

AACN CCNS-Pediatric Exam

Volume: 203 Questions

Question No: 1

A clinical nurse specialist is caring for a one-year-old baby boy. During the assessment, the nurse notes that the patient is in respiratory distress. Which signs confirm this assessment?

- A. Cyanosis and crackles
- B. Crackles and wheezing
- C. Tachypnea, crackles, and wheezing
- D. Retractions, crackles, and cyanosis

Answer: D

Explanation: Signs that confirm respiratory distress among neonates include cyanosis, tachypnea, and retractions. Cyanosis occurs as a result of inadequate oxygenation. Tachypnea is a compensatory mechanism to increase oxygenation. Retractions occur in an effort to increase lung capacity.

Question No: 2

An adolescent patient who sustained an inhalation injury arrives in the emergency department. On assessment of the patient, the nurse notes that the patient is very confused and combative. The nurse determines that the patient is experiencing:

- A. Pain
- B. Fear
- C. Hypoxia
- D. Anxiety

Answer: C

Explanation: The nurse determines that the patient is experiencing hypoxia. After a burn injury, patients are normally alert. If a patient becomes confused or combative, hypoxia may be the cause. Hypoxia occurs after inhalation injuries and may also occur after an electrical injury. Although the patient may experience anxiety, fear, and pain, these would not be the cause of the patient's confusion and combativeness.

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Question No: 3

A clinical nurse specialist is caring for a pediatric patient who is diagnosed with diabetic ketoacidosis. The nurse expects that this patient will experience Kussmaul respiration and there will be a high level of ketones in the blood as a result of incomplete oxidation of:

- A. Carbohydrates
- B. Proteins
- C. Fats
- D. Glucose

Answer: C

Explanation: The nurse expects that this patient will experience Kussmaul respiration and that there will be a high level of ketones in the blood as a result of incomplete oxidation of fats. Incomplete oxidation of fat results in fatty acids that further break down to ketones. Carbohydrates do not contain fatty acids. Protein metabolism results in nitrogenous waste production, causing elevation of BUN. Glucose is unavailable for metabolism in cases of ketoacidosis as a result of inadequate production of insulin.

Question No: 4

A ten-year-old patient is admitted with a diagnosis of diabetic ketoacidosis. He is receiving intravenous fluids and insulin. The patient has complaints of tingling and numbness of the fingers and toes and shortness of breath. The nurse looks at the cardiac monitor and notes a U wave. The clinical nurse specialist should recognize that these indicate:

- A. Hypercalcemia
- B. Hypoglycemia
- C. Hyponatremia
- D. Hypokalemia

Answer: D

Explanation: The nurse should recognize that the symptoms are indicative of hypokalemia. These classic signs occur when potassium levels are reduced as potassium re-enters cells with glucose.

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Question No: 5

A five-year-old boy was brought by his mother to the emergency room due to muscle weakness. The patient was diagnosed with Guillain-Barre syndrome. The nurse is aware that a potential treatment option for this patient would be:

- A. Immunosuppression therapy
- B. Hemodialysis
- C. Plasmapheresis
- D. Thrombolytic therapy

Answer: C

Explanation: The nurse is aware that a potential treatment option for this patient would be plasmapheresis. This type of treatment is the removal of plasma from the withdrawn blood, followed by the reconstitution of its cellular components in an isotonic solution and the reinfusion of this solution.

Question No: 6

A twelve-year-old baseball player was admitted to the hospital due to an accident that led to a subarachnoid hemorrhage. The clinical nurse specialist caring for the patient should position the patient:

- A. In supine position
- B. With the head of the bed elevated
- C. On the unaffected side
- D. Using sandbags on both sides of the head

Answer: B

Explanation: The clinical nurse specialist caring for the patient should position the patient with the head of the bed elevated. This position uses the force of gravity to prevent additional intracranial pressure, which would intensify the ischemic manifestation of hemorrhage.

Question No: 7

A mother of a ten-month-old infant asks the nurse why her baby is not receiving an

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anticoagulant drug considering that her baby has an intracranial bleeding. The nurse explains that in her infant's situation, anticoagulant:

- A. Is necessary to prevent pulmonary thrombosis
- B. Will be started soon to enhance circulation
- C. Is not advisable because it can hide signs and symptoms
- D. Is contraindicated because bleeding would be increased

Answer: D

Explanation: The nurse explains that in this infant's situation, anticoagulant is contraindicated because bleeding would be increased. Anticoagulant would interfere with clotting.

Question No: 8

Roger, a seven-year-old child, was admitted to the hospital with a diagnosis of intervertebral disc herniation at the level of L5-S1. A nurse who is assigned to Roger should include which of the following nursing interventions?

- A. Prepare the patient for lumbar puncture
- B. Encourage the patient to ambulate freely
- C. Assess the skeletal traction insertion site for redness and swelling
- D. Position the patient with knees slightly flexed, with the head of the bed elevated

Answer: D

Explanation: A nurse who is assigned to Roger should include a nursing intervention which is positioning the patient with knees slightly flexed, with the head of the bed elevated. This position increases the disc space and may help to decrease pain. Other options are not advisable for this type of patient.

Question No: 9

A nurse is preparing a nursing care plan for a six-year-old patient who is in the acute phase of sickle cell vaso-occlusive crisis. Which of the following interventions should be included in the plan?

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- A. Administration of analgesia as prescribed
- B. Ambulation for at least six hours a day
- C. Fluid restriction of 1L per day
- D. Encourage patient to increase caloric intake

Answer: A

Explanation: Intervention that should be included in the plan is administration of analgesia as prescribed. The general objective in the treatment of a sickle cell crisis is bed rest, antibiotics for any infection, electrolyte replacement, analgesics, hydration, and blood replacement.

Question No: 10

A nine-year-old child was admitted with a diagnosis of acute glomerulonephritis. She has moderate edema and mild hypertension. Which of the following nursing actions would be most appropriate at this time?

- A. Maintain a high protein diet
- B. Encourage physical activity to eliminate boredom
- C. Observe seizure precautions
- D. Obtain body weight QID

Answer: C

Explanation: The most appropriate nursing action at this time is to observe seizure precautions. The severity of the acute phase of the disease is unpredictable, therefore, a child with edema and hypertension may be subject to complications and anticipatory preparations, such as seizure precautions, are needed.

Question No: 11

A clinical nurse specialist is caring for a four-year-old child after a surgery for correction of tetralogy of fallot. The mother runs to the nurse's station and reports that the child started to seize. The nurse recognizes that the problem is due to:

- A. Meningitis

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- B. Unexpected reaction to medications
- C. Metabolic alkalosis
- D. Cerebral vascular accident

Answer: D

Explanation: The nurse recognizes that the problem is due to 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 seizures, sudden paralysis, extreme irritability or fatigue, and altered speech.

Question No: 12

A mother brought her child to the emergency department following an ingestion of aspirin. The nurse should frequently monitor the child's:

- A. Body temperature
- B. Blood pressure
- C. Serum glucose level
- D. Apical pulse

Answer: A

Explanation: The nurse should frequently monitor the child's body temperature. Elevated body temperature is a manifestation of acute aspirin poisoning; it can lead to heat loss and increased oxygen consumption.

Question No: 13

Cara, a clinical nurse specialist, is assigned to a one-year-old patient who is admitted to the unit. The child is receiving gastric feedings and Cara suspects that the patient might have a necrotizing enterocolitis. Which of the following would support this conclusion?

- A. A large amount of residual formula withdrawn before lavage
- B. A noticeable increase in bowel movement was noted

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C. Circumoral pallor develops during the feeding process

D. Several severe bouts of projectile vomiting were noted

Answer: A

Explanation: An assessment that would support that the baby is having necrotizing enterocolitis is that a large amount of residual formula is withdrawn before lavage. Other manifestations include bile-stained emesis and feeding intolerance.

Question No: 14

Angela, a four-year-old preschooler, is admitted due to acoustic neuroma. She experiences progressive nerve deafness, tinnitus, and vertigo. The nurse is aware that these symptoms are due to the destruction of which of the following?

A. Cranial nerve 5

B. Cranial nerve 7

C. Cranial nerve 8

D. Ossicles

Answer: C

Explanation: The symptoms are due to the destruction of cranial nerve 8, or the vestibulocochlear nerve. Cranial nerve 8 is most commonly affected in patients with acoustic neuroma, although cranial nerve 5 and cranial nerve 7 can be affected as the tumor progresses.

Question No: 15

A clinical nurse specialist is caring for a two-year-old child who is diagnosed with intussusception at the ileocecal valve. The nurse did an assessment and noted all of the following except:

A. Weakness and lethargy

B. Sausage-shaped stool

C. Sudden acute episodes of severe abdominal pain

D. Distended abdomen

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Answer: B

Explanation: The nurse did an assessment and noted all of the listed items except sausage-shaped stool. Intussusception is characterized by a “currant-jelly stool” which is composed of blood and mucous that occurs in almost 60% of all cases. The mass in the RUQ of the abdomen is the one that is shaped like a sausage. Other symptoms are sudden acute episodes of severe abdominal pain, during which the child pulls knees to chest; vomiting; lethargy and weakness; distended abdomen, painful to palpation; progressive fever; and prostration if peritonitis occurs.

Question No: 16

Which of the following is true about plasma?

- A. It functions to transport hormones, ions, and nutrients throughout the body
- B. It makes up nearly 22% of the blood
- C. It may contain 10% or less of waste products
- D. It comprises tissue macrophages derived from monocytes

Answer: C

Explanation: The fact that is true about plasma is that it may contain 10% or less of waste products. Plasma contains serum (the liquid portion of blood (90%)), plasma proteins, coagulation factors (fibrinogen), and some nutrients, enzymes, gases, and waste products (10%). Option A is a function of the blood. Option B is incorrect, as plasma comprises 78% of the blood. Option D is true of reticuloendothelial system.

Question No: 17

A pediatric patient has been admitted to the hospital with multiple injuries including a fractured left humerus, left femur, and ribs. Because of the patient’s fractured ribs, the nurse should assess for signs of:

- A. Pulmonary edema
- B. Hematemesis
- C. Respiratory acidosis
- D. Pneumonitis

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Answer: C

Explanation: Because of the patient's fractured ribs, the nurse should assess for signs of respiratory acidosis. Pain causes shallow breathing that could result in the retention of carbon dioxide.

Question No: 18

A nine-year-old child was admitted to the hospital with a tentative diagnosis of leukemia. In order to confirm the diagnosis, a bone marrow aspiration is scheduled. Aside from giving an age-appropriate explanation of the procedure, the nurse should:

- A. Administer the prescribed sedative before the procedure
- B. Position the child in semi-fowler's position, supported by pillows
- C. Let the child hold some equipment that is not sterile
- D. Tell the child that there will be no pain, only pressure will be felt

Answer: A

Explanation: Aside from giving an age-appropriate explanation of the procedure, the nurse should administer the prescribed sedative before the procedure. This action minimizes discomfort. The child will be placed in prone position, with a rolled towel under the hips.

Question No: 19

A nurse is caring for a three-year-old patient with a diagnosis of congestive heart failure. The nurse notes that the apical pulse is 118 beats per minute and is about to administer Lanoxin. Based on this finding, the nurse should:

- A. Administer the medication as ordered
- B. Recheck the apical pulse after twenty-thirty minutes
- C. Hold the medication
- D. Notify the physician

Answer: A

Explanation: Based on this finding, the nurse should administer the medication as ordered. The

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finding is within the normal range of 80-120 beats per minute.

Question No: 20

Among adults, body fluids are primarily intracellular with slightly less extracellular fluid. In infants and children, all of the following but one is true about extracellular fluid:

- A. At three years of age, the balance between ICF and ECF is more like that in adults
- B. Infants and children have proportionately less extracellular fluid than adults
- C. At birth, more than half of the child's weight is ECF
- D. three years of age, the extracellular fluid is about 45% from interstitial fluid, plasma, and transcellular fluid

Answer: B

Explanation: In infants and children, all of the listed facts are true about extracellular fluid except that infants and children have proportionately less extracellular fluid than adults. They actually have proportionately more extracellular fluid as compared to adults.

Question No: 21

A nurse is aware that the physiologic compensatory mechanism that is activated to counteract the effects of acid-base imbalance in a child with severe dehydration is:

- A. Extremely high body temperature
- B. Renal retention of hydrogen ions
- C. Increased respirations
- D. Profuse diaphoresis

Answer: C

Explanation: A nurse is aware that the physiologic compensatory mechanism that is activated to counteract the effects of acid-base imbalance in a child with severe dehydration is increased respirations. In metabolic acidosis, the lungs try to compensate by blowing off excess carbonic acid in the form of carbon dioxide.