Chapter 01: Perspectives of Pediatric Nursing

MULTIPLE CHOICE

1. The clinic nurse is reviewing statistics on infant mortality for the United States versus other countries. Compared with other countries that have a population of at least 25 million, the nurse makes which determination?

a. The United States is ranked last among 27 countries.

b. The United States is ranked similar to 20 other developed countries.

c. The United States is ranked in the middle of 20 other developed countries.

d. The United States is ranked highest among 27 other industrialized countries.

ANS: A

Although the death rate has decreased, the United States still ranks last in infant mortality among nations with a population of at least 25 million. The United States has the highest infant death rate of developed nations.

DIF: Cognitive Level: Remembering REF: p. 6

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

2. Which is the leading cause of death in infants younger than 1 year in the United States?

a. Congenital anomalies

b. Sudden infant death syndrome

c. Disorders related to short gestation and low birth weight

d. Maternal complications specific to the perinatal period

ANS: A

Congenital anomalies account for 20.1% of deaths in infants younger than 1 year compared with sudden infant death syndrome, which accounts for 8.2%; disorders related to short gestation and unspecified low birth weight, which account for 16.5%; and maternal complications such as infections specific to the perinatal period, which account for 6.1% of deaths in infants younger than 1 year of age.

DIF: Cognitive Level: Remembering REF: p. 7 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

3. What is the major cause of death for children older than 1 year in the United States?

a. Heart disease

b. Childhood cancer

c. Unintentional injuries

d. Congenital anomalies

ANS: C

Unintentional injuries (accidents) are the leading cause of death after age 1 year through adolescence. The leading cause of death for those younger than 1 year is congenital anomalies, and childhood cancers and heart disease cause a significantly lower percentage of deaths in children older than 1 year of age.

DIF: Cognitive Level: Understanding REF: p. 7 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

4. In addition to injuries, what are the leading causes of death in adolescents ages 15 to 19 years?

a. Suicide and cancer

b. Suicide and homicide

c. Drowning and cancer

d. Homicide and heart disease

ANS: B

Suicide and homicide account for 16.7% of deaths in this age group. Suicide and cancer account for 10.9% of deaths, heart disease and cancer account for approximately 5.5%, and homicide and heart disease account for 10.9% of the deaths in this age group.

DIF: Cognitive Level: Remembering REF: p. 7 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

5. The nurse is planning a teaching session to adolescents about deaths by unintentional injuries. Which should the nurse include in the session with regard to deaths caused by injuries?

a. More deaths occur in males.

b. More deaths occur in females.

c. The pattern of deaths does not vary according to age and sex.

d. The pattern of deaths does not vary widely among different ethnic groups.

ANS: A

The majority of deaths from unintentional injuries occur in males. The pattern of death does vary greatly among different ethnic groups, and the causes of unintentional deaths vary with age and gender.

DIF: Cognitive Level: Applying REF: pp. 7-8

TOP: Integrated Process: Teaching/Learning

MSC: Client Needs: Health Promotion and Maintenance

6. What do mortality statistics describe?

a. Disease occurring regularly within a geographic location

b. The number of individuals who have died over a specific period

c. The prevalence of specific illness in the population at a particular time

d. Disease occurring in more than the number of expected cases in a community

ANS: B

Mortality statistics refer to the number of individuals who have died over a specific period.

Morbidity statistics show the prevalence of specific illness in the population at a particular time. Data regarding disease within a geographic region, or in greater than expected numbers in a community, may be extrapolated from analyzing the morbidity statistics.

DIF: Cognitive Level: Remembering REF: p. 3 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

7. The nurse should assess which age group for suicide ideation since suicide in which age group is the third leading cause of death?

a. Preschoolers

b. Young school age

c. Middle school age

d. Late school age and adolescents

ANS: D

Suicide is the third leading cause of death in children ages 10 to 19 years; therefore, the age group should be late school age and adolescents. Suicide is not one of the leading causes of death for preschool and young or middle school-aged children.

DIF: Cognitive Level: Understanding REF: p. 6

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

8. Parents of a hospitalized toddler ask the nurse, "What is meant by family-centered care?" The nurse should respond with which statement?

a. Family-centered care reduces the effect of cultural diversity on the family.

b. Family-centered care encourages family dependence on the health care system.

c. Family-centered care recognizes that the family is the constant in a child's life.

d. Family-centered care avoids expecting families to be part of the decision-making process.

ANS: C

The three key components of family-centered care are respect, collaboration, and support. Family-centered care recognizes the family as the constant in the child's life. The family should be enabled and empowered to work with the health care system and is expected to be part of the decision-making process. The nurse should also support the family's cultural diversity, not reduce its effect.

DIF: Cognitive Level: Applying REF: p. 8

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

9. The nurse is describing clinical reasoning to a group of nursing students. Which is most descriptive of clinical reasoning?

a. Purposeful and goal directed

b. A simple developmental process

c. Based on deliberate and irrational thought

d. Assists individuals in guessing what is most appropriate

ANS: A

Clinical reasoning is a complex developmental process based on rational and deliberate thought. When thinking is clear, precise, accurate, relevant, consistent, and fair, a logical connection develops between the elements of thought and the problem at hand.

DIF: Cognitive Level: Applying REF: p. 12

TOP: Integrated Process: Teaching/Learning

MSC: Client Needs: Health Promotion and Maintenance

10. Evidence-based practice (EBP), a decision-making model, is best described as which?

a. Using information in textbooks to guide care

b. Combining knowledge with clinical experience and intuition

c. Using a professional code of ethics as a means for decision making

d. Gathering all evidence that applies to the child's health and family situation

ANS: B

EBP helps focus on measurable outcomes; the use of demonstrated, effective interventions; and questioning what is the best approach. EBP involves decision making based on data, not all evidence on a particular situation, and involves the latest available data. Nurses can use textbooks to determine areas of concern and potential involvement.

DIF: Cognitive Level: Remembering REF: p. 11 TOP: Nursing Process: Planning

MSC: Client Needs: Safe and Effective Care Environment

11. Which best describes signs and symptoms as part of a nursing diagnosis?

a. Description of potential risk factors

b. Identification of actual health problems

c. Human response to state of illness or health

d. Cues and clusters derived from patient assessment

ANS: D

Signs and symptoms are the cues and clusters of defining characteristics that are derived from a patient assessment and indicate actual health problems. The first part of the nursing diagnosis is the problem statement, also known as the human response to the state of illness or health. The identification of actual health problems may be part of the medical diagnosis. The nursing diagnosis is based on the human response to these problems. The human response is therefore a

component of the nursing diagnostic statement. Potential risk factors are used to identify nursing care needs to avoid the development of an actual health problem when a potential one exists.

DIF: Cognitive Level: Understanding REF: p. 13

TOP: Integrated Process: Communication and Documentation

MSC: Client Needs: Safe and Effective Care Environment

12. The nurse is talking to a group of parents of school-age children at an after-school program about childhood health problems. Which statement should the nurse include in the teaching?

a. Childhood obesity is the most common nutritional problem among children.

b. Immunization rates are the same among children of different races and ethnicity.

c. Dental caries is not a problem commonly seen in children since the introduction of fluoridated water.

d. Mental health problems are typically not seen in school-age children but may be diagnosed in adolescents.

ANS: A

When teaching parents of school-age children about childhood health problems, the nurse should include information about childhood obesity because it is the most common problem among children and is associated with type 2 diabetes. Teaching parents about ways to prevent obesity is important to include. Immunization rates differ depending on the child's race and ethnicity; dental caries continues to be a common chronic disease in childhood; and mental health problems are seen in children as young as school age, not just in adolescents.

DIF: Cognitive Level: Applying REF: p. 3

TOP: Integrated Process: Teaching/Learning

MSC: Client Needs: Health Promotion and Maintenance

13. The nurse is planning care for a hospitalized preschool-aged child. Which should the nurse plan to ensure atraumatic care?

a. Limit explanation of procedures because the child is preschool aged.

b. Ask that all family members leave the room when performing procedures.

c. Allow the child to choose the type of juice to drink with the administration of oral medications.

d. Explain that EMLA cream cannot be used for the morning lab draw because there is not time for it to be effective.

ANS: C

The overriding goal in providing atraumatic care is first, do no harm. Allowing the child a choice of juice to drink when taking oral medications provides the child with a sense of control. The preschool child should be prepared before procedures, so limiting explanations of procedures would increase anxiety. The family should be allowed to stay with the child during procedures, minimizing stress. Lidocaine/prilocaine (EMLA) cream is a topical local anesthetic. The nurse should plan to use the prescribed cream in time for morning laboratory draws to minimize pain.

DIF: Cognitive Level: Applying REF: pp. 8-9 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

14. Which situation denotes a nontherapeutic nurse–patient–family relationship?

a. The nurse is planning to read a favorite fairy tale to a patient.

b. During shift report, the nurse is criticizing parents for not visiting their child.

c. The nurse is discussing with a fellow nurse the emotional draw to a certain patient.

d. The nurse is working with a family to find ways to decrease the family's dependence on health care providers.

ANS: B

Criticizing parents for not visiting in shift report is nontherapeutic and shows an underinvolvement with the parents. Reading a fairy tale is a therapeutic and age appropriate action. Discussing feelings of an emotional draw with a fellow nurse is therapeutic and shows a willingness to understand feelings. Working with parents to decrease dependence on health care providers is therapeutic and helps to empower the family.

DIF: Cognitive Level: Analyzing REF: p. 9 TOP: Integrated Process: Caring

MSC: Client Needs: Psychosocial Integrity

15. The nurse is aware that which age group is at risk for childhood injury because of the cognitive characteristic of magical and egocentric thinking?

a. Preschool

b. Young school age

c. Middle school age

d. Adolescent

ANS: A

Preschool children have the cognitive characteristic of magical and egocentric thinking, meaning they are unable to comprehend danger to self or others. Young and middle school-aged children have transitional cognitive processes, and they may attempt dangerous acts without detailed planning but recognize danger to themselves or others. Adolescents have formal operational cognitive processes and are preoccupied with abstract thinking.

DIF: Cognitive Level: Understanding REF: p. 4

TOP: Nursing Process: Assessment

MSC: Client Needs: Safe and Effective Care Environment

16. The school nurse is assessing children for risk factors related to childhood injuries. Which child has the most risk factors related to childhood injury?

a. Female, multiple siblings, stable home life

b. Male, high activity level, stressful home life

c. Male, even tempered, history of previous injuries

d. Female, reacts negatively to new situations, no serious previous injuries

ANS: B

Boys have a preponderance for injuries over girls because of a difference in behavioral characteristics, a high activity temperament is associated with risk-taking behaviors, and stress predisposes children to increased risk taking and self-destructive behaviors. Therefore, a male child with a high activity level and living in a stressful environment has the highest number of risk factors. A girl with several siblings and a stable home life is low risk. A boy with previous injuries has two risk factors, but an even temper is not a risk factor for injuries. A girl who reacts negatively to new situations but has no previous serious illnesses has only one risk factor.

DIF: Cognitive Level: Analyzing REF: p. 4

TOP: Nursing Process: Assessment

MSC: Client Needs: Safe and Effective Care Environment

17. The school nurse is evaluating the number of school-age children classified as obese. The nurse recognizes that the percentile of body mass index that classifies a child as obese is greater than which?

a. 50th percentile

b. 75th percentile

c. 80th percentile

d. 95th percentile

ANS: D

Obesity in children and adolescents is defined as a body mass index at or greater than the 95th percentile for youth of the same age and gender.

DIF: Cognitive Level: Remembering REF: p. 3 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

18. The nurse is teaching parents about the types of behaviors children exhibit when living with chronic violence. Which statement made by the parents indicates further teaching is needed?

a. "We should watch for aggressive play."

b. "Our child may show lasting symptoms of stress."

c. "We know that our child will show caring behaviors."

d. "Our child may have difficulty concentrating in school."

ANS: C

The statement that the child will show caring behaviors needs further teaching. Children living with chronic violence may exhibit behaviors such as difficulty concentrating in school, memory impairment, aggressive play, uncaring behaviors, and lasting symptoms of stress.

DIF: Cognitive Level: Applying REF: p. 6

TOP: Integrated Process: Teaching/Learning

MSC: Client Needs: Health Promotion and Maintenance

19. The nurse is evaluating research studies according to the GRADE criteria and has determined the quality of evidence on the subject is moderate. Which type of evidence does this determination indicate?

a. Strong evidence from unbiased observational studies

b. Evidence from randomized clinical trials showed inconsistent results

c. Consistent evidence from well-performed randomized clinical trials

d. Evidence for at least one critical outcome from randomized clinical trials had serious flaws

ANS: B

Evidence from randomized clinical trials with important limitations indicates that the evidence is of moderate quality. Strong evidence from unbiased observational studies and consistent evidence from well-performed randomized clinical trials indicates high quality. Evidence for at least one critical outcome from randomized clinical trials that has serious flaws indicates low quality.

DIF: Cognitive Level: Remembering REF: p. 12 TOP: Nursing Process: Evaluation

MSC: Client Needs: Safe and Effective Care Environment

20. An adolescent patient wants to make decisions about treatment options, along with his parents. Which moral value is the nurse displaying when supporting the adolescent to make decisions?

a. Justice

b. Autonomy

c. Beneficence

d. Nonmaleficence

ANS: B

Autonomy is the patient's right to be self-governing. The adolescent is trying to be autonomous, so the nurse is supporting this value. Justice is the concept of fairness. Beneficence is the obligation to promote the patient's well-being. Nonmaleficence is the obligation to minimize or prevent harm.

DIF: Cognitive Level: Analyzing REF: p. 11 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

21. The nurse manager is compiling a report for a hospital committee on the quality of nursing-sensitive indicators for a nursing unit. Which does the nurse manager include in the report?

a. The average age of the nurses on the unit

b. The salary ranges for the nurses on the unit

c. The education and certification of the nurses on the unit

d. The number of nurses who have applied but were not hired for the unit

ANS: C

Nursing-sensitive indicators reflect the structure, process, and outcomes of nursing care. For example, the number of nursing staff, the skill level of the nursing staff, and the education and certification of nursing staff indicate the structure of nursing care. The average age of the nurses, salary range, and number of nurses who have applied but were not hired for the unit are not nursing-sensitive indicators.

DIF: Cognitive Level: Applying REF: p. 15

TOP: Integrated Process: Communication and Documentation

MSC: Client Needs: Safe and Effective Care Environment

MULTIPLE RESPONSE

1. Which responsibilities are included in the pediatric nurse's promotion of the health and well-being of children? *(Select all that apply.)*

a. Promoting disease prevention

b. Providing financial assistance

c. Providing support and counseling

d. Establishing lifelong friendships

e. Establishing a therapeutic relationship

f. Participating in ethical decision making

ANS: A, C, E, F

The pediatric nurse's role includes promoting disease prevention, providing support and counseling, establishing a therapeutic relationship, and participating in ethical decision making; a pediatric nurse does not need to establish lifelong friendships or provide financial assistance to children and their families. Boundaries should be set and clear.

DIF: Cognitive Level: Applying REF: pp. 9-11 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

2. The nurse is conducting a teaching session for parents on nutrition. Which characteristics of families should the nurse consider that can cause families to struggle in providing adequate nutrition? *(Select all that apply.)*

a. Homelessness

b. Lower income

c. Migrant status

d. Working parents

e. Single parent status

ANS: A, B, C

Families that struggle with lower incomes, homelessness, and migrant status generally lack the resources to provide their children with adequate food intake, nutritious foods such as fresh fruits and vegetables, and appropriate protein intake. Working parents and single parent status do not mean the families will struggle to provide adequate nutrition.

DIF: Cognitive Level: Applying REF: p. 2

TOP: Integrated Process: Teaching/Learning

MSC: Client Needs: Health Promotion and Maintenance

3. The nurse is preparing to complete documentation on a patient's chart. Which should be included in documentation of nursing care? *(Select all that apply.)*

a. Reassessments

b. Incident reports

c. Initial assessments

d. Nursing care provided

e. Patient's response of care provided

ANS: A, C, D, E

The patient's medical record should include: initial assessments, reassessments, nursing care provided, and the patient's response of care provided. Incident reports are not documented in the patient's chart.

DIF: Cognitive Level: Applying REF: p. 14

TOP: Integrated Process: Communication and Documentation

MSC: Client Needs: Safe and Effective Care Environment

4. Which actions by the nurse demonstrate overinvolvement with patients and their families?*(Select all that apply.)*

a. Buying clothes for the patients

b. Showing favoritism toward a patient

c. Focusing on technical aspects of care

d. Spending off-duty time with patients and families

e. Asking questions if families are not participating in care

ANS: A, B, D

Actions that show overinvolvement include buying clothes for patients, showing favoritism toward a patient, and spending off-duty time with patients and families. Focusing on technical aspects of care is an action that indicates underinvolvement, and asking questions if families are not participating in care indicates a positive action.

DIF: Cognitive Level: Analyzing REF: pp. 9-10 TOP: Integrated Process: Caring

MSC: Client Needs: Health Promotion and Maintenance

5. Which are included in the evaluation step of the nursing process? *(Select all that apply.)*

a. Determination if the outcome has been met

b. Ascertaining if the plan requires modification

c. Establish priorities and selecting expected patient goals

d. Selecting alternative interventions if the outcome has not been met

e. Determining if a risk or actual dysfunctional health problem exists

ANS: A, B, D

Evaluation is the last step in the nursing process. The nurse gathers, sorts, and analyzes data to determine whether (1) the established outcome has been met, (2) the nursing interventions were appropriate, (3) the plan requires modification, or (4) other alternatives should be considered. Establishing priorities and selecting expected patient goals are done in the outcomes identification stage. Determining if a risk or actual dysfunctional health problem exists is done in the diagnosis stage of the nursing process.

DIF: Cognitive Level: Understanding REF: p. 14 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

6. Which should the nurse teach to parents regarding oral health of children? *(Select all that apply.)*

a. Fluoridated water should be used.

b. Early childhood caries is a preventable disease.

c. Dental caries is a rare chronic disease of childhood.

d. Dental hygiene should begin with the first tooth eruption.

e. Childhood caries does not happen until after 2 years of age.

ANS: A, B, D

Oral health instructions to parents of children should include use of fluoridated water and dental hygiene beginning with the first tooth eruption. In addition, early childhood caries is a preventable disease and should be included in the teaching session. Dental caries is a common, not rare, chronic disease of childhood. Childhood caries may begin before the first birthday.

DIF: Cognitive Level: Applying REF: p. 2

TOP: Integrated Process: Teaching/Learning

MSC: Client Needs: Health Promotion and Maintenance

7. The school nurse is explaining to older school children that obesity increases the risk for which disorders? *(Select all that apply.)*

a. Asthma

b. Hypertension

c. Dyslipidemia

d. Irritable bowel disease

e. Altered glucose metabolism

ANS: B, C, E

Overweight youth have increased risk for a cluster of cardiovascular factors that include hypertension, altered glucose metabolism, and dyslipidemia. Irritable bowel disease and asthma are not linked to obesity.

DIF: Cognitive Level: Applying REF: p. 3

TOP: Integrated Process: Teaching/Learning

MSC: Client Needs: Health Promotion and Maintenance

8. The nurse is reviewing the *Healthy People 2020* leading health indicators for a child health promotion program. Which are included in the leading health indicators? *(Select all that apply.)*

a. Decrease tobacco use.

b. Improve immunization rates.

c. Reduce incidences of cancer.

d. Increase access to health care.

e. Decrease the number of eating disorders.

ANS: A, B, D

The *Healthy People 2020* leading health indicators provide a framework for identifying essential components for child health promotion programs designed to prevent future health problems in our nation's children. Some of the leading health indicators include decreasing tobacco use, improving immunization rates, and increasing access to health care. Reducing the incidence of cancer and decreasing the number of eating disorders are not on the list as leading health indicators.

DIF: Cognitive Level: Analyzing REF: p. 2 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

9. Which actions by the nurse demonstrate clinical reasoning? *(Select all that apply.)*

a. Basing decisions on intuition

b. Considering alternative action

c. Using formal and informal thinking to gather data

d. Giving deliberate thought to a patient's problem

e. Developing an outcome focused on optimum patient care

ANS: B, C, D, E

Clinical reasoning is a cognitive process that uses formal and informal thinking to gather and analyze patient data, evaluate the significance of the information, and consider alternative actions. Clinical reasoning is a complex developmental process based on rational and deliberate thought and developing an outcome focused on optimum patient care. Clinical reasoning is based on the scientific method of inquiry; it is not based solely on intuition.

DIF: Cognitive Level: Applying REF: p. 12 TOP: Nursing Process: Evaluation

MSC: Client Needs: Safe and Effective Care Environment

COMPLETION

1. The nurse is determining if a newborn is classified in the low birth weight (LBW) category of less than 2500 g. The newborn's weight is 5 lb, 4 oz. What is the newborn's weight in grams? Record your answer in a whole number.

_____

ANS:

2386

Convert the 4 oz to a decimal by dividing 4 by 16 = 0.25. Use 5.25 lb and divide by 2.2 to get 2.386 kg. Multiply by 1000 to convert to grams = 2386.

DIF: Cognitive Level: Applying REF: p. 3

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

MATCHING

The nursing process is a method of problem identification and problem solving that describes what the nurse actually does. Match each step of the nursing process with its definition.

a. Assessment

b. Diagnosis

c. Outcomes identification

d. Planning

e. Implementation

f. Evaluation

1. Problem identification

2. Expected patient goals

3. Purposeful collection of data

4. Development of a care plan

5. Determines if the outcome was met

6. Interventions are put into action

1. ANS: B DIF: Cognitive Level: Understanding REF: p. 13

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

2. ANS: C DIF: Cognitive Level: Understanding REF: p. 13

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

3. ANS: A DIF: Cognitive Level: Understanding REF: p. 13

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

4. ANS: D DIF: Cognitive Level: Understanding REF: p. 13

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

5. ANS: F DIF: Cognitive Level: Understanding REF: p. 14

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

6. ANS: E DIF: Cognitive Level: Understanding REF: p. 14

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

Ethical dilemmas arise when competing moral considerations underlie various alternatives. Match each competing moral value with its definition.

a. Autonomy

b. Nonmaleficence

c. Beneficence

d. Justice

7. The obligation to promote the patient's well-being

8. The obligation to minimize or prevent harm

9. The patient's right to be self-governing

10. The concept of fairness

7. ANS: C DIF: Cognitive Level: Understanding REF: p. 11

TOP: Integrated Process: Caring MSC: Client Needs: Health Promotion and Maintenance

8. ANS: B DIF: Cognitive Level: Understanding REF: p. 11

TOP: Integrated Process: Caring MSC: Client Needs: Health Promotion and Maintenance

9. ANS: A DIF: Cognitive Level: Understanding REF: p. 11

TOP: Integrated Process: Caring MSC: Client Needs: Health Promotion and Maintenance

10. ANS: D DIF: Cognitive Level: Understanding REF: p. 11

TOP: Integrated Process: Caring MSC: Client Needs: Health Promotion and Maintenance