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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 An adolescent client is diagnosed with **conjunctivitis,** and the nurse provides information to the client about the use of contact lenses. Which client statement indicates the need for **further information**?

1. "I need to obtain new contact lenses."
2. "I need to not wear my contact lenses."
3. "My old contact lenses need to be discarded."
4. "My contact lenses can be worn if they are cleaned as directed."

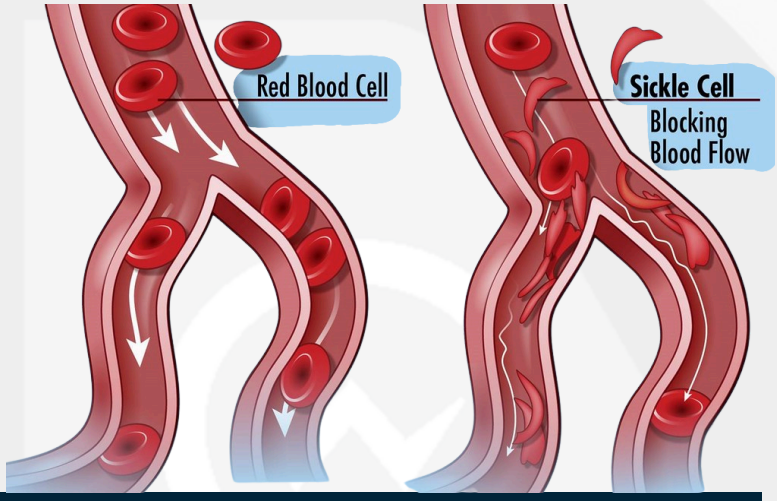
Q2 A 6-year-old child has just been diagnosed with localized **Hodgkin's disease**, and chemotherapy is planned to begin immediately. The parent of the child asks the nurse why radiation therapy was not prescribed as a part of the treatment. The nurse would plan to make which **best response**?

1. "It's very costly, and chemotherapy works just as well."
2. "I'm not sure. I'll discuss it with the primary health care provider."
3. "Sometimes age has to do with the decision for radiation therapy."
4. "The primary health care provider would prefer that you discuss treatment options with the oncologist."

**NOTES:**

Q3 The nurse is preparing to perform an assessment on a child being admitted to the hospital with a diagnosis of **sickle cell crisis, vaso-occlusive crisis.** Which findings would the **nurse expect** to note on assessment of the child? Select all that apply.

1. Pallor
2. Fever
3. Joint swelling
4. Blurred vision
5. Abdominal pain




Q4 A 1-year-old infant with a diagnosis of **heart failure is prescribed digoxin.** The nurse takes the apical pulse for 1 minute before administering the medication and obtains a result of 102 beats/minute. What is the nurse's **best** action?

1. Retake the apical pulse.
2. Withhold the medication.
3. Administer the medication.
4. Notify the primary health care provider.

**NOTES:**

Q5 The nurse is creating a plan of care for a child admitted with a diagnosis of Kawasaki disease. In developing the initial plan of care, the nurse would include monitoring the child for signs of which condition?

1. Bleeding
2. Heart failure
3. Failure to thrive
4. Decreased tolerance to stimulation



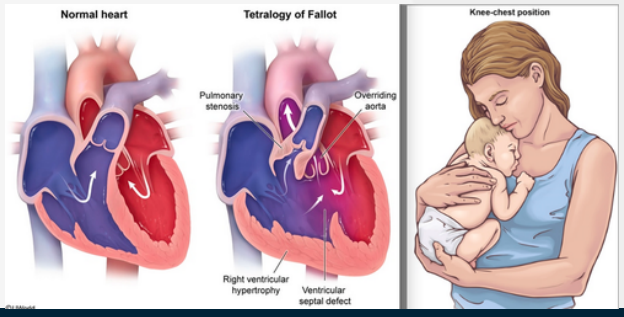

Q6 The nurse is reviewing the primary health care provider's prescriptions for a child with rheumatic fever who is suspected of having a viral infection. The nurse notes that aspirin is prescribed for the child. Which nursing action is most appropriate?

1. Administer acetaminophen for temperature elevation.
2. Administer the aspirin if the child's temperature is elevated.
3. Administer the aspirin if the child experiences any joint pain.
4. Consult with the primary health care provider to verify the prescription.

**NOTES:**

Q7 The nurse is assigned to care for an infant with Tetralogy of Fallot. The parent of the infant calls the nurse to the room because the infant suddenly seems to be having difficulty breathing. The nurse enters the room and notes that the infant is experiencing a hypercyanotic episode. What is the priority action by the nurse?

1. Notify the nursing supervisor.
2. Contact the respiratory therapist.
3. Place the infant in a prone position.
4. Place the infant in a knee-chest position.




Q8 A home care nurse instructs the parent of a 5-year-old child with lactose intolerance about dietary measures for the child. The nurse would tell the parent that it is necessary to provide which dietary supplement in the child's diet?

1. Fats
2. Zinc
3. Protein
4. Calcium

**NOTES:**

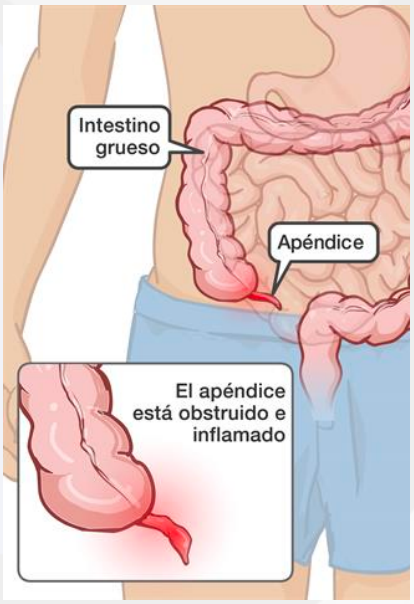
Q9 The nurse has been assigned to care for a neonate just delivered who has gastroschisis. Which concern would the nurse address in the client's plan of care?

1. Infection
2. Poor body image
3. Decreased urinary elimination
4. Cracking oral mucous membranes




Q10 The nurse is assigned to care for a child who is scheduled for an appendectomy. Which prescriptions would the nurse expect to be prescribed. Select all that apply.

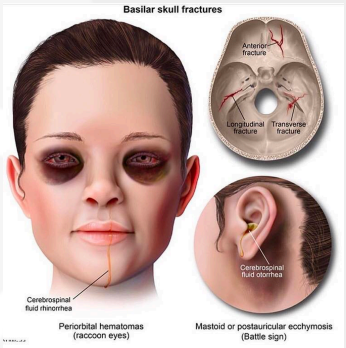
1. Initiate an IV line.
2. Maintain an NPO status.
3. Administer a Fleet enema.
4. Administer intravenous antibiotics.
5. Administer preoperative medications.
6. Place a heating pad on the abdomen to decrease pain.




**NOTES:**

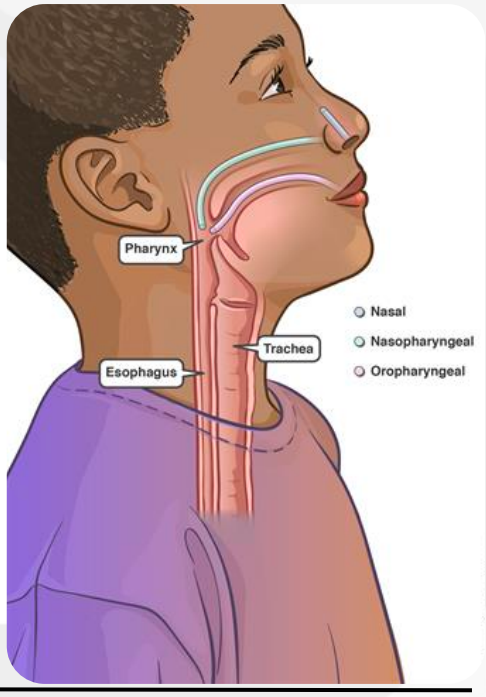
Q11 The parents of a child recently diagnosed with cerebral palsy ask the nurse about the limitations of the disorder. The nurse plans to respond by explaining that the limitations occur as a result of which pathophysiological process?

1. An infectious disease of the central nervous system
2. An inflammation of the brain as a result of a viral illness
3. A chronic disability characterized by impaired muscle movement and posture
4. A congenital condition that results in moderate to severe intellectual disabilities




Q12 The nurse is assigned to care for an 8-year-old child with a diagnosis of a basilar skull fracture. The nurse reviews the primary health care provider's (PHCP's) prescriptions and would contact the PHCP to question which prescription?

- Obtain daily weight.
- Provide clear liquid intake.
- Nasotracheal suction as needed.
- Maintain a patent intravenous line.




**NOTES:**

Q13 The nurse is creating a plan of care for a child who is at risk for seizures. Which interventions apply if the child has a seizure? Select all that apply.

1. Time the seizure.
2. Restrain the child.
3. Stay with the child.
4. Place the child in a prone position.
5. Move furniture away from the child.
6. Insert a padded tongue blade in the child's mouth.

Q14 The nurse analyzes the laboratory values of a child with leukemia who is receiving chemotherapy. The nurse notes that the platelet count is 19,500 mm3 (19.5 × 109/L). On the basis of this laboratory result, which intervention would the nurse include in the plan of care?

1. Initiate bleeding precautions.
2. Monitor closely for signs of infection.
3. Monitor the temperature every 4 hours.
4. Initiate protective isolation precautions.

**NOTES:**

# Seizure First Aid

How to help someone having a seizure

## 1

**STAY** with the person until they are awake and alert after the seizure.

- ✓ **Time** the seizure
- ✓ Remain **calm**
- ✓ Check for **medical ID**



## 2

Keep the person **SAFE**.

- ✓ Move or guide away from **harm**



## 3

Turn the person onto their **SIDE** if they are not awake and aware.

- ✓ Keep **airway clear**
- ✓ **Loosen tight clothes** around neck
- ✓ Put **something small and soft** under the head



## Call 911 if...

- Seizure lasts longer than 5 minutes
- Person does not return to their usual state
- Person is injured, pregnant, or sick
- Repeated seizures
- First time seizure
- Difficulty breathing
- Seizure occurs in water

## Do NOT

- ✕ Do **NOT** restrain.
- ✕ Do **NOT** put any objects in their mouth.
  - **Rescue medicines can be given** if prescribed by a health care professional

**NOTES:**

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## CLINICAL CASES

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A 10-year-old child was admitted to the pediatric unit of the hospital one day ago. The history reveals that the child was brought to the ED one day prior to admission because of fever and chills, lethargy, chest pain and shortness of breath, and a congested cough. The parent told the ED nurse that the child had a recent history of tracheobronchitis but that the cough worsened, and the child started coughing up mucus. Symptoms are not resolving and the child has not been eating or drinking and has not been active. On further testing, the child was diagnosed with acute Mycoplasma pneumoniae and intravenous erythromycin lactobionate, intravenous methylprednisolone, and respiratory treatments were prescribed.

08:00 - The nurse caring for the child performs an assessment and documents the following in the medical record.

T 99.8°F (37.6°C), HR 110 BPM, RR 24 bpm, BP 100/64 mmHg, SpO2 89% RA, Pain 7/10 on 0 to 10 pain scale. Appetite poor, refusing breakfast or liquids. Scattered crackles bilaterally in lower lobes; rapid and shallow respirations. Reports fatigue, chest pain, and shortness of breath Dry skin and mucous membranes; sores in mouth. Voided 25 mL concentrated urine. Color pale, capillary refill 4 seconds. Flat round red patches on the abdomen and back.

0830: The nurse contacts the pediatrician and reports the assessment findings. The pediatrician visits the child and determines that the child is having some respiratory compromise from the Mycoplasma pneumonia, is dehydrated, and has erythema multiforme.

**Highlight the findings in the medical record that require immediate follow-up by the nurse.**

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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.

| Client Finding | Mycoplasma pneumoniae | Erythema multiforme | Dehydration |
|---|---|---|---|
| Sores in the mouth | | | |
| Rapid respirations | | | |
| Concentrated urine | | | |
| Capillary refill 4 seconds | | | |
| Scattered lung crackles | | | |
| Chest pain and shortness of breath | | | |
| Dry skin and mucous membranes | | | |
| Round red patches noted on the back and abdomen | | | |




Matrix Multiple Choice. This is a Matrix Multiple Choice question. These items have columns and rows. Make 1 selection per row. Each row must have 1 response selected in order for the test to move on. This analysis will assist you in determining the client findings associated with each disease process by grouping the findings with the main body systems, as illustrated below.

| Disease Process | Main Body Systems Affected |
|---|---|
| *Mycoplasma pneumoniae* | Respiratory |
| Erythema multiforme | Integumentary |
| Dehydration | Cardiovascular, respiratory, integumentary |

| Disease Process | Main Body Systems Affected | Client Findings |
|---|---|---|
| *Mycoplasma pneumoniae* | Respiratory | Rapid respirations<br>Scattered lung crackles<br>Chest pain and shortness of breath |
| Erythema multiforme | Integumentary | Sores in the mouth<br>Round red patches noted on the back and abdomen |
| Dehydration | Cardiovascular, respiratory, integumentary | Rapid respirations<br>Concentrated urine<br>Capillary refill 4 seconds<br>Dry skin and mucous membranes |

**08:45 -** The nurse reviews the assessment findings and the pediatrician's notes to determine the priority client needs. Complete the following sentence from the lists of options provided.

**As a priority, the nurse would address the child's** _____

1. appetite
2. temperature
3. red skin patches

**because of** _____

1. infection
2. fatigue
3. a possible allergic response

**and the child's** _____

1. pain level
2. capillary refill
3. shortness of breath

**because of the need to** _____

1. improve oxygenation
2. improve hydration status
3. lower the blood pressure

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

The nurse is initiating the child's plan of care. For each body system below, click to specify the potential nursing interventions the nurse would plan for the child. Each body system may support more than one potential nursing intervention.

09:15 - The nurse checks on the child and the child reports itchy skin. The nurse assesses the skin and notes no change in the size of the red patches on the skin and back but notes that there are also red patches on the palms of the hand and the soles of the feet. The nurse asks the child about a preferred drink and something to eat and the child refuses stating "I don't want anything." The nurse reassesses the child and notes no change as compared to previous findings. The pediatrician writes orders in the child's medical record.

| Body System | Potential Nursing Intervention |
|---|---|
| **Integumentary** | 1. Moist cool compresses<br>2. Topical antibiotic cream<br>3. Antihistamines |
| **Respiratory** | 1. Oxygen<br>2. Respiratory treatments<br>3. Head elevation at 30 to 45 degrees |
| **Fluid and Electrolyte Balance** | 1. Intravenous fluids<br>2. Monitor body weight<br>3. Oral potassium chloride |

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09:15 - The nurse checks on the child and the child reports itchy skin. The nurse assesses the skin and notes no change in the size of the red patches on the skin and back but notes that there are also red patches on the palms of the hand and the soles of the feet. The nurse asks the child about a preferred drink and something to eat and the child refuses stating "I don't want anything." The nurse reassesses the child and notes no change as compared to previous findings. The pediatrician writes orders in the child's medical record.

Complete the following sentence from the lists of options provided.

**As a priority, the nurse would address the child's** _____

1. obtaining a nose and throat culture
2. applying oxygen via NC at 2 L/min
3. applying cool compresses to skin lesions
4. discontinuing erythromycin lactobionate
5. starting an IV of 5% dextrose in 0.9 normal saline and run at 50 mL/hr

**followed by** _____

1. obtaining a nose and throat culture
2. applying oxygen via NC at 2 L/min
3. applying cool compresses to skin lesions
4. discontinuing erythromycin lactobionate
5. starting an IV of 5% dextrose in 0.9 normal saline and run at 50 mL/hr

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

Highlight the day 3 findings in the medical record that indicate improvement in the child's condition.

Day 3: 0900: VS: T 99.8°F (37.6°C), HR 90 BPM, RR 20 bpm, BP 100/64 mmHg, SpO2 94% RA, Pain 2/10 on 0 to 10 scale. Appetite poor, sipping on apple juice. Scattered crackles bilaterally in lower lobes, reports fatigue, minimal chest pain and denies shortness of breath. Dry skin and mucous membranes Voided 100 mL yellow urine. Color pale, capillary refill 3 seconds. Flat, round, red patches noted on the abdomen and back; none noted on the palms or soles.



To Evaluate Outcomes, think about each finding, whether it was initially abnormal, and how it has changed if it has (unchanged, improved, not improved).

Then, think about whether the latest finding would indicate an improvement.



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