Mouth dryness
C. Height and weight
D. Excessive appetite
Answer: C
Explanation: Ritalin can affect the child's Growth and development. Dental problems are more likely to occur in children under going TCA therapy. Mouth dryness is an expected side effect of Ritalin since it activates the SNS. Also loss of appetite is more likely to happen, not increase in appetite.

Question No: 45
Which of the following statements by the family of a child with asthma indicates a need for additional teaching:
A. "We need to identify what things triggers his attacks"
B. "He is to use bronchodilator inhaler before steroid inhaler"
C. "We'll make sure he avoids exercise to prevent asthma attacks"
D. "he should increase his fluid intake regularly to thin secretions"
Answer: C
Explanation: Asthmatic children don't have to avoid exercise. They can participate on physical activities as tolerated. Using a bronchodilator before administering steroids is correct because steroids are just anti-inflammatory and they don't have effects on the dilation of the bronchioles.

Question No: 46
A child was scheduled for a palliative surgery, which creates anastomosis of the subclavian artery to the

pulmonary artery. This procedure is called:
A. Waterston-Cooley
B. Raskkind Procedure
C. Coronary artery bypass
D. Blalock-Tausig
Answer: D
Explanation: Blalock-Tausig procedure its just a temporary or palliative surgery which creates a shunt between the aorta and pulmonary artery so that the blood can leave the aorta and enter the pulmonary artery and thus oxygenating the lungs and return to the left side of the heart, then to the aorta then to the body. This procedure also makes use of the subclavian vein so pulse is not palpable at the right arm.

Question No: 47
A client with tetralogy fallot will become cyanotic and dyspneic after crying. To relieve this clinical manifestation, the nurse should place the infant in what position?
A. Sitting position
B. Modified trendelenburg position
C. Knee chest position
D. Lateral Sim's position
Answer: C
Explanation: Knee chest position is done by flexing the hips and knees. This way, there will be a decrease venous return to the heart from the legs; as a result, cardiac workload is decreased. Assuming a sitting position does reduce pressure of the abdominal organs on the diaphragm but does not put enough pressure on the femoral vein and vena cava to sufficiently reduce venous return to the heart.

Question No: 48
Which of the following would be an indicative of impending heart failure among infants:
A. notable increased in urinary output
B. shallow and grunting respirations
C. distended jugular vein
D. Dyspnea and tachycardia
Answer: D
Explanation: Dyspnea and tachycardia are signs that occur in infants if there's an impaired myocardial function. It is directly related to sympathetic stimulation. Note that the pulse is elevated even when the infant is at rest. There will be a decreased urinary output; abdominal respirations would be a late sign that occurs when pulmonary congestion sits in; neck vein distention is only seen in adult clients.

Question No: 49
An infant with heart failure was fed and burped, after burping; he was repositioned in semi-fowler then had a bowel movement. Afterwards, the infant became diaphoretic and cyanotic. The nurse is aware that these were most likely caused by:
A. feeding
B. burping
C. changing of position
D. defecating

Answer: D
Explanation: This is caused by defecating and the valsalva maneuver during bowel movement. The maneuver occasionally causes tet spell or blue spell that results in increased intrathoracic pressure, decreased blood return to the heart, increased venous pressure, and decreased pulse rate.

Question No: 50
What explanation would a nurse give to a parent of a pediatric client who will undergo a cardiac catheterization:
A. it will confirm if there is a pansystolic murmur.
B. it will establish the presence of heart muscle hypertrophy.
C. it will determine the degree of heart muscle problem
D. it will identify specific location of the defect.
Answer: D
Explanation: The procedure will identify the exact location of ventricular septal defect and also assess pulmonary pressure. Other options can be identified by using ECG and stethoscope.

Question No: 51
Michael, a toddler, was admitted at the hospital with a diagnosis of Wilm's tumor. The nurse should be aware that:
A. vigorous palpation of the mass must be avoided.
B. hypertension may occur at anytime of confinement.
C. respiratory problems should be expected and reported.
D. disease is communicable therefore the client must be isolated.
Answer: A
Explanation: The nurse should be aware that vigorous palpation of the mass must be avoided. The abdominal mass should be carefully examined. Palpating a mass too vigorously could lead to the rupture of a large tumor into the peritoneal cavity. There are hospitals that require nurses to put signs like" DO NOT PALPATE".

Question No: 52
Michael was diagnosed with Wilm's tumor and started on chemotherapy as treatment. The doctor ordered a Dactinomycin 0.015mg/kg slow IV push now. The nurse on duty should:
A. question the doctor's order to prevent over dosage.
B. administer the medicine and watch out for nausea and vomiting.
C. hold the medication until the doctor changed the dosage.
D. administer the medicine then give hydrocortisone 100 mg IV afterwards.
Answer: B
Explanation: The nurse should administer the medicine and watch out for nausea and vomiting. The dosage is safe for a pediatric client, we can administer until 1.5mg in 3 weeks time. Dactinomycin may cause nausea, vomiting, diarrhea and stomatitis.

Question No: 53
Britney, a mother of a child who was diagnosed with Guillain-Barre syndrome, asks the nurse about the treatment plan for her child. The nurse is aware that:
A. therapies will lessen the severity of the illness and speed the recovery in most patients.

B. the child will be given loading dose of antibiotics.
C. surgical treatment will be discuss by the doctor once cardio-pulmonary clearance is done.
D. the child needs several blood transfusion to prevent shock.
Answer: A
Explanation: Currently, plasmapheresis and high-dose immunoglobulin therapy are used to lessen the severity of the illness and speed the recovery in most patients. Plasmapheresis is a method by which whole blood is removed from the body and processed so that the red and white blood cells are separated from the plasma, or liquid portion of the blood. The blood cells are then returned to the patient without the plasma, which the body quickly replaces. In high-dose immunoglobulin therapy, doctors give intravenous injections of the proteins that, in small quantities, the immune system uses naturally to attack invading organisms

Question No: 54
Olga is a 4 year old girl who was diagnosed with Trisomy 21. During the clinical check-up the nurse would expect to find:
A. gigantism
B. hydrocephalus
C. multiple-creased hand
D. protruding tongue
Answer: D
Explanation: Children with Trisomy 21 or Down's syndrome are typically recognizable based on some physical characteristics that includes: retarded growth and slower-than-normal development, head that is smaller than typical, wide hands with short fingers, as well as palms with a single crease, rather than multiple creases, and protruding tongue.

Question No: 55
A nurse is caring for a child who has Trisomy 13. During a morning rounds, the mother asks how her child acquired the syndrome. The nurse's response will be based from the fact that:
A. it is an inherited condition.
B. it is caused by microorganism.
C. it is a complication of previous exposure to streptococcus
D. it is a chromosomal anomaly.
Answer: D
Explanation: Trisomy 13 is a genetic disorder in which a person has three copies of genetic material from chromosome 13, instead of the usual two copies.

Question No: 56
A mother of a child with heart failure questions the necessity of weighing the baby everyday. The nurse's best response should be guided by the fact that the daily weight is essential in determining:
A. fluid retention
B. nutritional status
C. dosage of medication
D. success of treatment
Answer: A
Explanation: Retention of fluid is reflected by excessive weight gain in just a short period of time. Insufficient

cardiac output lowers flow to the kidneys that leads to intracellular fluid increase and hypervolemia. Weight gain or loss due to nutrition is gradual. Dosage of medication is not recalculated everyday based on weight gain.

Question No: 57
The nurse scans the laboratory values of a pediatric client with rheumatic fever. Which data should be treated as insignificant:
A. positive antistreptolysin titer
B. positive C-reactive protein
C. elevated reticulocyte count
D. elevated ESR
Answer: C
Explanation: This is related to anemia. There would be a positive titer as a result of previous exposure to streptococcal infection; possitive C-reactive protein and elevated ESR are indicative of inflammatory process.

Question No: 58
A pediatric client was returned to the unit after a heart surgery. Contraptions are: Left chest tube drainage attached to a bottle system; an IVF of D5 NSS at 32 gtts/min; and an NGT to gravity. The client was then attached to a cardiac monitor. What would be the priority nursing intervention:
A. obtain vital signs
B. check the identification bracelet
C. check the IVF level and flow rate
D. measure the drainage of both tubing.
Answer: A
Explanation: Vital signs should be the priority to determine the child's status and compare it with the data obtained during the pre-operative period.

Question No: 59
Included in the plan of care of a 7 year old client with diabetes is glucose monitoring. As a nurse, we must be aware that the most accurate way to evaluate the effectiveness of client and insulin therapy over time is the test that measures:
A. Serum protein levels
B. Urine ketones
C. Serum glucose level
D. Glycosylated Hemoglobin
Answer: D
Explanation: GHb test provides an accurate long-term index of the client's average blood glucose level for the 100-120 day period before the test. The more glucose the RBC was exposed to, the greater the GHb percent.

Question No: 60
Channel is a 3 year old girl who has Thalassemia. She underwent several blood transfusion and folate intake as treatments. After 2 months, the doctor planned a therapy to remove too much iron in the blood. The nurse is aware that this therapy is called:

A. Chelation
B. Hemoglobin electrophoresis
C. Plasmapheresis
D. Cautery
Answer: A
Explanation: Person who received significant numbers of blood transfusions need a treatment called Chelation therapy to remove excess iron from the body. The chelating agent may be administered intravenously, intramuscularly, or orally, depending on the agent and the type of poisoning

Question No: 61
A Multi-Electrolyte Solution (MES) 150 ml/kg of body weight Q 24 hours is ordered for a pediatric client weighing 14.3 lbs. The nurse calculates for the intake of MES for this client is:
A. 40 ml
B. 2145 ml
C. 975 ml
D. 89 ml
Answer: C
Explanation: The nurse calculates for the intake of MES for this client is 975ml (2.2 lbs =1kg; 14.3lbs /2.2 lbs = 6.5 kg; 6.5 kg x 150 ml = 975 ml).

Question No: 62
A 5-month-old infant, weighing 15 lbs, is admitted with a diagnosis of diarrhea with moderate dehydration. The doctor ordered oral rehydration therapy of 40-50 ml/kg of pedialyte over 4 hours. What would be the appropriate amount of fluid that the infant should ingest during the 4 hour period:
A. 250 ml
B. 330 ml
C. 360 ml
D. 400 ml
Answer: B
Explanation: 15 lbs is about 7 kg; at 40 ml/kg x 4 hours = 280 ml; at 50ml/kg x 4 hours = 350 ml; 330ml is within these parameters.

Question No: 63
Poisoning among toddlers is common because of the ingestion of different things like medicines that looks like candies. What would be the priority plan of care for a toddler who has ingested aspirin:
A. monitor BP
B. monitor Cardiac rate
C. monitor body temperature
D. monitor serum glucose level.
Answer: C
Explanation: Elevation in body temperature or hyperpyrexia is a manifestation of acute aspirin toxicity. It leads to increase oxygen consumption and heat loss.

Question No: 64

An infant with Myelomeningocoele underwent a surgical repair. Suddenly, the client developed metabolic acidosis, notable decreased urinary output and diarrhea. The nurse at the unit anticipates that the doctor will order:
A. Hypertonic saline
B. Potassium chloride
C. Isotonic saline
D. Sodium Lactate
Answer: D
Explanation: T o correct the sodium deficit and metabolic acidosis, the client needs Sodium Lactate. Sodium Lactate is converted to sodium bicarbonate. Saline intensifies acidosis. Potassium will only be given once kidney function was restored.

Question No: 65
What nursing action should be done in an infant who receives IVF via a scalp vein:
A. restrain the extremities when there's no one to see the child.
B. assess for signs of infiltration behind the occiput
C. assess the pupils every 1 hour for any untoward reaction.
D. explain to the parents that they cant hold the client while the IV therapy is ongoing.
Answer: A
Explanation: Extremities need to be restrained as infants use them to dislodge the needle. Pupillary reaction and assessing at the occiput do not relate to scalp vein and IV therapy.

Question No: 66
An IV solution of 10% glucose and mannitol are administered to an infant with Reye's syndrome. The client's vital signs should be monitored by the nurse to prevent the occurrence of:
A. hypovolemic shock
B. fluid volume excess
C. heart failure
D. seizure episodes.
Answer: A
Explanation: The therapy causes diuresis therefore the infant should be monitored for excessive fluid loss. Options B and C are related to fluid gain. Any changes in vital signs are not indicative of impending seizure.

Question No: 67
A student nurse is caring for a 4-year old child diagnosed with croup and the clinical instructor asks the student about the clinical manifestations associated with the illness. Which statement by the student indicates a need for further research:
A. cough is harsh and brassy
B. inspiratory stridor and a low-grad fever may be present
C. symptoms usually worsen at night and are better during the day
D. symptoms usually worsen during the day and are relieved during sleep
Answer: D
Explanation: Croup often begins at night and may be preceded by several days of upper respiratory infection symptoms. Croup is characterized by a sudden onset of a harsh, brassy cough, sore throat, and inspiratory

stridor. Symptoms usually worsen at night and are better in the day. Croup usually is accompanied by a low-grade fever.

Question No: 68
A nurse is preparing for the admission of a child with a diagnosis of acute-stage Kawasaki disease. The nurse expects to note which clinical manifestation of the acute stage of the disease:
A. cracked lips
B. conjunctival hyperemia
C. desquamation of the skin
D. swollen joints
Answer: B
Explanation: In the acute stage, the child has a fever, conjunctival hyperemia, red throat, swollen hands, rash, and enlargement of the cervical lymph nodes. In the subacute stage, cracking lips and fissures, desquamation of the skin on the tips of the fingers and toes, joint pain, cardiac manifestations, and thrombocytosis occur. In the convalescent stage, the child appears normal, but signs of inflammation may be present.

Question No: 69
A nurse is preparing to care for a child with a diagnosis of intussusception. The nurse reviews the child's record and expects to note which symptom of this disorder documented:
A. watery diarrhea
B. ribbon-like stools
C. profuse projectile vomiting
D. bright red blood and mucus in the stools
Answer: D
Explanation: 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: 70
A child is receiving succimer (Chemet) for the treatment of lead poisoning. A nurse monitors which of the following most important laboratory results:
A. SGOT and SGPT
B. blood urea nitrogen level
C. red blood cell count
D. serum albumin
Answer: B
Explanation: A nurse will monitor blood urea nitrogen level. Renal function is monitored closely during the administration of Chelation therapy because the medications are excreted via the kidneys. Although it is important to monitor the red blood cell count for the presence of anemia in a child with lead poisoning, this laboratory result is not specific to chelation therapy. Options A and D are unrelated to the administration of chelation therapy.

Question No: 71