Ball, Child Health Nursing, 3/E
Chapter 1

Question 1
Question 1
Type: MCSA

The nurse in a pediatric acute care unit is assigned the following tasks. Based on recognition that the action defined requires training beyond the preparation of a registered nurse, the nurse would refuse to:

1. Diagnose a six-year-old with diversional activity deficit related to placement in isolation.

2. Listen to the concerns of an adolescent about being out of school for a lengthy surgical recovery.

3. Diagnose an eight-year-old with acute otitis media and prescribe an antibiotic.

4. Provide information to a mother of a newly diagnosed four-year-old diabetic about local support group options.

Correct Answer: 3

Rationale 1: Nursing diagnoses are a responsibility of the nurse in an acute care unit.

Rationale 2: Listening to concerns is within the expectations of a nurse in an acute care unit.

Rationale 3: Advanced practice nurse practitioners perform assessment, diagnosis, and management of health conditions. The role of the pediatric nurse includes providing nursing assessment, direct nursing care interventions, client and family education at developmentally appropriate levels, client advocacy, case management, minimization of distress, and enhancement of coping.

Rationale 4: Providing information about support groups is within the expectations of the nurse in an acute care unit.

Global Rationale:

Cognitive Level: Applying
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 1-1

Question 2
Type: MCSA

Despite the availability of Children's Health Insurance Programs (CHIP), many eligible children are not enrolled. The nursing intervention that can best help eligible children to become enrolled is:

1. Educating the family about the need for keeping regular well-child visit appointments.

2. Assessing details of the family's income and expenditures.

3. Limiting costly, unnecessary duplication of services through case management.

4. Advocating for the child by encouraging the family to investigate CHIP eligibility.

Correct Answer: 4

Rationale 1: While it is the nurse's responsibility to educate the family, this intervention is not what will best help eligible children to become enrolled.

Rationale 2: Financial assessment is more commonly the function of a social worker.

Rationale 3: The case management activity mentioned will not provide a source of funding.

Rationale 4: In the role of an advocate, a nurse advances the interests of the child by suggesting that the family investigate CHIP eligibility.

Global Rationale:

Cognitive Level: Analyzing
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 1-1

Question 3
Type: MCSA

A nurse is examining different nursing roles. Which best illustrates an advanced practice nursing role?

1. A clinical nurse specialist with whom other nurses consult for her expertise in caring for high-risk children

2. A clinical nurse specialist working as a staff nurse on a medical-surgical pediatric unit

3. A registered nurse who is the circulating nurse in surgery

4. A registered nurse who is the manager of a large pediatric unit

Correct Answer: 1

Rationale 1: A clinical nurse specialist with whom other nurses consult for expertise in caring for high-risk children would define an advanced practice nursing role. Advanced practice nurses have specialized knowledge and competence in a specific clinical area and have earned a master's degree.

Rationale 2: A clinical nurse specialist working as a staff nurse on a medical-surgical pediatric unit might have the qualifications for an advanced practice nursing staff but is not working in that capacity.

Rationale 3: A registered nurse who is a circulating nurse in surgery is defined as a professional nurse and has graduated from an accredited program in nursing and completed the licensure examination.

Rationale 4: A registered nurse who is the manager of a large pediatric unit is defined as a professional nurse and has graduated from an accredited program in nursing and completed the licensure examination.

Global Rationale:

Cognitive Level: Analyzing

Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 1-1

Question 4
Type: MCSA

The role of the registered nurse as a nurse educator is to:

1. Provide primary care for healthy children.

2. Assist the family in making informed decisions by providing information about the pros and cons of the treatment plan.

3. Assist the primary care nurse with procedures requiring advanced practice skills.

4. Communicate with the hospitalized school-aged child's classroom teacher to assist the child in achieving classroom goals.

Correct Answer: 2

Rationale 1: The nurse educator does not provide primary care for healthy children.

Rationale 2: The educator works with the family toward the goal of making informed choices through education and explanation.

Rationale 3: The nurse educator does not assist with procedures requiring advance practice skills.

Rationale 4: The nurse educator is concerned with teaching the child and parents health care practices related to the child's condition.

Global Rationale:

Cognitive Level: Applying
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 1-1

Question 5
Type: MCSA

A 7-year-old child has been admitted for acute appendicitis. The parents are questioning the nurse about expectations during the child's recovery. Which information tool would be most useful in answering a parent's questions about timing of key events?

1. *Healthy People 2020*

2. National clinical practice guidelines

3. Child mortality statistics

4. Critical clinical pathways

Correct Answer: 4

Rationale 1: *Healthy People 2020* contains objectives set by the U.S. government to improve the health and reduce the incidence of death in the twenty-first century.

Rationale 2: National clinical practice guidelines promote uniformity in care for specific disease conditions by suggesting expected outcomes from specific interventions.

Rationale 3: Child mortality statistics can be compared with those from other decades for the evaluation of achievement toward health care goals.

Rationale 4: Critical clinical pathways are interdisciplinary documents provided by a hospital to suggest ideal sequencing and timing of events and interventions for specific diseases to improve efficiency of care and enhance recovery. These pathways serve as models outlining the typical hospital stay for individuals with specified conditions.

Global Rationale:

Cognitive Level: Analyzing
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 1-2

Question 6
Type: MCSA

The telephone triage nurse at a pediatric clinic knows that each call is important. However, recognizing that infant deaths are most frequent in this group, the nurse must be extra attentive during the call from the parent of an infant who is:

1. Between six and eight months old.

2. Of a Native American family.

3. Of a non-Hispanic black family.

4. Younger than three weeks old.

Correct Answer: 4

Rationale 1: About two-thirds of infant deaths occur much earlier—in the first 28 days of life.

Rationale 2: Native American and Alaskan natives experience an infant mortality rate of 8.3 per 100,000 live births.

Rationale 3: During 2000, the infant mortality statistics for non-Hispanic blacks was 13.6 per 100,000 live births.

Rationale 4: Almost two-thirds of all infant deaths occur during the first 28 days after birth.

Global Rationale:

Cognitive Level: Applying
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 1-3

Question 7
Type: MCSA

When discussing injury prevention with the parents of a toddler, which statement indicates teaching has been successful? "The leading cause of death in children is:

1. Unintentional injury."

2. Infectious disease."

3. Congenital anomalies."

4. Cancer."

Correct Answer: 1

Rationale 1: The most common cause of death for children between 1 and 19 years of age is unintentional injury, which includes motor vehicle crashes, drowning, fire, burns, firearms, and suffocation.

Rationale 2: Infectious disease is not the cause of most deaths in children.

Rationale 3: The leading cause of death in children is unintentional injuries, not congenital anomalies.

Rationale 4: Cancer is not the leading cause of child mortality.

Global Rationale:

Cognitive Level: Applying
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: 1-3

Question 8
Type: MCSA

With regard to child mortality statistics, which nursing intervention would be most effective in decreasing mortality from unintentional injury?

1. Teaching children about dangers of contact sports

2. Encouraging parents to obtain genetic counseling

3. Educating parents about the benefits of immunizations

4. Teaching parents about proper use of vehicle restraint seats

Correct Answer: 4

Rationale 1: Teaching about the dangers of contact sports will not decrease mortality from unintentional injuries, such as burns, motor vehicle crashes, and suffocation.

Rationale 2: Obtaining genetic counseling will not decrease mortality from unintentional injuries.

Rationale 3: Since the most common cause of mortality in children is unintentional injury, educating about immunizations will not be most effective.

Rationale 4: The most common cause of death for children between 1 and 19 years of age is unintentional injury. The major causes of death from unintentional injury in childhood include motor vehicle crashes, drowning, fires and burns, firearms, and suffocation.

Global Rationale:

Cognitive Level: Applying
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 1-3

Question 9
Type: MCSA

With regard to infant mortality statistics, which nursing intervention would be most effective in decreasing post-neonatal mortality?

1. Teaching parents about "baby-proofing" their home

2. Educating parents on acceptable feeding techniques

3. Providing support for first-time mothers

4. Educating parents on the importance of positioning the baby on his back whenever sleeping

Correct Answer: 4

Rationale 1: Baby-proofing homes will not decrease post-neonatal mortality.

Rationale 2: Teaching acceptable feeding techniques is not the most effective intervention to decrease post-neonatal mortality.

Rationale 3: Providing support for first-time mothers will not decrease post-neonatal mortality.

Rationale 4: Sudden infant death syndrome accounts for nearly 8% of deaths to infants and usually occurs during the post-neonatal period (between 1 and 12 months of age). Positioning babies on their backs to sleep has significantly reduced the incidence of sudden infant death syndrome.

Global Rationale:

Cognitive Level: Applying
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 1-3

Question 10
Type: MCSA

Despite the availability of the Children's Health Insurance Program (CHIP), families often fail to obtain coverage for eligible children because:

1. They do not see the importance of insurance coverage.

2. Families do not have adequate time to complete the enrollment process.

3. They do not know their child is eligible.

4. Parents do not value medical interventions for their children.

Correct Answer: 3

Rationale 1: Most families do value insurance coverage, so this is not the reason for failing to obtain SCHIP coverage.

Rationale 2: Families have adequate time to complete the enrollment process, but some do not believe they will qualify and therefore do not try to enroll.

Rationale 3: Despite availability of CHIP, many eligible children are not enrolled. Reasons families have not enrolled include not being aware that their child is eligible, viewing the enrollment requirements and income verification tests as barriers, and the monthly premium or co-payment for healthcare visits that are required in some states.

Rationale 4: Parents do value medical interventions for their children, but some do not believe they can qualify, believing that their income is too high.

Global Rationale:

Cognitive Level: Applying
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 1-3

Question 11
Type: MCSA

A 12-year-old pediatric client is in need of surgery. The health care member who is legally responsible for obtaining informed consent for an invasive procedure is the:

1. Nurse.

2. Social worker.

3. Unit secretary.

4. Physician.

Correct Answer: 4

Rationale 1: A nurse cannot legally obtain informed consent for a procedure but can witness the signature on the consent form.

Rationale 2: A social worker is not responsible for obtaining informed consent for an invasive procedure.

Rationale 3: The unit secretary cannot obtain or sign as a witness for an informed consent document.

Rationale 4: Informed consent is legal preauthorization for an invasive procedure. It is the physician's legal responsibility to obtain this because it consists of an explanation about the medical condition, a detailed description of treatment plans, the expected benefits and risks related to the proposed treatment plan, alternative treatment options, the client's questions, and the guardian's right to refuse treatment.

Global Rationale:

Cognitive Level: Applying
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 1-4

Question 12
Type: MCSA

A child is being prepared for an invasive procedure in the presence of the child's babysitter. The single mother of the child has legal custody but is not present. After details of the procedure are explained, the legal informed consent for treatment on behalf of a minor child will be obtained from:

1. The divorced parent without custody.

2. The babysitter with written proxy consent.

3. A grandparent who lives in the home with the child.

4. The cohabitating unmarried boyfriend of the child's mother.

Correct Answer: 2

Rationale 1: State laws vary. In the case of divorced parents, the parent with custody may be the only parent allowed to give informed consent.

Rationale 2: A parent may grant proxy consent in writing to another adult so that children are not denied necessary health care.

Rationale 3: Residence in the same household with a child does not authorize an adult to sign consent for treatment.

Rationale 4: Residence in the same household with a child does not authorize an adult to sign consent for treatment.

Global Rationale:

Cognitive Level: Applying
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 1-4

Question 13
Type: MCSA

A 12-year-old child is being admitted to the unit for a surgical procedure. The child is accompanied by two parents and a younger sibling. The level of involvement in treatment decision making for this child is:

1. That of a mature minor.

2. That of an emancipated minor.

3. That of assent.

4. None.

Correct Answer: 3

Rationale 1: A mature minor is a 14- or 15-year-old whom the state law designates as being able to understand medical risks and who is thus permitted to give informed consent for treatment.

Rationale 2: An emancipated minor is a self-supporting adolescent who is not subject to the control of a parent or guardian.

Rationale 3: Assent requires the ability to generally understand what procedure and treatments are planned, to understand what participation is required, and to make a statement of agreement or disagreement with the plan. Usually, in Piaget's stage of formal operations, 11- to 13-year-olds should be able to problem-solve using abstract concepts and are able to give valid assent when parents sign the informed consent.

Rationale 4: The child has some involvement at age 12, so this answer is not correct.

Global Rationale:

Cognitive Level: Applying
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 1-4

Question 14

Type: MCSA

All of the following adolescents are in the emergency room for treatment. Which adolescent would be an emancipated minor?

1. The 15-year-old adolescent who disagrees with the parents in regard to the medical plan of care

2. The 14-year-old adolescent who understands the risks and benefits of treatment

3. The 17-year-old adolescent who is self-supporting and maintains her own apartment

4. The 16-year-old adolescent who ran away from home and is living with a friend

Correct Answer: 3

Rationale 1: Emancipated minors are not designated only when the parents and child have a disagreement but when the minor becomes solely responsible for all aspects of her life.

Rationale 2: Emancipated minors have more knowledge than just understanding. They are solely responsible for themselves and can give informed consent.

Rationale 3: Emancipated minors are economically self-supporting adolescents under 18 years of age, no longer living at home, and not subject to parental control. They can legally give informed consent for themselves.

Rationale 4: Emancipated minors are not declared as such only when there is a conflict of interest between the child and parents. Emancipated minors have sole responsibility for all aspects of their life.

Global Rationale:

Cognitive Level: Analyzing
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 1-4

Question 15
Type: MCMA

A nurse is working with pediatric clients in a research facility. The nurse recognizes that federal guidelines are in place to delineate which pediatrics clients must give assent for participation in research trials. Based upon the client's age, the nurse would seek assent from which children?

Standard Text: Select all that apply.

1. The 13-year-old client beginning participation in a research program for ADHD treatments

2. The precocious four-year-old starting as a cystic fibrosis research study participant

3. The 10-year-old starting in an investigative study for clients with precocious puberty

4. The seven-year-old leukemia client electing to receive a newly developed medication being researched

Correct Answer: 1,3,4

Rationale 1: Federal guidelines mandate that research participants seven years old and older must receive developmentally appropriate information about healthcare procedures and treatments and give assent.

Rationale 2: A four-year-old is not old enough to understand any of the benefits and risks of the research trial and is not required to assent.

Rationale 3: Federal guidelines mandate that research participants seven years old and older must receive developmentally appropriate information about healthcare procedures and treatments and give assent.

Rationale 4: Federal guidelines mandate that research participants seven years old and older must receive developmentally appropriate information about health care procedures and treatments and give assent.

Global Rationale:

Cognitive Level: Applying
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 1-5

Question 16
Type: MCSA

A supervisor is reviewing the documentation of the nurses in the unit. The documentation that most accurately and correctly contains all the required parts for a narrative entry is the entry that reads:

1. "1630 catheterized using an 8 French catheter, 45 ml clear yellow urine obtained, specimen sent to lab, squirmed and cried softly during insertion of catheter. Quiet in mother's arms following catheter removal. M. May RN"

2. "1/9/05 2 p.m. g-tube accessed, positive air gurgle over stomach: 5 ml air injected, 10 ml residual stomach contents returned to stomach, PediaSure formula hung on Kangaroo pump infusing at 60 ml/hr for 1 hour. Child grunting intermittently throughout procedure. K. Earnst RN"

3. "Feb. '05 Portacath assessed with Huber needle. Blood return present. Flushed with NaCl sol., IV gamma globulins hung and infusing at 30 ml/hr. Child smiling and playful throughout the procedure. P. Potter, RN"

4. "4:00 Trach dressing removed with dime-size stain of dry serous exudate. Site cleansed with normal saline. Dried with sterile gauze. New sterile trach sponge and trach ties applied. F. Luck RN"

Correct Answer: 2

Rationale 1: While the description of the procedure is appropriate, this documentation does not include the date the note was written.

Rationale 2: The client record should include the date and time of entry, nursing care provided, assessments, an objective report of the client's physiologic response, exact quotes if applicable, and the nurse's signature and title.

Rationale 3: This note does not specify the exact date and time at which the portacath was accessed. It also does not include the size of the Huber needle that was used.

Rationale 4: This option appropriately describes the procedure but neglects to include the date and how the client tolerated it.

Global Rationale:

Cognitive Level: Applying
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 1-5

Question 17
Type: MCSA

The pediatric nurse's best defense against an accusation of malpractice or negligence is that the nurse:

1. Is a nurse practitioner or clinical nurse specialist.

2. Met the Society of Pediatric Nurses standards of practice.

3. Was acting on the advice of the nurse manager.

4. Followed the physician's written orders.

Correct Answer: 2

Rationale 1: Being a clinical nurse specialist or nurse practitioner does not defend the nurse against these accusations if he does not follow the Society of Pediatric Nurses standards of practice.

Rationale 2: Meeting the Society of Pediatric Nurses standards of practice would cover the pediatric nurse against an accusation of malpractice or negligence because the standards are rigorous and cover all bases of excellent nursing practice.

Rationale 3: Acting on the advice of the nurse manager is not enough to defend the nurse from accusations because the advice could be wrong or unethical.

Rationale 4: Following the physician's written orders is not enough to defend the nurse from accusations because the orders could be wrong or unethical.

Global Rationale:

Cognitive Level: Applying
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 1-5

Question 18
Type: MCSA

Following a traumatic birth, an infant is admitted to the neonatal intensive care unit. When the grandparents arrive at the hospital, they question the nurse caring for the baby about its condition and plan of care. The nurse who provides this information without permission from the parents would be committing:

1. Negligence

2. A breach of privacy

3. Malpractice

4. A breach of ethics

Correct Answer: 2

Rationale 1: Negligence occurs when the nurse does something or fails to do something that a reasonably prudent nurse would not do or would not have done

Rationale 2: A breach of privacy would have been committed in this situation because it violates the right to privacy of this family. The right to privacy is the right of a person to keep his person and property free from public scrutiny (even by other family members).

Rationale 3: A nurse charged with malpractice may face a lawsuit for engaging in nursing practice that caused harm to a patient.

Rationale 4: Ethics is a system of moral principles that guides nursing behavior. This situation does not describe an ethical issue.

Global Rationale:

Cognitive Level: Applying
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 1-5

Question 19
Type: MCSA

While changing the diaper on a newborn in the presence of the mother, the nurse notes a belly binder wrapped around the umbilical cord. When questioned, the mother states this is the way the umbilical area is cared for in her culture. The nurse should:

1. Accept this practice as a cultural variation and allow the mother to care for the umbilicus.

2. Explain to the mother the risks associated with belly binders and encourage her to remove it.

3. Remove the belly binder and discard it.

4. Replace the belly binder with a coin as a safer cultural practice.

Correct Answer: 2

Rationale 1: A belly binder prevents the cord from drying and may promote infection in the area. Cultural practices that are harmful should be discouraged through education of those involved.

Rationale 2: In this case, the belly binder is a cultural practice. While not accepting the practice as safe, the nurse recognizes the practice as a cultural variation and will work with the mother to provide for the needs of her infant.

Rationale 3: While the use of a belly binder varies from traditional American practice, the nurse should avoid offending the family and creating a barrier to accepted medical practice.

Rationale 4: This response does not show cultural acceptance and may negatively impact the therapeutic relationship.

Global Rationale:

Cognitive Level: Applying
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 1-2

Question 20
Type: MCSA

The nursing supervisor is observing the staff on the pediatric unit. Which nurse is providing family-centered care?

1. The nurse who delays morning care until after the family has visited the child

2. The nurse who suggests the mother take a break and get breakfast while the nurse changes the child's dressings

3. While admitting a new client, the nurse explains the visitation rules of the unit to the parents and grandparents.

4. During discharge planning, the nurse recognizes the mother is unable to perform wound care on the client, so the nurse works with the family to determine which family member will be available to meet this child's health care needs.

Correct Answer: 4

Rationale 1: This observation does not involve the nurse partnering with the family to meet the health care needs of the child.

Rationale 2: While encouraging the mother to maintain her own health, this observation does not promote nurse-family interaction to improve the health of the child.

Rationale 3: There is no evidence of family-centered care in this interaction.

Rationale 4: Assisting the family in planning for the health care needs of the child is an example of family-centered care. The nurse accepts the limitations of the mother while problem solving with the family to find a solution.

Global Rationale:

Cognitive Level: Analyzing
Client Need:

Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 1-4

Question 21
Type: MCMA

A registered nurse has been asked to join the ethics committee of the hospital. In considering this appointment, the nurse would recognize that the committee might be considering ethical situations including:

Standard Text: Select all that apply.

1. Issuance of a "Do Not Resuscitate" (allow natural death) order on a child who has been determined brain dead against the wishes of the parents.

2. Determining if a minor child who disagrees with the parents about the treatment plan can make an informed decision.

3. Determining if a non-salvageable newborn can be used as an organ donor.

4. Investigating a medication error.

5. Consulting and intervening when parents are not in agreement on decisions of health care for their child.

Correct Answer: 1,3

Rationale 1: Ethical issues arise when the health care team must make decisions regarding potential outcome for the child and the beneficence of treatment.

Rationale 2: Informed decisions and the rights of the individual are legal issues, not ethical issues.

Rationale 3: Issues of organ donations and waiting lists for organs involve ethical issues that might be presented to the hospital ethics committee.

Rationale 4: Medication errors do not involve ethical issues but are system failures that need to be investigated.

Rationale 5: Staff nurses may work with parents in conflict resolution; it is not a function of an ethics committee.

Global Rationale:

Cognitive Level: Analyzing
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 1-5

Question 22
Type: MCSA

The rationale for nurses utilizing nursing intervention classifications (NICs) when developing a nursing care plan for a child on the unit is to:

1. Improve communication among nurses working with the child.

2. Assist medical records in documenting care provided for insurance purposes.

3. Aid the nursing supervisor in evaluating the nursing staff.

4. Coordinate medical orders with nursing orders.

Correct Answer: 1

Rationale 1: Standardizing the language assists each individual providing care to be consistent in the health care approach.

Rationale 2: The purpose of the nursing care plan is to improve care provided to the child and is not related directly to insurance.

Rationale 3: The nursing care plan is a communication tool for all health care members caring for the child and is not related to nursing supervision.

Rationale 4: While the nursing care plan includes dependent and independent orders, this is not the purpose of standardized NICs.

Global Rationale:

Cognitive Level: Analyzing
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 1-2

Question 23
Type: MCSA

A 14-month-old child is admitted to the hospital. During the admission process, the nurse determines that the child and family are visiting this country from a foreign country. The nurse is unaware of the cultural traditions and values of that country. How can the nurse best provide culturally competent health care?

1. Read about that country on the internet.

2. Ask the family members how care would be provided in their own country.

3. Ask a nurse who has visited the child's home country about life in that country.

4. Ask a coworker who comes from the same region about customs and cultures in their country.

Correct Answer: 2

Rationale 1: While this may provide some information about culture, this is not the best choice for this particular child and family.

Rationale 2: This response provides accurate information about this family's beliefs and culture.

Rationale 3: This choice provides an outsider's view of the country and is not the best response.

Rationale 4: While this may be helpful in seeing the full picture, the family is the most direct and complete source of information.

Global Rationale:

Cognitive Level: Analyzing
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 1-2

Question 24
Type: MCSA

While working on the pediatric unit, the nurse recognizes a neighbor whose child has been admitted to the hospital pediatric intensive care. Out of curiosity, the nurse visits the PICU and reviews the child's chart for information about the child's diagnosis. This nurse:

1. Has violated HIPAA laws.

2. Was working within the legal limitations of his/her job.

3. Was not guilty of violating HIPAA laws unless the nurse shares the information with someone outside the hospital.

4. Was working as a member of the health care team to provide family-centered nursing.

Correct Answer: 1

Rationale 1: Because the nurse was not involved in the child's care, the nurse had no right to review the chart and violated the family's right to privacy by reviewing the chart.

Rationale 2: This nurse was not involved in the child's care and had no legal right to the information.

Rationale 3: The nurse had no legal right to the information even if the information was not shared with others.

Rationale 4: Although the nurse was a member of the health care team, this nurse was not on the team assigned to this patient. It is a HIPAA violation.

Global Rationale:

Cognitive Level: Analyzing
Client Need:
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 1-6