2091 (1)**ANSWER: B**, **C, E**

A. A tongue blade inserted into the adolescent's mouth during a seizure can cause injury.
B. Padding protects the adolescent's limbs from injury against the hard side rails during a seizure.
C. Airway obstruction can occur during or after the seizure. An oropharyngeal airway should be available but should not be inserted during the seizure. If the seizure has commenced, nothing should be forced into the adolescent's mouth.
D. The etiology is unknown. Only if an airborne or droplet infectious disease were suspected as the cause would droplet precautions be considered.
E. Suctioning equipment may be needed to clear secretions after the seizure.

2092(2). **ANSWER: C**

A. Myoclonic seizure involves muscle movement and not just lost of awareness.
B. Febrile seizures occur when the child's temperature is excessively elevated and usually includes tonic-clonic muscle movement.
C. An absence seizure is a generalized seizure (involving loss of awareness) that might involve minor motor movements (e.g., eye blinking). The child appears to be staring.
D. Atonic means absence of tone and would involve loss of muscle control and not eye blinking, which requires muscle control.

2093(3). **ANSWER: A**

A. For most children, absence seizures stop during early teen years.
B. Absence seizures rarely progress to other seizures-
C. Teachers often note signs of absence seizures, but seeing them is not adequate for diagnosis.
D. Absence seizures usually exist in isolation; usually the child has no other neurological condition.

2094(4). **ANSWER: A**

A. Gingival hyperplasia (overgrowth of gum tissue) is unique to phenytoin (Dilantin) among antiepileptic medications. About 20% of people taking phenytoin have gingival hyperplasia. This can be minimized with thorough oral care.
B. Valproic acid (Depakote) does not have a side effect of gingival hyperplasia.
C. Gingival hyperplasia is not a side effect of carbamazepine (Tegretol).
D. Gingival hyperplasia is not a side effect of phenobarbital (Luminal).

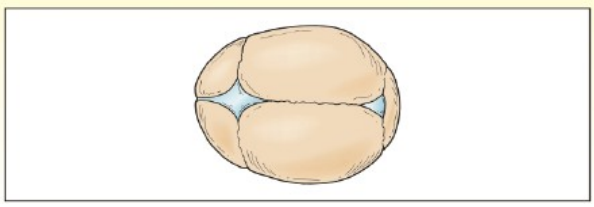
2095(5). **ANSWER: B**

A. While an increasing temperature may be associated with ICP, it may also be due to an infection. It is more important for the nurse to report the widened pulse pressure as a sign of increased ICP.
B. A widened pulse pressure (increased systolic BP and a decreased diastolic BP) is one of the signs of Cushing's triad and is indicative of ICP.
C. Bradycardia (not tachycardia) is associated with ICP.
D. An increased systolic BP (not decreased systolic BP) is another sign of Cushing's triad.

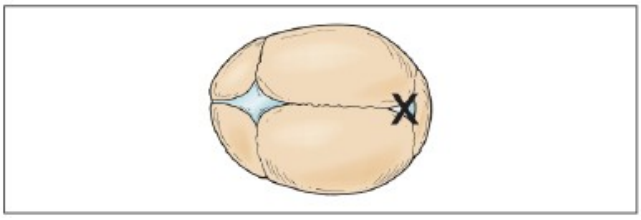
2096(6). **ANSWER: D**

A. A score of 0 is not possible on the Glasgow Coma Scale. The lowest possible score is 3.
B. A score of 3 on the Glasgow Coma Scale indicates that the child has an absent eye opening, verbal, and motor response. This score is not expected with a mild head injury.
C. A score of 10 on the Glasgow Coma Scale indicates an altered eye opening, verbal, or motor response and would not be expected with a mild head injury.
D. Glasgow Coma Scale scores range from 3 (no response) to 15 (normal response). A score of 15 indicates that brain function is intact. A child with a mild head injury should have intact neurological function.

7. The nurse is palpating the fontanelles of an infant hospitalized with a head injury. Which area should the nurse palpate to assess the posterior tbntanelle? Place an X on the posterior fontanel.



ANSWER:



8. The pregnant client learns that her unborn child might have a neural tube defect. In response to the woman's question about neural tube defects, the nurse describes one possible defect. Which neural tube defect is the nurse describing when stating that the vertebral arch fails to close and the spinal cord and meninges stay within the vertebral canal?

A. Meningocele

B. Spina bifida occulta
C. Spina bifida cystica
D. Myelomeningocele

ANSWER: B

9. The nurse is caring for a child who had spina bifida (myelodysplasia) at birth and has knee deformities, detrusor hyperreflexia, dyssynergia, and problems with constipation. Which is most important for the nurse to include in the child's plan of care?

A. Avoid the child's exposure to latex.
B. Do intermittent urinary catheterization.
C. Provide dietary fiber supplements daily.
D. Complete a referral for physical therapy.

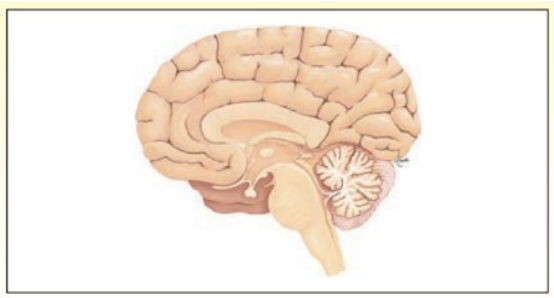
ANSWER: A

10. The child had a myelomeningocele that was diagnosed at birth and surgically corrected. Which instruction should the nurse include when reinforcing teaching with the parents about safety considerations?

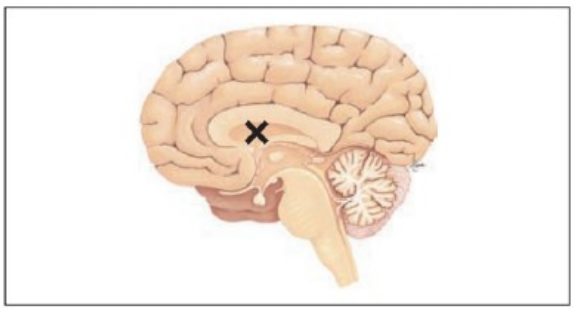
A. Make sure braces lie smoothly against the child's skin.
B. Ensure that the child shifts position at least every 3 hours.
C. Place a blanket between the child and the wheel- chair seat.
D. Check all of the child's skin daily for redness or irritation.

ANSWER: D

11 . The child is being screened for hydrocephalus. In teaching the parents about the condition, the nurse illustrates the location of the lateral ventricle. Place an X on the area the nurse should point out to the parents.



ANSWER:



12. The nurse is caring for multiple hospitalized children. In which conditions might the nurse assess for the presence of papilledema? Select all that apply.

A. Eczema
B. Craniosynostosis
C. Shaken baby syndrome
D. Hydrocephalus
E. Chest trauma

ANSWER: B, C, D

13. The nurse is caring for the child immediately following insertion of a ventriculoperitoneal (VP) shunt for treatment of hydrocephalus. Which intervention(s) should the nurse include in the child's plan of care?

A. Maintain the head of the bed in an elevated position.
B. Ensure that the child minimizes movement of the extremities.
C. Provide a pressure dressing over the cephalic insertion site.
D. Maintain a flat position and reposition the child every 2 hours.

ANSWER: D

14. The 7-year-old child may have hydrocephalus secondary to a malignancy. Which assessment findings should the nurse associate with the development of hydrocephalus? Select all that apply.

A. Headache
B. Vomiting
C. Angioedema
D. Personality change
E. Increased head circumference

ANSWER: A, B, D

15. The HCP's progress note states that the infant with meningitis is in an opisthotonus position. What should the nurse observe when performing an assessment?

A. Resistance with specific leg movement
B. Knee or hip flexion with head flexion
C. A high-pitched cry with neck flexion
D. Hyperextension of the head and neck

ANSWER: D

16. The nurse is planning teaching about bacterial meningitis for a group of parents. Which statement should the nurse include when teaching the parents?

A. Symptoms of meningitis often develop over time, making it easier to diagnose than other infections.
B. Having a seizure associated with a high temperature usually indicates a problem other than meningitis.
C. High-risk children 2 to 10 years and other children 11 years and older should receive the meningococcal conjugate vaccine (MCV4).
D. Intravenous antibiotics are administered to family members who may have been in close contact with the child.

ANSWER: C

17. The nurse is admitting a hospitalized child newly diagnosed with Reye's syndrome. Which action by the nurse would be most appropriate?

A. Determining if the child had a bacterial infection recently
B. Placing the child in a private room with droplet precautions
C. Taking the child to the unit's play area to interact with others
D. Assessing for signs of bleeding and for prolonged bleeding time

ANSWER: D

18. The child with autism has been admitted to a four-bed ward on a pediatric unit. What should the nurse admitting the child do about the room assignment?

A. Request that the child be transferred to a private room.
B. Request that the child be transferred to a double room.
C. Admit the child to the room that has been preassigned.
D. Request that the child be assigned to an isolation room.

ANSWER: A

19. The school nurse learns that the parents wish to enroll their 5-year-old child in school. Their child has autism. When preparing to meet with the parents and child, which behaviors should the nurse anticipate that the child might display? Select all that apply.

A. Polydactyly
B. Leukoderma
C. Poor eye contact
D. Restricted interests
E. Atypical language

ANSWER: C, D, E

20. The nurse is preparing to care for the hospitalized child with autism. Which intervention should the nurse implement?

A. Hold and stroke the child while doing the assessment
B. Play the radio or turn on the television for distraction
C. Have the parent bring the child's favorite toy from home
D. Provide plenty of age-appropriate foods on the meal tray

ANSWER: C

21 . The nurse is completing a health history and physical assessment for the 4-year-old who has spastic-type CP. Which statements made by a parent indicate that appropriate care is being provided? Select all that apply.

A. "I perform range of motion (ROM) exercises every 4 hours to help prevent contractures."
B. "I give my child a therapeutic massage after the stretching exercises to help manage pain."
C. "I minimize the calories I provide with meals because my child is more prone to obesity."
D. "I have my child wear a helmet during the day because of chronic tonic-clonic seizures."
E. "Using utensils with large, padded handles makes it easier for my child to feed himself."

ANSWER: A, B, D, E

22. The nurse is preparing to teach the child who has CP. What is the most important factor for the nurse to consider when teaching the child?

A. Current age
B. Type of cerebral palsy
C. Prior illness experience
D. Developmental level

ANSWER: D

23.During a physical exam on the 18-month-old, the nurse observes genu varum. What should the nurse do?

A. Document the finding as normal
B. Report this finding to the HCP
C. Teach the parents about rickets
D. Prepare the parent about using braces

ANSWER: A

24. The nurse is planning to develop teaching materials for new mothers. The nurse should plan to include information about which common practice that can increase the risk for developmental dysplasia of the hip (DDH)?

A. Carrying a child in a backpack
B. Carrying a child in a frontpack
C. Swaddling of a child
D. Extended time in a car seat

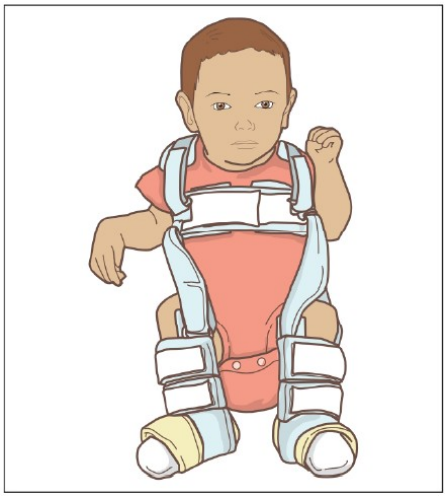
ANSWER: C

25. The HCP is adducting the newborn's hip while pushing the thigh forward to detect developmental dysplasia of the hip (DDH). The nurse should identify this screening test as which maneuver?

A. Barlow maneuver
B. Pavlik maneuver
C. Gowers maneuver
D. Allis maneuver

ANSWER: A

26. The nurse is preparing to teach the family of an infant with developmental dysplasia of the hip how to apply the Pavlik harness illustrated that has white velcro straps. Place the steps for applying the harness in the correct sequence.



A. Connect the chest halter and leg straps in front.
B. Position the legs and feet in the stinups.
C. Connect the chest halter and leg straps in back.
D. Position the chest halter at nipple line and fasten with Velcro.
E. Be sure the hips are flexed and abducted before fastening with Velcro.

ANSWER: D, B, E, A, C

27. The child has a newly applied fiberglass hip-Spica cast. Which interventions should the nurse implement? Select all that apply.

A. Use a hair dryer on a low setting to help dry the cast.
B. Place on a Bradford frame for elevation off the bed.
C. Place pillows to support the child's lower extremities.
D. Turn the child every 2 hours and monitor the CMS.
E. Petal the perineal area and other edges of the cast.

ANSWER: C, D, E

28. The nurse is educating the family whose child is newly diagnosed with scoliosis. What is the goal of therapy as explained by the nurse?

A. Limit or stop progression of the curvature of the spine.
B. Prepare the child for surgical correction at a later date.
C. Minimize the complications of prolonged immobilization.
D. Develop a pain management plan to minimize complications.

ANSWER: A

29. The nurse is teaching the adolescent who requires surgical treatment for scoliosis- Which is the nurse's best explanation regarding the goal of the surgery?

A. "The surgery will allow you to grow to be taller."
B. "The surgery will decrease the recurrence of pain."
C. "The surgery will prevent problems with breathing."
D. "The surgery will allow your clothes to fit you better."

ANSWER: C

30. The nurse is completing a thorough assessment of the spine. The nurse is concerned about the spinal curve in the young child and documents the exaggerated lumbar curve. Which condition was likely documented?

A. Scoliosis
B. Lordosis
C. Kyphosis
D. Kyphoscoliosis

ANSWER: B

31 . The school-aged child has an Ilizarov external fixator applied to a lower extremity for bone lengthening. Which intervention should the nurse implement when caring for the child?

A. Loosening the bolts and lengthening the rods on the fixator every other day
B. Cleansing the extemal fixator pin sites with sterile saline twice daily
C. Discouraging the child from bearing any weight on the involved extremity
D. Removing sections of the fixator apparatus when the child is positioned in bed

ANSWER: B

32. The nurse at the high school works with the trainers to develop early identification of injuries. The nurse teaches the trainers that adolescent soccer players are at increased risk for which abnormality?

A. Varus knee deformities
B. Valgus knee deformities
C. Varus ankle deformities
D. Valgus ankle deformities

ANSWER: A

33. The child with hip pain for several months was diagnosed with Legg-Calvé-Perthes disease. What should the nurse emphasize when preparing to teach the child and family about the treatment?

A. Once treatment starts, it will likely continue for about 6 months.
B. The treatment goal is a pain-free joint with full range of motion.
C. Activities requiring hip adduction are encouraged for joint placement.
D. Most of the treatments will be completed while the child is hospitalized.

ANSWER: B

34. The parents of the child with Duchenne muscular dystrophy just learned that children with the disease have a limited life expectancy. Which explanation by the nurse is best when the parents ask how their child will be treated knowing that the life expectancy is limited?

A. "Due to your child's cognitive impairment, your child will be unaware of a shortened life."
B. "We will focus on maximizing your child's abilities and promoting your child's comfort."
C. "There is not enough known about this disease to know what will happen in the future."
D. "Nothing is likely to happen for a long time; we'll deal with it when the time comes."

ANSWER: B

35. The nurse is working with the parents and their son who was newly diagnosed with Duchenne muscular dystrophy (DMD). The mother tells the nurse that she is pregnant. She is concerned that her unborn child, who is a girl, may also develop DMD because the mother's brother and son have DMD- Which response by the nurse is most appropriate?

A. "You already have one child with muscular dystrophy; it's unlikely you'll have another."
B. "Your brother and son have DMD; it's unlikely that you'll have another child with DMD."
C. "As many as one-third of children born with DMD have no family history of the disease."
D. "If your unborn child is a girl, she may carry the gene, but she will not develop DMD."

ANSWER: D

36. The nurse is assessing the 4-year-old with Duchenne muscular dystrophy (DMD). Which observation indicates that the child has a Gowers sign?

A. Rises from the floor to stand by walking the hands up the legs
B. Unable to initiate an effective cough or expectorate secretions
C. Has difficulty lifting the head and supporting it in an upright position
D. Tests at a high IQ and is advanced for the child's developmental age

ANSWER: A

37. The school nurse assesses that the child who is crying and in pain sustained a twisting injury of the right arm. What interventions should the nurse implement? Select all that apply.

A. Elevate the arm and apply ice at the site of the child's injury.
B. Wrap the child's arm with an elastic bandage.
C. Telephone the child's parent to discuss the injury.
D. Call the health care provider identified by the child.
E. Make arrangements to obtain an x-ray of the child's arm.
F. Meet with the student who caused the child's injury.

ANSWER: A. B. C

38. The child is admitted to an ED with a dislocated kneecap that occurred while skiing. Which most immediate treatment by the HCP should the nurse anticipate?

A. Open surgical intervention to repair the kneecap
B. Arthroscopy to surgically repair the torn cartilage
C. Realignment of the kneecap by sliding it back into position
D. Application of a cast to the affected leg until the kneecap heals

ANSWER: C

39. The child with myelodysplasia has a TEV (talipes equinomrus) repair that requires a cast application. In the postoperative period, the nurse notes serosan- guineous drainage on the cast. What should the nurse do after making this observation?

A. Cut a window where the drainage is seeping through the cast.
B. Petal the cast to minimize skin irritation and decrease leakage.
C. Measure the area of drainage on the cast and document this.
D. Telephone the surgeon to report the serosan-guineous drainage.

ANSWER: C

40. The nurse is planning teaching for parents of children with genetic conditions. The parent of the child with which condition would be excluded from the teaching session?

A. Spina bifida
B. Osteomyelitis
C. Muscular dystrophy
D. Tourette's syndrome

ANSWER: B

41 . The nurse is teaching parents of a child with juvenile arthritis. How should the nurse explain the purpose of methotrexate in treating their child?

A. Improves functional ability
B. Controls the febrile response
C. Minimizes the effects of uveitis
D. Decreases the inflammatory response

ANSWER: D

42. The 10-year-old, who is Chinese, is scheduled to receive methotrexate to treat IRA. Which information in the child's medical record illustrated should prompt the nurse to withhold the dose and contact the HCP?

History and Physical (H&P)	Laboratory Findings
• Age of onset 3 years • Onset after severe illness • Stiffness, swelling of hip joints with some loss of motion • Stiffness worse upon rising after sleep • No family history of JRA • Chinese ethnicity • Had last acupuncture treatment 9 days ago • Indirect moxibustion by chiropractor 1 mo ago	• Urine pH 7.4 • Hgb 13 g/dL • Serum creatinine 2.2 mg/dL • ALT 38 international units/L

Vital Signs	Physical Assessment
• T: 100.1°F • BP: 124/69 mm Hg • P: 102 bpm • RR: 28 bpm	• Joint pain 10 out of 10 • Crying with movement • Limited movement due to pain • Respirations, deep and labored • Had nausea after eating lunch of yang ("hot" foods); no emesis

A. H&P documentation
B. Laboratory findings
C. Vital signs abnormalities
D. Physical assessment findings

ANSWER: B

43. The nurse is teaching the parents about how to care for their infant with osteogenesis imperfecta (01). Which statement should the nurse include in the instructions?

A. "Check the color of your infant's nailbeds and mucous membranes for signs of circulatory impairment."
B. "If you note signs of infection, bring your infant to the clinic because the infant has a significant immune dysfunction."
C. "Protect your infant from injury and handle your baby carefully because your infant's bones can break very easily."
D. "Notify your physician if your infant does not respond to sound because the infant's CNS fails to develop completely."

ANSWER: C

44. During a physical examination of the 1-month-old, the nurse notes that the infant has blue sclerae. The nurse should further assess for signs and symptoms of which disorder?

A. Juvenile rheumatoid arthritis (JRA)
B. Tay-Sachs disease
C. Duchenne muscular dystrophy (DMD)
D. Osteogenesis imperfecta (OI)

ANSWER: D

45. The teen is brought to an ED with a possible SCI. To minimize the extent of the damage to the spinal cord, which classification of medication should the nurse expect to administer?

A. An antibiotic
B. An analgesic
C. A steroid medication
D. An antihypertensive medication

ANSWER: C

46. The nurse is teaching the adolescent who has 21 T12 SCI about the need to be diligent about skin protection. The nurse explains that the primary reason for the client's increased risk for altered skin integrity is due to which factor?

A. The inability to perceive extremes in temperature leading to burns
B. The inability to feel skin irritation such as wrinkled linens or clothing
C. The increased likelihood of bowel and bladder dysfunction and skin irritation
D. The circulatory changes that cause vasoconstriction and decreased blood supply

ANSWER: B

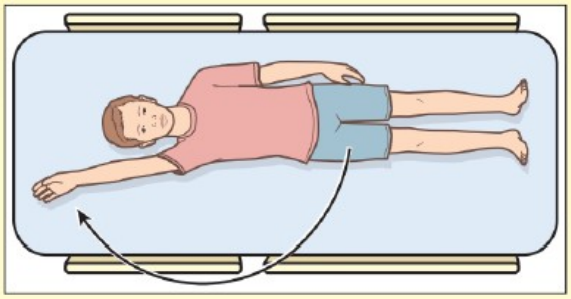
47. The nurse is caring for the 14-year-old who has a neurogenic bladder from an SCI with a lower motor neuron lesion occurring 2 years previously. Which intervention for bladder emptying should the nurse plan to implement?

A. Intermittent catheterization
B. Insertion of a retention catheter
C. Insertion of a suprapubic catheter
D. Giving an anticholinergic medication

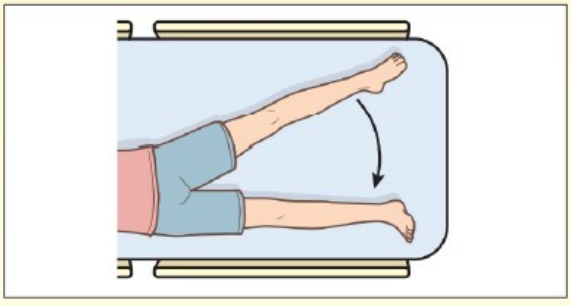
ANSWER: A

48. The nurse is teaching the parent of a 10-year-old who had an SCI about ROM exercises. Which illustration demonstrates abduction?

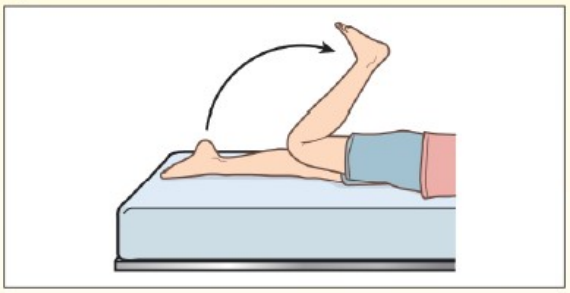
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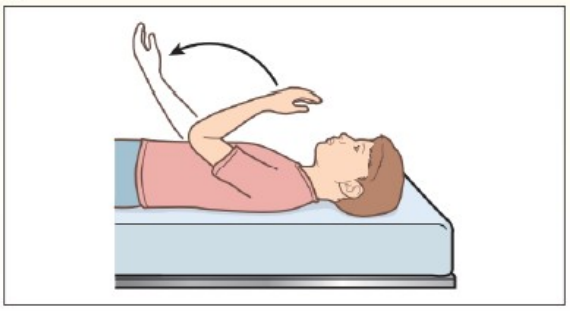
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ANSWER: A

49. The child with an SCI is prescribed baclofen 5 mg tid orally to treat muscle spasticity. How many tablets should the nurse administer for one dose if 20-mg tablets are available?

_____ tablet (Record your answer rounded to the nearest hundredth.)

ANSWER: 0.25

50. The nurse is preparing to assess the 9-year-old who has mental retardation with an IQ level of 45. Which level of participation should the nurse expect?

A. Able to communicate verbally only with two- letter words
B. Able to read and comprehend simple written instructions
C. Able to walk independently and perform a simple skill
D. Able to perform tasks that require careful manual dexterity

ANSWER: C