PREBOARD-NURSING PRACTICE III

1. Whichof the following would the nurse identify as an advantage to using a cervical cap for contraception?

a. Provides continuous protection for 48 hours
b. Is disposable and available over the counter
c. Allows Spermicide application 2 hours before intercourse
d. Minimizes risk for allergic reactions to plastic

2.Which of the following statements by a male client would indicate that he understands the instructions for use of a condom?

a. "I should lubricate the condom with an oil-based product to avoid friction that could rupture the condom."
b. "I should unroll the condom and check it for holes before applying it."
c. "I should hold the rim of the condom while withdrawing my penis from the vagina to avoid leakage."
d. "I should begin sexual intercourse without the condom and don the condom just before ejaculation."

3.A woman using a diaphragm for contraception should be instructed to leave it in place for at least how long after intercourse?

a. 1 hour
b. 6 hours
c. 12 hours
d. 28 hours

4.The client has completed an at-home pregnancy test with positive results. Which of the following indicates that the client understands the meaning of the test results?

a. "I understand that this means I have ovulated in the past 24 hours."
b. "I understand that this means I am not pregnant."
c. "I understand that this means I might be pregnant."
d. "I understand that this means I am pregnant."

5.When describing to a client how a pregnancy test works, the nurse understands that which of the following hormones is being evaluated?

a. Human chorionic gonadotropin
b. Estrogen
c. Follicle-Stimulating hormone
d. Progesterone

6.A pregnant client asks about the function of the placenta. Which of the following should the nurse include in the teaching plan?

a. The placenta filters fetal urine
b. Fetal and maternal blood mix in the placenta to exchange nutrients
c. The placenta filters alcohol from the mother's blood
d. Substances are exchanged by the placenta without mixing maternal and fetal blood.

7.A client is pregnant with twins, a boy and a girl, and she asks if they will be identical. The nurse's best response is:

a. "They are not identical because the ultrasound showed one was bigger than the other."
b. "I'll discuss this with the doctor and give you a call later."
c. "We won't know until the babies are delivered."
d. "The twins are not identical. Identical twins are always the same sex."

8.Which of the following hormones stimulates the ovary to produce estrogen during the menstruation cycle?

a. Follicle stimulating hormone (FSH)
b. Gonadotropic releasing hormone (GnRH)
c. Luteinizing hormone (LH)
d. Human chorionic gonadotropin hormone (HCG)

9.A 24-year old woman comes to the physician's office for a routine check-up at 34 weeks gestation. Abdominal palpation reveals the fetal position as right occipital anterior (ROA). To which of the following sites would the nurse expects to find the fetal heart tones.

a.Below the umbilicus, on mother's left side.
b.Below the umbilicus, on mother's right side.
c. Above the umbilicus, on mother's left side.
d.Above the umbilicus, on mother's right side.

10. The client has come to the clinic because she suspects that she is pregnant. Which of the following would be the most definitive way to confirm the diagnosis?

a. Client's report of amenorrhea for 3 months
b. Positive Hegar's sign
c. Pigmentation changes of the breasts
d. Palpation of fetal movement by the care provider.

11. The client's prenatal education includes danger signs to report. Which of the following, if reported, would indicate that the client understood the teaching?

a. Dizziness and blurred vision
b. Occasional nausea and vomiting
c. No bowel movement for 3 days
d. Ankle edema.

12. The nurse in the prenatal clinic is planning care for a pregnant 15-year –old client. The nurse knows that this adolescent is at risk for which of the following maternal complications?

a.Postpartum hemorrhage
b.Hypoglycemia
c. Cesarean birth
d.Pre-eclampsia

13. Which of the following nursing actions would take priority when caring for the woman with a suspected ectopic pregnancy?

a. Administer oxygen
b. Monitor vital signs
c. Obtaining surgical consent
d. Providing emotional support.

14. A client with pre-eclampsia is receiving magnesium sulfate and oxytocin (Pitocin) to induce labor at 38 weeks. What is the main indication of the magnesium sulfate for this client?

a. Lower blood pressure
b. Prevent convulsions
c. Provide sedation
d. Soften stools

15. The nurse is counseling a prenatal client regarding the need to take folic acid supplements during pregnancy. The nurse also encourages the client to eat foods high in folic acid, such as:

a. Fruits and fruit juice
b. Rice and Pasta
c. Eggs and yogurt
d. Fresh green leafy vegetables and legumes

16. On which of the following areas would the nurse expect to observe chloasma?

a. Breast, areola, and nipple
b. Chest, neck, arms, and legs

c. Abdomen, breast, and thighs
d. Cheeks, forehead, and nose

17. The client is concerned about facial chloasma that has developed since her last prenatal visit. The best response by the nurse is:

a. "You should apply a facial skin bleach twice a day."
b. "Avoiding sun exposure may keep the pigmentation from getting any darker."
c. "This is a permanent condition caused by hormonal changes. You may be able to cover it with makeup."
d. "This is a condition associated with the development of skin cancer. I will make an appointment for you with a dermatologist."

18. An antepartal client at 29 weeks gestation is assessed in the prenatal clinic. All assessment data are within normal limits. When should the nurse schedule the client's next appointment?

a. In one week
b. In 2 weeks
c. In 3 weeks
d. In 4 weeks

19. When PROM occurs, which of the following provides evidence of the nurses understanding of the client's immediate needs?

a. The chorion and amnion rupture 4 hours before the onset of labor.
b. PROM removes the fetus' most effective defense against infection.
c. Nursing care is based on fetal viability and gestational age.
d. PROM is associated with malpresentation and possibly incompetent cervix.

20. A client who is 34 weeks gestation has been having contractions every 10 minutes regularly. In addition to instructing her to lie down and rest while continuing to time contractions, the nurse should also tell her to:

a. Refrain from eating or drinking anything
b. Take slow deep breathes with each contraction
c. Go to the hospital if contractions continue for more than 1 hour
d. Drink 3 to 4 cups of water.

21. The nurse is caring for a laboring client with a known history of cocaine abuse. What complication is most likely for this client?

a. Placenta previa
b. Prolapsed cord
c. Abruption placenta
d. Polyhydramnios

22. When taking an obstetrical history on a pregnant client who states, "I had a son born at 38 weeks' gestation, a daughter born at 30 weeks' gestation, and I lost a baby at about 8 weeks, "the nurse should record her obstetrical history as which of the following?

a. G2 T2 P0 A0 L2
b. G3 T1 P1 A0 L2
c. G3 T2 P0 A0 L2
d. G4 T1 P1 A1 L2

23. A pregnant client states that she "waddles" when she walks. The nurse's explanation is based on which of the following as the cause?

a. The large size of the newborn
b. Pressure on the pelvic muscles
c. Relaxation of the pelvic joint
d. Excessive weight gain

24. According to Rubin, during which of the following periods would the new mother frequently review her labor and delivery experience?

a. Letting-down
b. Letting-go

c. Taking-hold
d. Taking-in

25. The nurse discovers a loop of the umbilical cord protruding through the vagina when preparing to perform a vaginal examination. The most appropriate intervention is to:

a. Call the physician immediately
b. Place a moist clean towel over the cord to prevent drying
c. Immediately turn the client on her side and listen to the fetal heart rate.
d. Perform the vaginal examination and apply upward digital pressure to the presenting part while having the mother assume a knee-chest position.

26. A nurse is planning to perform Leopold's maneuvers on a laboring client. What should be the nurse's initial action?

a. Position client in a supine position
b. Have the client void
c. Wash hands in warm water
d. Apply sterile lubricant to the abdomen

27. One hour after delivery, assessment reveals the client's uterus is one-finger breath below the umbilicus and deviated to the right of midline. Which of the following would be the nurse's priority action at this time?

a. Assist the mother to void
b. Vigorously massage the fundus
c. Administer additional oxytocin to contract the uterus
d. Give a tocolytic drug intravenously

28. The nurse is assessing the fundal height of a client at 26 weeks gestation. The nurse should expect the fundus to be:

a. Level with the umbilicus
b. Halfway between symphysis and umbilicus
c. Slightly below ensiform cartilage
d. At 26cm.

29. The plan of care for the pregnant client who experienced an unexplained intrauterine fetal demise during her last pregnancy should include:

a. Education on the cause of intrauterine fetal demise given to both parents
b. Encouragement to think positively and not dwell on the previous fetal loss
c. Support for increased fears as this fetus reaches the gestational age of the previous fetal loss.
d. Facilitation of grieving of the lost fetus through carrying a photo and a lock of hair at all times.

30. The nurse is evaluating an intrapartal client's lab results. Which laboratory finding should the nurse report to the physician or nurse-midwife?

a. Hematocrit: 45%
b. Leukocyte count: 19,000/mm
c. Platelets: 120,000/mm
d. White blood count: 11,000/mm

31. The client has been having contractions every 5 minutes for 7 hours. Which factor is used to determine if this is true or false?

a. The cervix is effacing and dilating
b. This is the client's second baby
c. The contractions are becoming more intense and lasting longer.
d. The membranes have ruptured.

31. After 4 hours of active labor, the nurse notes that the contractions of a primigravid client are not strong enough to dilate the cervix. Which of the following would the nurse anticipate?

a. Obtaining an order to begin IV oxytocin
b. Administering a light sedative to allow the patient to rest for several hours
c. Preparing for cesarean section for failure to progress
d. Increasing the encouragement to the patient when pushing begins.

32. During which of the following stages of labor would the nurse asses “crowning”?

a. First stage
b. Second stage
c. Third stage
d. Fourth stage

33. The highest priority in nursing care of the laboring client is:

a. Pain relief measures are offered that are acceptable to the client.
b. The client’s partner is involved with the labor and delivery
c. Appropriate fluid intake is monitored
d. Fetal response to the labor is assessed.

34. Which of the following fundal heights indicates less than 12 weeks’ gestation when the date of the LMP is unknown?

a. Uterus in the pelvis
b. Uterus at the xiphoid
c. Uterus in the abdomen
d. Uterus at the umbilicus

35. Which of the following danger signs should be reported promptly during the antepartum period?

a. Constipation
b. Breast tenderness
c. Nasal stuffiness
d. Leaking amniotic fluid

36. FHR can be auscultated with a fetoscope as early as which of the following?

a. 5 weeks’ gestation
b. 10 weeks’ gestation
c. 15 weeks’ gestation
d. 20 weeks’ gestation

37. A client at 8 weeks’ gestation calls complaining of slight nausea in the morning hours. Which of the following client interventions should the nurse question?

a. Taking 1 teaspoon of bicarbonate of soda in an 8-ounce glass of water
b. Eating a few low-sodium crackers before getting out of bed
c. Avoiding the intake of liquids in the morning hours
d. Eating six small meals a day instead of three large meals

38. A client with severe pre-eclampsia is admitted with a BP 160/110, proteinuria, and severe pitting edema. Which of the following would be mot important to include in the client’s plan of care?

a. Daily weights
b. Seizure precautions
c. Right lateral positioning
d. Stress reduction

39. The client is receiving intravenous magnesium sulfate at 2 g/h to stop premature labor. The most important nursing assessments of this client include:

a. Intake and output, level of consciousness, and blood pressure.
b. Blood pressure, pulse, and uterine activity
c. Deep tendon reflex, hourly urine output, and respiratory rate
d. Intake and output, blood pressure, and reflexes.

40. A client's amniotic fluid is greenish-tinged. The fetal presentation is vertex. Fetal heart rate (FHR) and uterine activity have remained within normal limits. At the time of delivery, the nurse should anticipate the need for:

a. An infant laryngoscope and suction catheters
b. Forceps
c. A transport isolette
d. Emergency cesarean set-up

41. Following amniotomy, the most important nursing action is to:

a. Reposition the mother on her left side
b. Place a clean underpad on the bed
c. Listen to fetal heart tones
d. Observe the color and consistency of the amniotic fluid

42. Assessment of a normal episiotomy immediately post delivery is most likely to reveal:

a. Gaping between the sutures
b. Slight bruising
c. Pus coming from the sutures
d. Edema that makes the tissue looks shiny.

43. If the fetal head is determined to be presenting in a position of complete extension, the nurse should anticipate a:

a. Precipitous labor and delivery
b. Prolonged labor and possible cesarean delivery
c. Normal labor and spontaneous vaginal delivery
d. Forceps-assisted vaginal delivery.

44. A nurse is caring for four postpartum clients who each have an order for Methergine (methylgonovine maleate). Based on the data collected during the nurse's initial shift assessment, which client would not receive the medication?

a. The client with a blood pressure of 156/94
b. The client with a hematocrit of 33%
c. The client with a white blood cell count of 22,000
d. The client with a temperature of 101˚F

45. A 22-year old woman is admitted to the hospital and delivers a healthy 7lbs 2 oz girl. The mother decides to bottle-feed her infant. Which of the following statements, if made by the mother after a teaching session, indicates to the nurse that the patient needs further teaching?

a. "I'll pump my breast and use warm packs to relieve breast pain."
b. "I'll use a tight bra and ice packs to relieve engorgement discomfort."
c. "I'll take the medication prescribed by the doctor for pain."
d. "I'll take the pills ordered by my doctor to help stop the production of milk."

46. The nurse in the postpartum unit cares for a 27-year old woman who delivered her first child the previous day. During her assessment of the patient, the nurse notes multiple varicosities on the patient's lower extremities. The nurse should:

a. Teach the patient to rest in bed when the baby sleeps
b. Encourage early and frequent ambulation
c. Apply warm soaks for 20 minutes every four hours'
d. perform passive range of motion exercises three times daily

47. It is most important for the nurse to have which drug readily available when the client is being treated with heparin therapy for thrombophlebitis?

a. Calcium gluconate
b. Aquamephyton
c. Protamine sulfate
d. Ferrous sulfate

48. A priority intervention that the nurses do immediately after delivery is suctioning out the baby's mouth and nares. Why?

a.Suctioning decreases surface tension and prevents alveolar collapse.
b.Suctioning assists with increasing the pulmonary vascular resistance in the lungs, resulting in a decrease in the blood flow to the pulmonary bed.
c.Suctioning removes 80-110 ml of fluids that remain in the respiratory passages, permitting adequate movement of air.
d.Suctioning is not necessary because the birth process squeezes all fluid out of the lungs

49. The nurse is admitting a neonate 2 hours after delivery. Which assessment data should the nurse be concerned about?

a.Hands and feet blue
b. Nasal flaring
c.Minimal response to verbal stimulation
d.Apical heart rate 156

50. The nurse assesses the postpartum vaginal discharge (lochia) on four clients. Which of the following assessments would warrant notification of the physician?

a. A dark red discharge on a 2-day postpartum client
b. A pink to brownish discharge on a client who is 5 days postpartum
c. Almost colorless to creamy discharge on a client 2 weeks after delivery
d. A bright red discharge 5 days after delivery

51. The nurse assesses the vital signs of the client, 4 hours' postpartum that are as follows: BP 90/60; temperature 100.4°F; pulse 100 weak, thready; R 20 per minute. Which of the following should the nurse do first?

a. Report the temperature to the physician
b. Recheck the blood pressure with another cuff
c. Assess the uterus for firmness and position
d. Determine the amount of lochia

52. When preparing to listen to the fetal heart rate at 12 weeks' gestation, the nurse would use which of the following?

b. Stethoscope placed midline at the umbilicus
c. Doppler placed midline at the suprapubic region
d. Fetoscope placed midway between the umbilicus and the xiphoid process
e. External electronic fetal monitor placed at the umbilicus

53. Which of the following additional assessment findings would be most suspicious and lead the nurse to suspect postpartum "blues" in a client who is anxious and crying?

a. Loss of appetite, constipation, abdominal pain
b. Despondency, loss of appetite, difficulty sleeping
c. Increased appetite, urinary retention, diarrhea
d. Poor concentration, constipation, diarrhea

54. Which of the following would the nurse expect to find when assessing a client who delivered a newborn 12 hours ago?

a. Lochia alba
b. Soft boggy fundus
c. Transient tachycardia
d. Complaints of hunger

55. Which of the following intervention results in convection heat loss in the newborn?

a. Removal from an incubator for procedures
b. Placing the newborn on a cold surface, such as scale
c. Giving a bath
d. Placing the isolette near a cold surface such as window or outside wall

56. The initial respirations in the newborn are a result of which of the following?

a. A rise in temperature.
b. A change in pressure gradients
c. Increased blood pH
d. Decreased blood CO2 level

57. The nurse determines that teaching about sudden infant death syndrome (SIDS) has been effective when the client states:

a. "No definite cause of death is found at autopsy."
b. "The cause is a brain malformation.'
c. "Breast- feeding causes sudden infant death.'
d. "Genetic disorders are the cause of SIDS."

58. Which nursing diagnosis should be the highest priority when caring for a preterm newborn?

a. Ineffective thermoregulation related to lack of subcutaneous fat
b. Anticipatory grieving related to loss of "perfect delivery"
c. Imbalanced nutrition related to immature digestive system
d. Risk for injury related to thin epidermis

59. The parents of a 28-week-gestation neonate ask the nurse, "Why does he have to be fed through a tube in his mouth?" The nurse's best response is that:

a. It allows an accurate assessment of intake
b. The baby's sucking, swallowing, and breathing are not coordinated yet
c. The baby's stomach cannot digest formula
d. It helps prevent thrush

60. A mother is crying at baby's bedside. The most therapeutic response by the nurse is:

a."Don't worry. Everything will be fine."
b."Why are you upset?"
c."Would you like me to call the hospital chaplain?"
d."This must be hard for you."

61. Which behavior observed by the nurse indicates good bottle-feeding technique? The mother:

a. Keeps the nipple full of formula throughout the feeding
b. Props the bottle on a rolled towel

c. Points the bottle at the infant's tongue
d. Enlarges the nipple hole to allow for a steady stream of formula to flow

62. Which of the following criteria of gestational age must be assessed within 2 hours of birth for the results to be valid:

a. Breast tissue
b. Posture
c. Soles of feet creases
d. Scarf sign

63. The nurse test the newborn's Babinski reflex by:

a. Touching the corner of the newborn's mouth or cheek
b. Changing the newborn's equilibrium
c. Placing a finger in the palm of the newborn's hand
d. Stroking the lateral aspect of the sole from the heel upward and across the ball of the foot.

64. The nurse conducts a new parent support group for her community. Two mothers ask how their 8-month-old children can be so different in height and weight? What is the appropriate response?

a. This is an abnormality that should be referred to the physician.
b. One of the children is displaying a "growth spurt.
c. Rates of growth vary and individual differences occur for each child.
d. The sequence of growth and development is unpredictable for each child.

65. Children are usually brought to the clinic for health care by a parent. At what age is it appropriate for the nurse to question the child about presenting symptoms?

a. 3 years
b. 5 years
c. 7 years
d. 9 years

66. When sharing the purpose of the Denver Development Screening Test (Denver II) with parents of an 18-month-old, the nurse should explain that:

a. The Denver II is a test that will predict future intellectual ability.
b. The Denver II is a screening test used to detect children who may be slow in development.
c. The Denver II is used for early detection of speech disorders.
d. The Denver II measures psychological, cognitive, and social development.

67. 4-year-old scores two failures on the Denver II. Which of the following statements is most accurate?

a. The child is not as intelligent as expected for age and should be referred to a learning specialist.
b. The child has a speech problem and should be referred to a speech therapist.
c. The child is at risk for school problems and should be retested.
d. The failures are to be expected in preschoolers who may not be cooperative with testing.

68. What is the most important sign of readiness to watch for when toilet training the child?

a. ability to walk
b. able to indicate that the diaper is wet
c. physical and psychological readiness
d. exhibits willingness to please parents

69. The mother of a 12-month-old infant who is hospitalized is upset that she must leave her baby to go home for a short time. What should the nurse suggest to this concerned parent?

a. Return as soon as possible to attend to her daughter's needs.
b. Leave a personal article with the child and reassure her that she will return.
c. Call a family relative to stay at all times with the child when the mother leaves.
d. Ask a nurse to sit at the child's bedside in her absence.

70. Piaget identifies that the 2- to 7-year-old child is in a preoperational stage. The nurse observes a toddler take a toy from another. The nurse recognizes the child unable to put him- or herself in the place of another is displaying:

a. Centration.
b. Negativism.
c. Egocentrism.
d. Selfishness.

71. The nurse is discussing STIs with a 17-year-old student. To correctly plan the teaching lesson, the nurse utilizes Piaget's theory to determine the adolescent's cognitive abilities. The educational plan should be based on the:

a. Sensorimotor reactions.
b. Limited cause and effect understanding.
c. Concrete thinking.
d. Mature abstract thinking

72. The mother discusses with the nurse that her toddler asks every night for a bedtime story. The mother asks why the child does this. The nurse would explain that this behavior demonstrates:

a. Ritualism.
b. Object permanence.
c. Dependency.
d. Conservation.

73. The nurse provides anticipatory guidance to parents of a 3-year-old child. Instructions should include:

a. To restrain the child in the car seat facing rear in the back seat of the car.
b. The use of syrup of ipecac for accidental poisonings.
c. Drug and alcohol education.
d. The proper use of sports equipment.

74. A teenager refuses to wear the clothes his mother bought for him. He states he wants to look like the other kids at school and wear clothes like they wear. The nurse explains this behavior is an example of teenage rebellion related to internal conflicts of:

Answer: C
Erikson's theory of psychosocial development states that the child is faced with conflicts that need to be resolved. Erikson identifies stages of personality development. Identity vs. role confusion (12 to 19 years) is a period when adolescents search for answers regarding their future. During this time, the child rejects the identity presented by his parents and attempts to create his own identity. Identity is often based on peers.

75. Hospitalization of a child results in disturbance of the dynamics in family life. The most appropriate nursing diagnosis is:

a. Diversional activity deficit related to separations from siblings and peers.
b. Sleep patterns disturbance related to unfamiliar surroundings.

c. Altered family processes related to hospitalization.
d. Ineffective individual coping related to procedures.

76. The charge nurse is developing plans to reduce the stress of hospitalized, chronically ill children. Coping for these children will be improved if:

a. They are allowed 24-hour open visitation with their peers.
b. They are assigned a primary nurse.
c. They avoid making all decisions while hospitalized.
d. All tutoring is postponed until discharge

77. What should the nurse do first when preparing to do a physical assessment on a sleeping 8-month-old baby?

a. Measure the occipital-frontal head circumference.
b. Auscultate the heart and lungs.
c. Check the eyes for the red reflex.
d. Wake the baby

78. The nurse is preparing an 8-year-old child for a procedure. What is the most appropriate nursing intervention?

a. Provide visual aids, such as dolls, puppets, and diagrams in the explanation.
b. Provide a written pamphlet for the child to review prior to the procedure.
c. Discourage any display of emotional outbursts.
d. Request that parents wait outside while the nurse provides instructions to the child.

79. When assessing a child who complains of abdominal pain, what is the most appropriate nursing action?

a. Palpate the most painful area first.
b. Palpate for rebound tenderness.
c. Avoid painful areas until the end of the assessment.
d. Use deep palpation for abdominal tenderness.

80. When preparing to examine a preschool child, the nurse should:

a. Give detailed explanations to alleviate the child's anxiety.
b. Give reassurance and feedback to the child during the examination.
c. Suggest that the child act like "the big kids" when he or she is examined.
d. Say that the shirt is the only clothing that must be removed.

81. The pediatric nurse practitioner is working with a group developing school playgrounds. The playground designers must identify the major causes of potential injury for the school-aged child. The nurse explains that the most frequent accidents in school-age children involve:

a. Motor vehicles, diving, and drugs and alcohol.
b. Swing sets, drowning, and poisonings.
c. Bicycles, skateboards, and in-line skates.
d. Aspiration of food, plastic bags, and stairways.

82. A father brings his 5-year-old to the doctor's office for a well-child visit. The father is embarrassed by his child's behavior during the visit. The father states that every time the child comes for an immunization she begins to cry and scream. An appropriate response to this father is:

a. "All children have a major fear of needles; preschoolers often believe pain is a punishment."
b. "Your child most likely had a traumatic experience at an early age."

c. "Next time the mother should accompany the child for an immunization."
d. "It is best to ignore this type of behavior as the child is seeking attention

83. Whenever the parents of a 10-month-old leave their hospitalized child for short periods, he begins to cry and scream. The nurse explains that this behavior demonstrates that the child:

a. Needs to remain with his parents at all times.
b. Is experiencing separation anxiety.
c. Is experiencing discomfort.
d. Is extremely spoiled.

84. The mother of a 5-year-old expresses concern about her child who believes that "Grandma is still alive" 3 months after the grandmother's death. The nurse explains that:

a.Magical thinking often accounts for a preschooler who believes that dead people will come back.
b.There is a need for psychological counseling for this child and family.
c.This is a form of regression exhibited by the preschooler.
d.The child is in denial regarding Grandma's death.

85. A mother asks the pediatric nurse about what she should begin to feed her 6-month-old infant. The correct response is:

a. Egg whites are the least allergenic food to be introduced into the baby's diet.
b. Rice cereal is the first solid introduced that is least allergenic of the cereals.
c. Formula is the only source of nutrition given for the first year.
d. Fruits and vegetables are good sources of iron.

86. The nurse would assess for which of the following as the most frequent cause of decreased hemoglobin and hematocrit levels in children

a. Dietary deficiency
b. Excess fluid intake
c. Chronic blood loss
d. Frequent cuts and bruises

87. A recently hospitalized 2-year-old client screams and shouts that he wants a "bottle." His parents are puzzled, and state that he has drank from a cup for the past year. The nurse explains that:
a. Irritability is exhibited in all age groups.
b. Temper tantrums often represent the child's need for parental attention.
c. Various forms of punishment are necessary when such behaviors occur.
d. Regression to an earlier behavior often helps the child cope with stress and anxiety.

88. The nurse discusses dental care with the parents of a 3-year-old. The nurse explains that by the age of 3, their child should have:

a. 5 "temporary" teeth.
b. 10 "temporary" teeth.
c. 15 "temporary" teeth.
d. 20 "temporary" teeth.

89. When observing an 18-month-old child, the nurse notes a rounded belly, sway back, bowlegs, and slightly large head. The nursing conclusion is that:

a. The child appears to be a normal toddler.
b. The child is likely developmentally delayed.

c. The child may be malnourished, especially with respect to calcium.
d. The enlarged head is of great concern and requires a thorough neurological exam.

90. When using the otoscope to examine the ears of a 2-year-old child, the nurse should:

a. Pull the pinna up and back.
b. Pull the pinna down and back.
c. Hold the pinna gently but firmly in its normal position.
d. Hold the pinna against the skull.

91. When assessing a 4-year-old child with a persistent cough, the nurse would assess respirations by observing which muscle group?

a. Thoracic
b. Abdominal
c. Accessory
d. Intercostal

92. Screening for strabismus and amblyopia should be part of the physical assessment of which children?

a. All children under 18
b. Infants
c. Preschool children
d. School-age children

93. At what age is it appropriate to change the sequence of the examination of the child from that of chest and thorax first to head-to-toe?

a. Infant
b. Toddler
c. Preschool child
d. School-age child

94. To assess the height of an 18-month-old child who is brought to the clinic for routine examination, the nurse should:

a. Measure arm span to estimate adult height.
b. Use a tape measure.
c. Use a horizontal measuring board.
d. Have the child stand on an upright scale and use the measuring arm.

95. The nurse who is examining a child understands that visual acuity of 20/20 as measured by the Snellen chart is reached by age:

a.2 years.
B 4 years.
c.6 years.
d.8 years.

96. A 1-year-old male child is scheduled for a routine exam at the pediatric clinic. The child's birth weight was 8 lbs. 2 oz. The child now weighs 18 pounds, 4 oz. The nurse knows that this weight is:

a. Below the expected weight.
b. Appropriate for the child's age.
c. Above the expected weight.
d. Individualized and thus unpredictable.

97. A 6-month-old child returns from surgery. PRN orders are available for pain management. The nurse would administer the pain medication when the baby is observed:

a. Crying loudly, grimacing, restlessness.
b. Displaying a change of color, decreased temperature.
c. Demonstrating shortness of breath, lack of responsiveness.
d. Sleeping more, refusing to eat.

98. A mother of a 4-year-old tells the nurse that her son is a "picky eater." The nurse should inform the mother that she should:

a. Increase the amount of carbohydrates in the daily menu plan.
b. Administer vitamins twice a day to her child.
c. Be more concerned with the quantity of food than the quality of food.
d. Recognize this is common for preschoolers as their caloric requirements have decreased slightly.

99. When examining the child, the nurse should remember that tonsillar tissue:

a. Enlarges until adolescence and then shrinks.
b. Continues to enlarge throughout childhood and adolescence.
c. Is readily visible in toddlers.
d. Normally has a small amount of exudate.

100. In discussing sexual maturation with a health class, the nurse would include the information that secondary sex characteristics begin to appear at:

a. 10 years in girls, 12 years in boys.
b. 12 years in girls, 16 years in boys.
c. 10 years in boys, 10 years in girls.
d. 12 years in girls and boys.