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Next Generation
NCLEX-RN®

STUDENT WORKBOOK

CHILD HEALTH

NCLEX® EXAM TIPS

- Familiarize yourself with the normal growth and development milestones for different age groups, including physical, cognitive, and psychosocial development. Understand how these milestones influence nursing care and assessment.
- Focus on the common pediatric disorders and conditions, such as respiratory disorders (e.g., asthma), gastrointestinal disorders (e.g., gastroenteritis), cardiovascular disorders (e.g., congenital heart defects), and neurological disorders (e.g., seizures). Understand their pathophysiology, signs and symptoms, nursing interventions, and potential complications.
- Child safety is crucial in nursing care. Understand the safety measures and precautions specific to pediatric patients, such as medication safety, prevention of falls or accidents, and infection control practices.
- Pediatric assessment techniques differ from adult assessment. Review the specific techniques for assessing the growth, development, and physical and psychosocial aspects of pediatric patients. Understand how to adapt your assessment based on the age and developmental stage of the child.
- Study pediatric pharmacology, including dosage calculations and administration of medications to children of different ages. Pay attention to the specific considerations for pediatric medication administration, such as dosage adjustments, appropriate routes, and potential adverse effects.
- Child Health nursing emphasizes family-centered care. Review the importance of involving families in care decisions, communication strategies with parents and caregivers, and supporting families with children who have chronic illnesses or special needs.
- Pediatric emergencies require rapid assessment and intervention. Understand the recognition and management of common pediatric emergencies, such as respiratory distress, choking, seizures, and cardiac arrest. Review pediatric cardiopulmonary resuscitation (CPR) guidelines.
- Developmentally appropriate care is essential in pediatric nursing. Understand how to provide age-appropriate interventions and explanations to pediatric patients based on their developmental stage.
- Review the importance of cultural diversity and cultural competence in pediatric nursing. Understand how cultural beliefs and practices may influence child health and healthcare decisions. Learn how to provide culturally sensitive care to diverse pediatric populations.

NCLEX® MNEMONICS

- FLACC Scale (Pain Assessment in Infants and Non-Verbal Children): The FLACC Scale is a pain assessment tool used for infants and non-verbal children. Each category is scored from 0 to 2 or 3, depending on the observed behaviors. The total score helps healthcare professionals evaluate the child's pain level and determine appropriate interventions.
  - F: Face (facial expression)
  - L: Legs (movement or activity)
  - A: Activity (muscle tone)
  - C: Cry (vocalization)
  - C: Consolability (ability to be comforted)

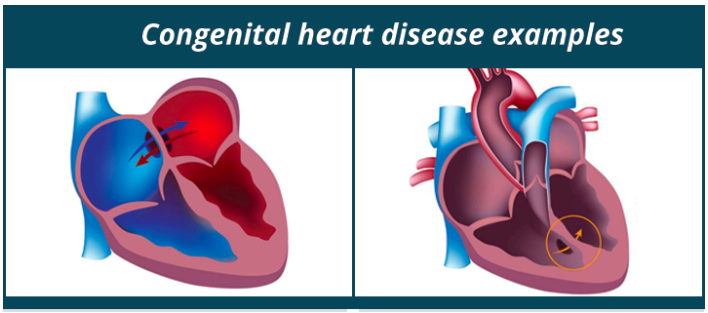
- ABCDE Assessment (Pediatric Emergency Assessment): The ABCDE Assessment is a systematic approach used in pediatric emergency care to quickly assess and prioritize the child's condition. It helps healthcare providers identify and manage life-threatening situations promptly.
  - A: Airway (assess and maintain a patent airway)
  - B: Breathing (evaluate respiratory rate, effort, and oxygenation)
  - C: Circulation (check heart rate, blood pressure, and peripheral perfusion)
  - D: Disability (evaluate level of consciousness, pupillary response)
  - E: Exposure/Environment (ensure adequate temperature control, remove clothing if necessary)

- AGE Assessment (Assessing Dehydration in Children): The AGE Assessment is a mnemonic used to evaluate dehydration in children. By observing the child's appearance, grimace, and eyes, healthcare professionals can assess the degree of dehydration and determine appropriate fluid replacement therapy.
  - A: Appearance (alertness, eyes, and skin turgor)
  - G: Grimace (degree of thirst and mucous membranes)
  - E: Eyes (sunken appearance)

- HEADSS Assessment (Psychosocial Assessment of Adolescents): The HEADSS Assessment is a tool used to assess various psychosocial aspects of adolescents' lives. It helps healthcare providers gather information about important areas that may impact the adolescent's health and well-being.
  - H: Home (family relationships, living situation)
  - E: Education and Employment (school performance, job status)
  - A: Activities (hobbies, extracurricular activities)
  - D: Drugs and Alcohol (substance use and abuse)
  - S: Sexuality (sexual activity, contraception)
  - S: Suicide and Depression (mood, suicidal ideation)

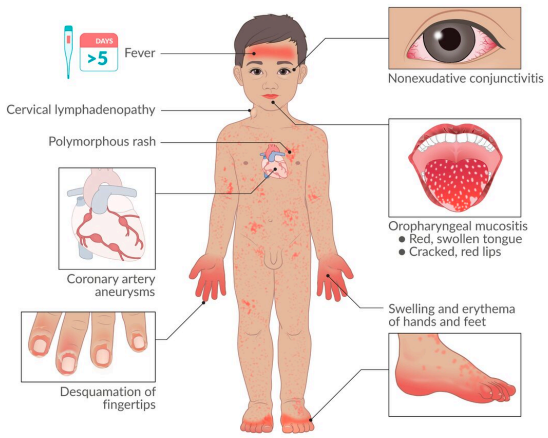
Q1 The nurse is caring for an infant with congenital heart disease. Which, if noted in the infant, would alert the nurse to the early development of heart failure?

1. Paleness of the skin
2. Strong sucking reflex
3. Diaphoresis during feeding
4. Slow and shallow breathing



Q2 The nurse is caring for a child diagnosed with Kawasaki's disease. Keeping the pathophysiology in mind, the nurse carefully monitors the child for which complication?

1. Fever
2. Paralytic ileus
3. Myocardial infarction
4. Arthralgic joint involvement



NOTES:

Q3 The nurse is providing care to a child admitted for acute otitis media. What is the nurse's **priority concern** for this child?

1. Acute pain
2. Problems with skin integrity
3. Risk for interrupted breathing patterns
4. Mucous membrane dryness and cracking

ABC's	
Airway	Physiological
Breathing	
Circulation	
Discomfort (Pain)	Psychosocial
Education	
Feelings	

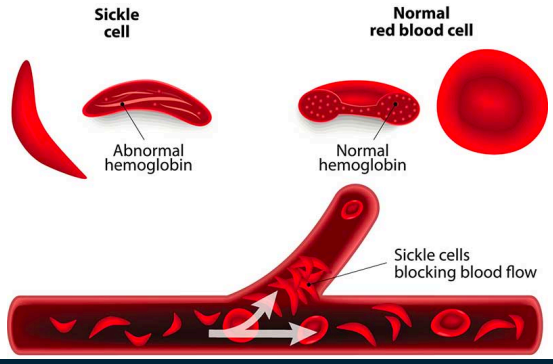
Q4 The nurse is initiating nasogastric tube feedings in a child. What is the nurse's **best** action?

1. Microwave the formula.
2. Place the child in a prone position.
3. Encourage the child to point the head downward.
4. Position the child with the head slightly hyperflexed.

NOTES:

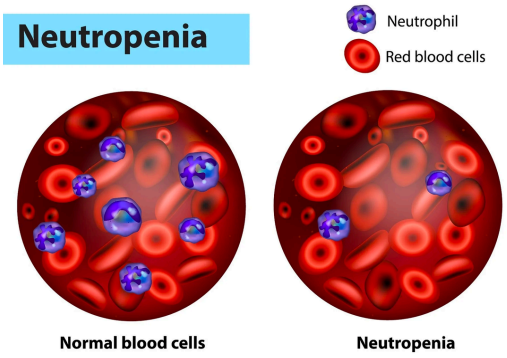
Q5 An 11-year-old child is admitted to the hospital in vaso-occlusive sickle cell crisis. The nurse plans for which **priority** treatments in the care of the child?

1. Splenectomy, correction of acidosis
2. Adequate hydration, pain management
3. Frequent ambulation, oxygen administration
4. Passive range-of-motion exercises, adequate hydration



Q6 The nurse is caring for a child with a diagnosis of neutropenia. Which nursing interventions are **most appropriate** for a child placed in **protective isolation** for neutropenia? **Select all that apply.**

1. Place the child on a low-bacteria diet.
2. Change dressings using sterile technique.
3. Put flowers in a vase with water before placing in the room.
4. Peel fruits and vegetables before allowing the child to eat them.
5. Allow individuals who are ill to visit as long as they wear a mask.



NOTES:

Q7 The home health nurse visits a child with infectious mononucleosis and provides home care instructions to the parents. Which **instruction** would the nurse **give to the parents?**

1. Maintain the child on bed rest for 2 weeks.
2. Maintain respiratory precautions for 1 week.
3. Notify the PHCP if the child develops abdominal pain or left shoulder pain.
4. Notify the primary health care provider (PHCP) if the child develops a fever.

Q8 The nurse is monitoring a child with burns during treatment for burn shock. Which **assessment** provides the **most accurate** guide to determine the **adequacy of fluid** resuscitation?

1. Skin turgor
2. Level of edema at burn site
3. Adequacy of capillary filling
4. Amount of fluid tolerated in 24 hours

NOTES:

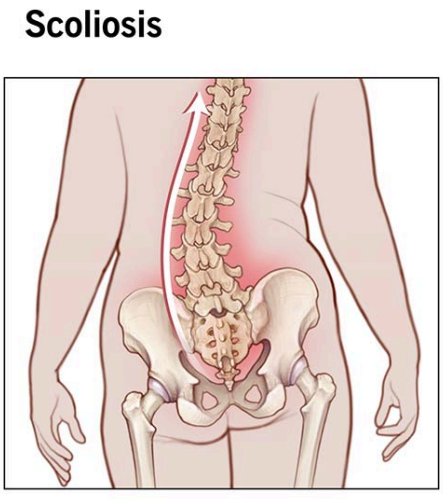
Q9 A student nurse is caring for a hospitalized child who has hypotonic dehydration. Which serum **sodium level** would the student **expect to observe?**

1. 125 mEq/L (125 mmol/L)
2. 135 mEq/L (135 mmol/L)
3. 145 mEq/L (145 mmol/L)
4. 155 mEq/L (155 mmol/L)

Q10 The nurse is providing instructions to the parents of a child with scoliosis regarding the use of a brace. Which statement by a parent indicates a **need for further teaching?**

1. "I cannot place powder under the brace."
2. "I need to place a soft shirt on my child under the brace."
3. "I need to be sure to apply lotion on the skin under the brace."
4. "I need to encourage my child to perform prescribed exercises."

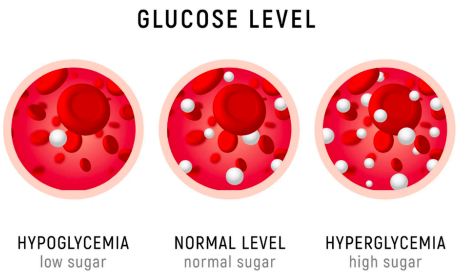
NOTES:



Scoliosis

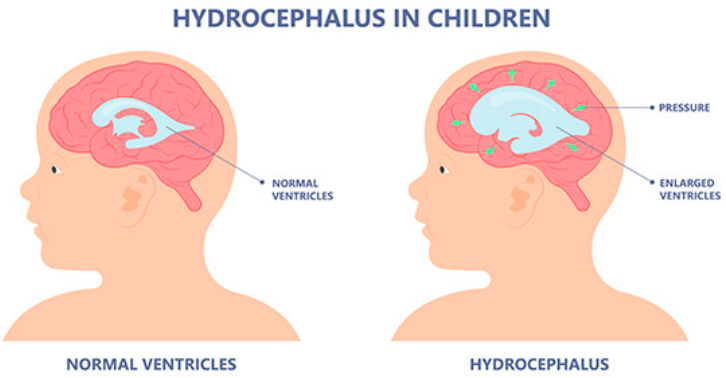
Q11 The nurse would implement **which interventions** for a 10-year-old child with type 1 diabetes mellitus who has a blood glucose level of **60 mg/dL**? **Select all that apply.**

1. Administer regular **insulin**.
2. Encourage the child to **ambulate**.
3. Give the child a teaspoon of **honey**.
4. Provide **electrolyte** replacement therapy intravenously.
5. **Wait 30 minutes** and confirm the blood glucose reading.
6. Prepare to administer **glucagon** subcutaneously if unconsciousness occurs.



Q12 The nurse is caring for a client diagnosed with a hydrocephalus. Which would the nurse **anticipate as being the cause** of this disorder?

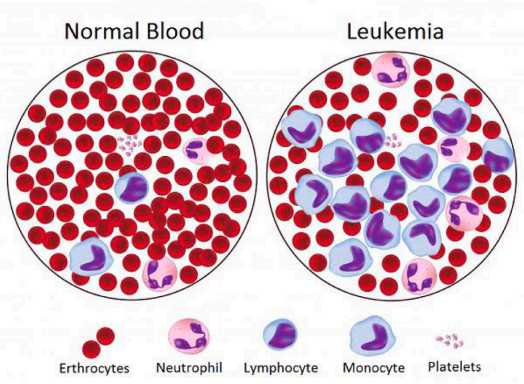
1. Closure of cranial sutures
2. Small aqueduct of Sylvius
3. Enlarged foramen of Monro
4. Increased number of arachnoid villi



NOTES:

Q13 The pediatric nurse clinician is discussing the pathophysiology related to childhood leukemia with a class of nursing students. Which statement made by a nursing student indicates a need for **further teaching of the pathophysiology** of this disease?

1. The platelet count is decreased.
2. Red blood cell production is affected.
3. Reed-Sternberg cells are found on biopsy.
4. Normal bone marrow is replaced by blast cells.



Q14 The nurse is reviewing the record of a 10-year-old child suspected of having Hodgkin's disease. Which **characteristic manifestation** would the nurse anticipate to be documented in the assessment notes?

1. Fever
2. Malaise
3. Painful lymph nodes in the supraclavicular area
4. Painless and movable lymph nodes in the cervical area

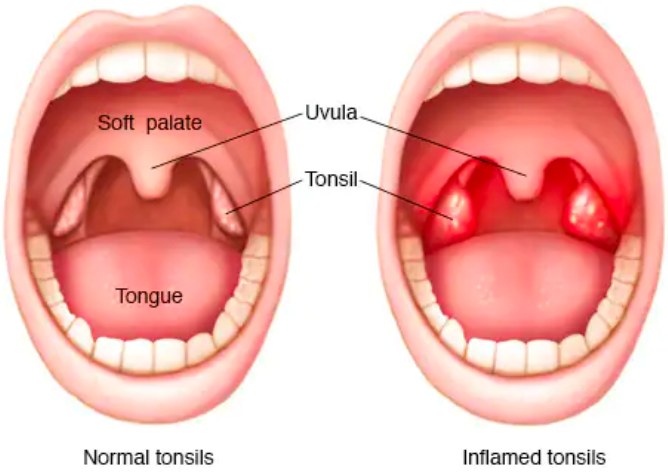
NOTES:

Q15 When collecting the history about a child who presents with signs of glomerulonephritis, the nurse would report which **most important** finding to the primary health care provider?

1. Child fell off a bike onto the handlebars
2. Nausea and vomiting for the last 24 hours
3. Urticaria and itching for 1 week before diagnosis
4. Streptococcal throat infection 2 weeks before diagnosis

Q16 A child is scheduled for a tonsillectomy. The nurse plans care, knowing that which condition would be a **priority** because it presents the highest **risk of aspiration** during surgery?

1. Presence of loose teeth
2. Bleeding during surgery
3. Difficulty in swallowing
4. Exudate in the throat area



NOTES:

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CLINICAL CASES

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1000: A 10-year-old child is brought to the ED by EMS, accompanied by the school nurse for seizures.

The school nurse reports that child has a history of tonic-clonic seizures. Parents informed the nurse that the child would have approximately 1 seizure every 2 months. This is the child's first seizure at school. At the time of arrival to the ED, the child is still seizing. The child is unconscious, eyes are rolling upward, legs, head, and neck are extended, arms are flexed, and the child is having increased salivation. The school nurse reports the seizure has been ongoing for 20 minutes. EMS started a peripheral IV while on the way to the hospital, and administered 4 mg lorazepam IV.

1015: The ED nurse assumes care and conducts a focused physical assessment, checks the blood glucose level, assesses vital signs, and administers lorazepam 4 mg.

- Fingerstick blood glucose level STAT
- Maintain O2 via facemask to maintain SpO2 greater than 92%
- Lorazepam 4 mg IV once PRN for seizure; may repeat in 3-5 minutes if needed

Highlight in Text question. Items include a paragraph of information and you need to select parts of the text based on what the question is asking you to select. There can be a maximum of 10 options in these question types and you can select and unselect options until you make a decision on the correct answers.

Scoring: Partial credit: earn 1 point for selecting the correct option; lose 1 point for each incorrect selection.

Based on the nurse's assessment findings, click to highlight below the findings that require immediate follow-up.

Vital signs: T 98.0°F (36.7°C), HR 108 BPM regular, RR 18 bpm with periods of apnea, BP 110/70 mmHg, SpO2 91% via facemask

Neurological: Loss of consciousness, twitching, jerking movements of all extremities, teeth clenched, frothing at mouth

Cardiovascular: Lips blue in color, HR 108 BPM, regular rate and rhythm on auscultation

Respiratory: Periods of apnea up to 15 seconds, RR 18 bpm in between apnea, unlabored breathing

Drop Down Rationale. Complete the sentence or fill-in-the-blank by choosing from a list of drop-down options and selecting the correct option. A full understanding of "paired" information is required to answer the question correctly. It is very important to choose the first option correctly so that the remaining option choices are based on the correct foundation.

Scoring: Both fill-in-the-blanks must be correct to earn a point; for a 2 fill-in-the-blank item (dyad), max point is 1; for a 3 fill-in-the-blank item (triad), max point is 2.

Based on the most recent assessment, select a condition (seizure type) and an assessment finding from the lists of options provided to fill in the blanks in the following sentence.

The nurse analyzes the child's findings to determine that the child is experiencing _____

1. febrile seizures
2. simple partial seizures
3. complex partial seizures
4. the tonic phase of generalized seizures
5. the clonic phase of generalized seizures

as evidenced by _____.

1. SpO2 91% via facemask
2. T 98.0°F (36.7°C)
3. RR 18 bpm in between apnea, unlabored breathing
4. AP 108 BPM, regular rate and rhythm on auscultation
5. loss of consciousness, twitching, jerking movements of all extremities, clenched teeth, frothing at mouth

Cloze DropDown. Complete the sentence or fill-in-the-blank by choosing from a list of drop-down options and selecting the correct option.

Complete the following sentence by choosing from the lists of options provided.

The child is most likely experiencing _____

1. hypotension
2. hyperthermia
3. status epilepticus
4. respiratory failure
5. intractable seizures

and needs **immediate** administration of _____.

1. oxygen
2. IV fluids
3. IV phenytoin
4. IV lorazepam
5. cooling measures

Multiple Response Select N question. The question specifies the number of options (N) that can be selected. Select the exact number of options specified in the directions. Scoring: Partial credit, 1 point for each correct option selection; 0 points for incorrect responses.

1035: The nurse has administered 4 mg of IV lorazepam as prescribed, and the child's is still seizing after 5 minutes. Which 4 additional interventions would the nurse plan to take to ensure safe client care during the seizure?

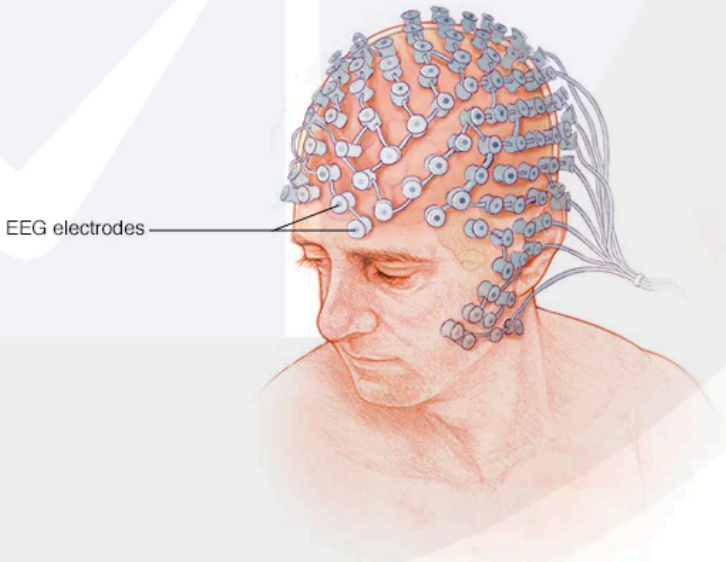
1. Remove eyeglasses.
2. Loosen restrictive clothing.
3. Position the child on the back.
4. Clear objects away from the child.
5. Place a folded blanket under the child's head.
6. Restrain the child to control movements.
7. Place a tongue blade between the child's teeth.



1045: The seizure has ended after administration of the second dose of 4 mg IV lorazepam. The child is transferred to the pediatric intensive care unit. The physician indicates the need for intubation due to the prolonged seizure to protect the airway while further testing and treatment is performed. The nurse conducts a physical assessment in the postictal phase and reviews the medical record for new physician orders. The nurse implements the physician orders.

1115: The child is intubated and on mechanical ventilation, and the nurse takes additional actions in the care of the child.

- Levetiracetam 60 mg/kg (maximum 4500 mg) IV over 15 minutes
- Continuous EEG monitoring
- Intubation and mechanical ventilation
- Continuous blood pressure monitoring
- Continuous cardiac monitoring
- Continuous diprivan infusion 7.5 mg/kg/hr



Cloze DropDown. Complete the sentence or fill-in-the-blank by choosing from a list of drop-down options and selecting the correct option.

Complete the following sentence by choosing from the lists of options provided.

Priority nursing **actions** for the client at this time would be

to _____ to _____

1. monitor temperature
2. monitor blood pressure
3. suction the oropharynx as needed

1. prevent aspiration
2. assess for hypertension
3. assess for hypothermia

and _____ to _____.

1. administer lorazepam
2. isolate the child from view
3. place the child in a supine position

1. minimize distress for family
2. prevent additional seizures
3. prevent airway occlusion

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Bilingual Review





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