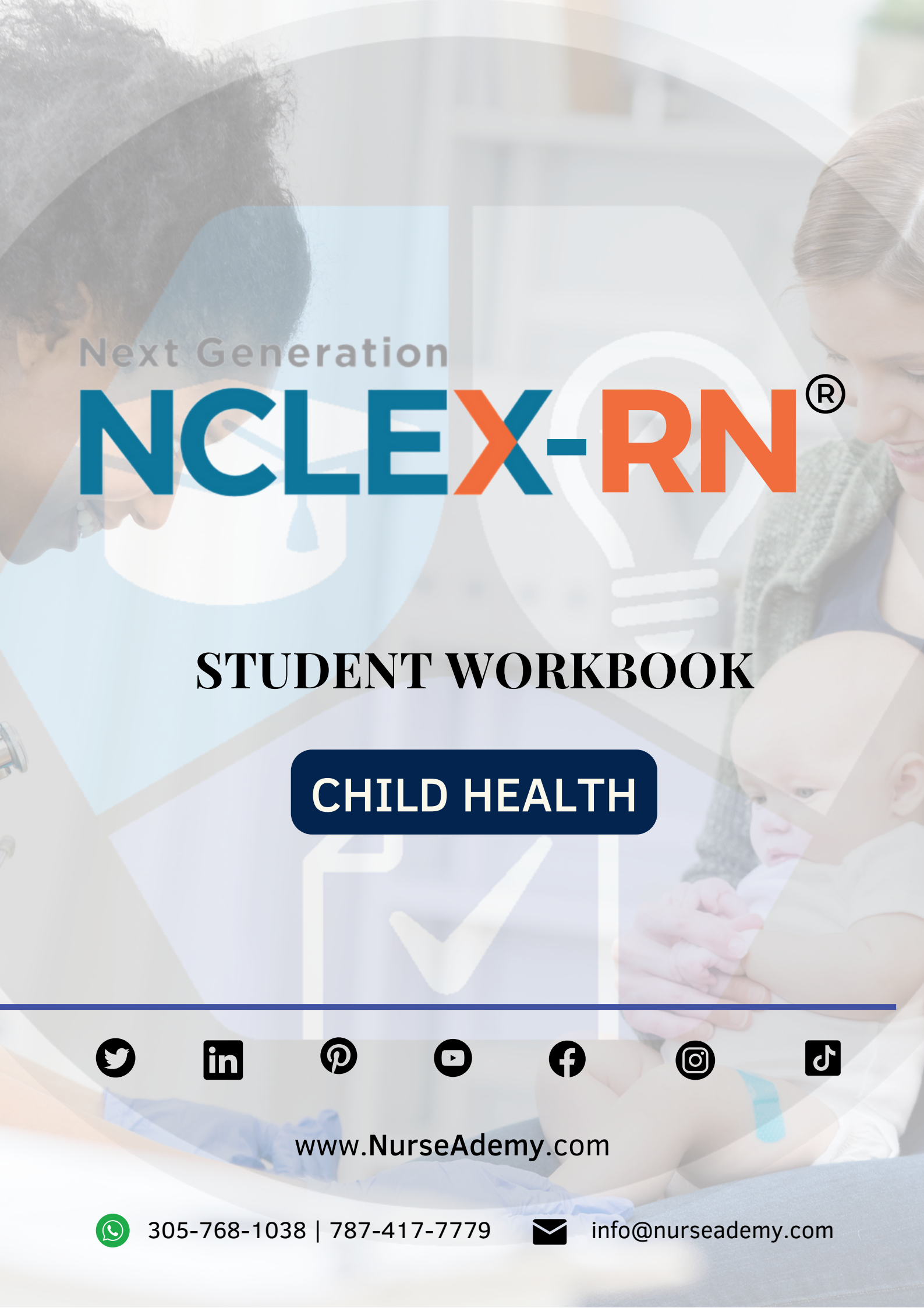

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NCLEX-RN®

STUDENT WORKBOOK

CHILD HEALTH

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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)

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?

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Multiple Choice Exercise: When an individual is diagnosed with conjunctivitis, what is the most appropriate action to take regarding their contact lenses?

A) Continue wearing the contact lenses but clean them more frequently
B) Temporarily stop wearing contact lenses until the infection resolves
C) Soak the contact lenses in disinfectant for an extended period
D) Switch to a different brand of contact lenses

Multiple Selection Exercise: An adolescent client is diagnosed with conjunctivitis. Which of the following statements are appropriate for the client to follow regarding contact lens use? (Select all that apply)

A) Obtain new contact lenses after the infection resolves
B) Stop wearing contact lenses until the infection clears up
C) Discard old contact lenses to prevent re-infection
D) Clean the contact lenses more frequently and continue wearing them

ANSWER KEY

Multiple Choice Exercise: When an individual is diagnosed with conjunctivitis, what is the most appropriate action to take regarding their contact lenses?

B) Temporarily stop wearing contact lenses until the infection resolves. When someone has conjunctivitis, it is generally advised to stop wearing contact lenses to prevent further irritation, give the eye a chance to heal, and avoid spreading the infection. Once the infection is resolved, the individual should discard the old contact lenses, obtain new ones, and maintain proper lens hygiene to prevent future infections.

Multiple Selection Exercise: An adolescent client is diagnosed with conjunctivitis. Which of the following statements are appropriate for the client to follow regarding contact lens use? (Select all that apply)

- A) Obtain new contact lenses after the infection resolves - Once the infection is resolved, the client should obtain new contact lenses to prevent re-infection and ensure proper lens hygiene.

- B) Stop wearing contact lenses until the infection clears up - It is generally advised to stop wearing contact lenses during an active conjunctivitis infection to prevent further irritation, give the eye a chance to heal, and avoid spreading the infection.

- C) Discard old contact lenses to prevent re-infection - Discarding infected contact lenses is crucial to prevent re-infection and the spread of conjunctivitis. This should be done after the infection is resolved and before starting to use new lenses.

REMEMBER

- It is important to replace the infected contact lenses once the conjunctivitis is resolved. However, it is not the main concern during an active infection.
- When someone has conjunctivitis, it is generally advised to stop wearing contact lenses to prevent further irritation, give the eye a chance to heal, and avoid spreading the infection.
- Discarding infected contact lenses is crucial to prevent re-infection and the spread of conjunctivitis. This should be done after the infection is resolved and before starting to use new lenses.
- While proper cleaning of contact lenses is essential for maintaining good eye health, it is not recommended to wear contact lenses during an active conjunctivitis infection. Wearing contact lenses can cause further irritation, prolong the infection, and potentially lead to complications. The client should be advised not to wear contact lenses until the infection is completely resolved and to consult their healthcare provider for further guidance.

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?

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Multiple Choice Exercise: Why is radiation therapy typically delayed, whenever possible, until a child is 8 years old?

A) To minimize the need for additional treatments in the future.
B) To prevent retardation of bone growth and soft tissue development.
C) To ensure the child can better tolerate the side effects of radiation therapy.
D) To allow time for the child to emotionally prepare for the treatment process.

Multiple Selection Exercise: Which of the following reasons explain why radiation therapy is typically delayed, whenever possible, until a child is 8 years old? (Select all that apply)

A) To prevent retardation of bone growth
B) To minimize the impact on a child's emotional well-being
C) To allow for more accurate targeting of cancerous cells
D) To prevent negative effects on soft tissue development

ANSWER KEY

Multiple Choice Exercise: Why is radiation therapy typically delayed, whenever possible, until a child is 8 years old?

B) To prevent retardation of bone growth and soft tissue development. Radiation therapy, while effective in treating various types of cancer, can have significant side effects on a child's growing body. In children under 8 years old, the potential risks of radiation therapy include retardation of bone growth and soft tissue development. By delaying radiation therapy until a child is older, medical professionals aim to minimize these risks and allow the child's body to develop more fully before undergoing treatment. This approach helps to protect the child's long-term health and quality of life.

Multiple Selection Exercise: Which of the following reasons explain why radiation therapy is typically delayed, whenever possible, until a child is 8 years old? (Select all that apply)

- A) To prevent retardation of bone growth: Radiation therapy can negatively impact the growth of a child's bones, leading to possible deformities and growth issues. By waiting until the child is older, medical professionals aim to reduce the risk of these side effects.

- D) To prevent negative effects on soft tissue development: In addition to bone growth, radiation therapy can also have detrimental effects on a child's soft tissue development. Delaying treatment helps protect the child's overall growth and development.

REMEMBER

- While it is true that radiation therapy can be expensive, cost is not the primary concern when determining the best treatment for a patient. Medical professionals consider the individual patient's needs, the stage of the disease, and potential side effects before deciding on a treatment plan.
- While it is always good to clarify doubts, it does not provide an immediate answer or explanation to the parent's question.
- In young children, radiation therapy can have long-term side effects, such as growth and development issues or secondary cancers. Medical professionals weigh the risks and benefits of radiation therapy before deciding on a treatment plan. In this case, chemotherapy might have been chosen because it is thought to be more appropriate for the child's age and the stage of the disease.
- While it is true that an oncologist is a specialist in cancer treatment, this response does not provide any immediate explanation or reassurance to the parent. It might be more helpful for the nurse to explain the potential reasons for the treatment decision and offer to arrange a discussion with the oncologist if the parent has further concerns.

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.

NOTES:

Multiple Choice Exercise: Which of the following best describes the cause and manifestations of a vaso-occlusive crisis in a patient with sickle cell disease?

A) Caused by excessive blood clotting, leading to joint pain, shortness of breath, and chest pain
B) Caused by hemolysis of red blood cells, leading to fatigue, jaundice, and anemia
C) Caused by stasis of blood and clumping of cells in the microcirculation, leading to pallor, fever, joint pain, and abdominal pain
D) Caused by an autoimmune response, leading to inflammation, joint stiffness, and muscle weakness

Multiple Selection Exercise: Which of the following manifestations are commonly associated with a vaso-occlusive crisis in a patient with sickle cell disease? (Select all that apply)

A) Pallor
B) Fever
C) Painful swelling of hands, feet, and joints
D) Blurred vision
E) Abdominal pain

ANSWER KEY

Multiple Choice Exercise: Which of the following best describes the cause and manifestations of a vaso-occlusive crisis in a patient with sickle cell disease?

C) Caused by stasis of blood and clumping of cells in the microcirculation, leading to pallor, fever, joint pain, and abdominal pain. A vaso-occlusive crisis in sickle cell disease is primarily caused by stasis of blood and the clumping of sickle-shaped red blood cells in the microcirculation, resulting in ischemia and infarction. This process leads to various manifestations, including pallor (paleness of the skin), fever, painful swelling of hands, feet, and joints, and abdominal pain. This accurately describes the cause and symptoms of a vaso-occlusive crisis in a patient with sickle cell disease.

Multiple Selection Exercise: Which of the following manifestations are commonly associated with a vaso-occlusive crisis in a patient with sickle cell disease? (Select all that apply)

- A) Paleness of the skin occurs as a result of poor blood circulation and a lack of oxygen and nutrients being delivered to the tissues.
- B) Fever can develop as the body responds to inflammation and potential infection during a sickle cell crisis.
- C) The obstruction of blood flow in small blood vessels can cause pain and swelling in the hands, feet, and joints.
- E) Sickle-shaped red blood cells can obstruct blood flow in the blood vessels of the abdominal organs, leading to pain, inflammation, and potential tissue damage.
- Blurred vision is not a common manifestation of a vaso-occlusive crisis, although it can occur in some cases if the blood vessels in the eyes are affected. It is more commonly associated with other complications of sickle cell disease, such as retinopathy.

REMEMBER

- Pallor, or paleness of the skin, is a common finding in children with a sickle cell crisis, particularly during a vaso-occlusive crisis. This occurs because the sickle-shaped red blood cells can obstruct blood flow, leading to a lack of oxygen and nutrients being delivered to tissues, causing the skin to appear pale.

- Fever can be present during a sickle cell crisis, as the body responds to inflammation and possible infection. Sickle-shaped red blood cells can cause tissue damage and inflammation, which can contribute to the development of fever.

- Joint swelling is a common symptom during a vaso-occlusive crisis. The sickle-shaped red blood cells can obstruct blood flow in the small blood vessels, leading to pain and swelling in the joints. This can be exacerbated by inflammation and the body's immune response.

- Blurred vision is not a common finding during a sickle cell crisis or vaso-occlusive crisis. However, it can occur in some cases if blood vessels in the eyes are affected by the sickle-shaped red blood cells, leading to a lack of oxygen and nutrients being delivered to the retina. This symptom is more commonly associated with other complications of sickle cell disease, such as retinopathy.

- Abdominal pain is another common symptom during a sickle cell crisis, particularly a vaso-occlusive crisis. The sickle-shaped red blood cells can obstruct blood flow in the blood vessels of the abdominal organs, causing pain, inflammation, and even tissue damage.

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?

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Multiple Choice Exercise:

A client diagnosed with heart failure is prescribed digoxin. Which of the following statements made by the client indicates a need for further teaching about the medication?

A. "I will take my digoxin with a glass of grapefruit juice every morning."
B. "I will check my pulse before taking the medication, and if it's below 60 beats per minute, I won't take it."
C. "I will report any nausea, vomiting, or vision changes to my healthcare provider."
D. "I will take my digoxin at the same time every day, with or without food."

Multiple Selection Exercise:

Which of the following are important nursing considerations when administering digoxin? Select all that apply.

A. Monitor the client's serum potassium levels.
B. Check the client's apical pulse before administering the medication.
C. Administer the medication with a high-fat meal.
D. Assess for signs and symptoms of digoxin toxicity.
E. Encourage the client to report any changes in vision.
F. Withhold the medication if the client's heart rate is below 100 beats per minute.

ANSWER KEY

Multiple Choice Exercise:

The correct answer is A. "I will take my digoxin with a glass of grapefruit juice every morning."

Rationale: Taking digoxin with grapefruit juice is not recommended. Grapefruit juice can interact with digoxin and increase the levels of the medication in the bloodstream, leading to an increased risk of digoxin toxicity. Therefore, it is important to educate the client to avoid consuming grapefruit juice while taking digoxin.

Multiple Selection Exercise:

B. Check the client's apical pulse before administering the medication: This is an essential nursing consideration for administering digoxin. Digoxin has a narrow therapeutic range, and checking the apical pulse helps assess the client's heart rate and rhythm, ensuring that it is within an appropriate range before administering the medication.

D. Assess for signs and symptoms of digoxin toxicity: This is an important nursing consideration when administering digoxin. Digoxin toxicity can occur due to an overdose or accumulation of the medication, leading to various symptoms such as nausea, vomiting, changes in vision, cardiac arrhythmias, and altered mental status. Regular assessment for signs and symptoms of digoxin toxicity is crucial for early identification and appropriate intervention.

E. Encourage the client to report any changes in vision: This is another important nursing consideration when administering digoxin. Digoxin toxicity can manifest with visual disturbances such as blurred or yellow-tinted vision, seeing halos around lights, or other changes. Instructing the client to report any changes in vision helps to monitor for potential medication-related adverse effects.

REMEMBER

- Retake the apical pulse: This option suggests that the nurse should retake the infant's apical pulse. The normal range for a 1-year-old infant's heart rate is typically between 80 and 160 beats per minute. A heart rate of 102 beats per minute falls within this normal range. However, it is essential to verify the accuracy of the initial measurement before proceeding. Therefore, retaking the apical pulse is a reasonable and prudent action to ensure an accurate reading.

- Withhold the medication: Withholding the medication is not necessary in this scenario. The heart rate of 102 beats per minute is within the normal range for a 1-year-old infant. Digoxin is commonly used to treat heart failure in infants, and a heart rate of 102 does not indicate an immediate need to withhold the medication.

- Administer the medication: This is the correct option. Since the heart rate of 102 beats per minute falls within the normal range for a 1-year-old infant, it is appropriate to administer the prescribed medication (digoxin). Digoxin is commonly used to manage heart failure and improve cardiac function in infants and children. The nurse should follow the prescribed dosage and administration instructions for the medication.

- Notify the primary healthcare provider: Notifying the primary healthcare provider is not necessary in this situation. The heart rate of 102 beats per minute is within the normal range for a 1-year-old infant, and there is no indication of any immediate concern or need for medical intervention. Therefore, there is no reason to notify the primary healthcare provider based on the heart rate alone.

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?

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Multiple Choice Exercise:

A 3-year-old child is admitted to the hospital with a diagnosis of Kawasaki disease. The nurse should prioritize which intervention?

A. Administering antipyretics to reduce fever.
B. Assessing for signs of cardiac involvement.
C. Initiating airborne precautions.
D. Implementing strict isolation measures.

Multiple Selection Exercise:

Which of the following are potential complications of Kawasaki disease? Select all that apply.

A. Coronary artery aneurysms
B. Liver dysfunction
C. Renal failure
D. Respiratory distress
E. Joint inflammation
F. Hyperthyroidism

ANSWER KEY

Multiple Choice Exercise:

The correct answer is B. Assessing for signs of cardiac involvement.

Rationale: Kawasaki disease is an acute systemic vasculitis that primarily affects children, particularly those under the age of five. It is characterized by fever, rash, conjunctival injection, changes in the extremities, and mucous membrane changes. One of the significant complications of Kawasaki disease is cardiac involvement, which can include myocarditis, coronary artery abnormalities, and even the development of coronary artery aneurysms. These cardiac complications can potentially lead to long-term cardiac issues or even life-threatening situations. Therefore, the nurse should prioritize assessing the child for signs of cardiac involvement, such as changes in heart rate, rhythm, or signs of heart failure, as early detection and appropriate intervention are crucial for optimal outcomes.

Multiple Selection Exercise:

A. Coronary artery aneurysms: This is a significant and well-known complication of Kawasaki disease. Inflammation of the blood vessels, including the coronary arteries, can lead to the development of aneurysms. These aneurysms can have serious implications for cardiac function and may require ongoing monitoring and management.

D. Respiratory distress: Respiratory distress is not a direct consequence of Kawasaki disease. However, in severe cases, systemic inflammation and cardiac complications can lead to heart failure, which may manifest with symptoms such as respiratory distress.

E. Joint inflammation: Joint inflammation, known as arthritis, can occur as a manifestation of Kawasaki disease. This joint involvement typically presents as transient arthritis and is one of the clinical criteria used to diagnose the disease.

REMEMBER

- Bleeding: Monitoring the child for signs of bleeding is important in various clinical situations. However, in the context of a child admitted with a diagnosis of Kawasaki disease, bleeding is not typically a primary concern. Kawasaki disease is an acute systemic vasculitis that primarily affects young children, particularly those under the age of five. The main clinical manifestations of Kawasaki disease include fever, rash, conjunctival injection, changes in the extremities, and mucous membrane changes. While bleeding can occur in severe cases of Kawasaki disease due to vascular inflammation, it is not a prominent feature or a primary concern in the initial plan of care.

- Heart failure: This is the correct option. Kawasaki disease can cause inflammation of the blood vessels, including the coronary arteries. In some cases, the inflammation can lead to the development of coronary artery aneurysms or other cardiac complications. These cardiac complications, including myocarditis and coronary artery abnormalities, can result in heart failure. Therefore, monitoring the child for signs of heart failure, such as increased respiratory rate, tachycardia, poor feeding, or fluid retention, is an important component of the initial plan of care for a child with Kawasaki disease.

- Failure to thrive: Failure to thrive refers to inadequate growth or weight gain in children. While Kawasaki disease can cause systemic symptoms and affect the child's overall well-being, failure to thrive is not a specific hallmark of the condition. The focus of care in Kawasaki disease is primarily on managing the acute vasculitis and potential cardiac complications rather than addressing failure to thrive.

- Decreased tolerance to stimulation: Kawasaki disease can cause various systemic symptoms, including fever, irritability, and general malaise. However, decreased tolerance to stimulation is not a specific sign or concern associated with Kawasaki disease. While the child may experience fatigue or irritability due to the systemic effects of the disease, monitoring for decreased tolerance to stimulation is not a primary consideration in the initial plan of care.

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?

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Multiple Choice Exercise:

Which of the following statements accurately describes rheumatic fever?

A. Rheumatic fever is caused by a bacterial infection.
B. Rheumatic fever primarily affects the lungs.
C. Rheumatic fever is commonly seen in older adults.
D. Rheumatic fever can lead to heart complications.

Multiple Selection Exercise:

Which of the following are clinical manifestations of rheumatic fever? Select all that apply.

A. Migratory polyarthritis
B. Skin rash
C. Epistaxis
D. Cardiac murmurs
E. Elevated blood pressure
F. Chorea (involuntary movements)

ANSWER KEY

Multiple Choice Exercise:

The correct answer is D. Rheumatic fever is an inflammatory condition that can develop as a complication of an inadequately treated group A Streptococcus infection, such as strep throat. It primarily affects children and young adults. Rheumatic fever is characterized by inflammation and can involve various parts of the body, including the joints, heart, skin, and central nervous system. The most significant and common complication of rheumatic fever is the involvement of the heart, known as rheumatic heart disease. Rheumatic heart disease can result in permanent damage to the heart valves, leading to valvular dysfunction, such as mitral valve stenosis or regurgitation. Therefore, the statement that accurately describes rheumatic fever is that it can lead to heart complications.

Multiple Selection Exercise:

A. Migratory polyarthritis: Migratory polyarthritis, which involves the sudden inflammation and swelling of multiple joints, is a classic manifestation of rheumatic fever. The joints are typically affected in a migratory pattern, with symptoms moving from one joint to another.

B. Skin rash: A characteristic skin rash called erythema marginatum can be present in rheumatic fever. This rash typically appears as pink or red, non-pruritic (non-itchy) patches with well-defined borders. The rash often occurs on the trunk or limbs and may come and go.

D. Cardiac murmurs: Cardiac murmurs can occur as a result of rheumatic heart disease, a complication of rheumatic fever. Rheumatic heart disease can cause damage to the heart valves, leading to the development of murmurs.

F. Chorea (involuntary movements): Chorea, characterized by rapid, jerky, and involuntary movements, can be seen in some cases of rheumatic fever. This movement disorder is known as Sydenham's chorea and is associated with autoimmune-mediated damage to the basal ganglia of the brain.

REMEMBER

- Administer acetaminophen for temperature elevation: This option suggests administering acetaminophen to the child if they have a fever. While acetaminophen is commonly used to reduce fever, the prescription in question is specifically for aspirin. Rheumatic fever is an inflammatory condition that can cause various symptoms, including joint pain and fever. However, in this scenario, the primary healthcare provider has specifically prescribed aspirin, so administering acetaminophen would not be appropriate without further clarification.

- Administer the aspirin if the child's temperature is elevated: This option suggests administering the prescribed aspirin if the child's temperature is elevated. While aspirin can be used to lower fever, its primary indication in this case is not for fever reduction but for its anti-inflammatory and antiplatelet properties. Aspirin is commonly prescribed in the management of rheumatic fever to reduce inflammation and prevent complications such as carditis and thromboembolism. Therefore, the administration of aspirin should be based on the primary healthcare provider's prescription and not solely on the child's temperature.

- Administer the aspirin if the child experiences any joint pain: This option suggests administering the prescribed aspirin if the child experiences joint pain. While joint pain is a symptom of rheumatic fever, the administration of aspirin is not solely based on the presence of joint pain. Aspirin is prescribed in rheumatic fever to reduce inflammation and prevent complications, regardless of the presence or absence of joint pain. Therefore, the administration of aspirin should be based on the primary healthcare provider's prescription and not solely on the child's joint pain.

- Consult with the primary health care provider to verify the prescription: This is the correct option. When there is a discrepancy or uncertainty regarding a prescription, it is crucial to consult with the primary healthcare provider for clarification. In this case, since the child is suspected of having a viral infection, and aspirin is typically contraindicated in children with viral illnesses due to the risk of developing Reye's syndrome, it is essential to verify the prescription and seek guidance from the primary healthcare provider before administering the medication.

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?

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Multiple Choice Exercise:

A nurse is providing education to parents about tetralogy of Fallot (TOF). Which of the following statements made by the parents indicates a need for further teaching?

A. "Our child may experience episodes of cyanosis during crying or feeding."
B. "Squatting can help relieve symptoms during a cyanotic episode."
C. "Our child may have a heart murmur due to the structural defects."
D. "Surgical repair is usually recommended during early infancy."

Multiple Selection Exercise:

Which of the following are common clinical manifestations of tetralogy of Fallot (TOF)? Select all that apply.

A. Cyanosis
B. Murmur
C. Clubbing of fingers
D. Hypertension
E. Tachypnea
F. Bradycardia

ANSWER KEY

Multiple Choice Exercise:

The correct answer is B. Tetralogy of Fallot (TOF) is a congenital heart defect characterized by four anatomical abnormalities in the heart. These abnormalities include a ventricular septal defect, pulmonary stenosis, overriding aorta, and right ventricular hypertrophy. Cyanosis, caused by inadequate blood flow to the lungs, is a common symptom of TOF. The parents' statement that squatting can help relieve symptoms during a cyanotic episode indicates a need for further teaching.

Multiple Selection Exercise:

A. Cyanosis: Cyanosis is a characteristic clinical manifestation of tetralogy of Fallot (TOF). It occurs due to the mixing of oxygen-poor and oxygen-rich blood in the heart, resulting in inadequate oxygenation of the blood. Cyanosis can be present during episodes of increased activity or crying and may vary in severity.

B. Murmur: A heart murmur is commonly heard in children with tetralogy of Fallot. The murmur is caused by the presence of a ventricular septal defect and the turbulent blood flow through the stenotic pulmonary valve.

C. Clubbing of fingers: Clubbing of fingers is often observed in individuals with chronic hypoxemia, such as those with tetralogy of Fallot. It is characterized by the enlargement and rounding of the fingertips, along with a loss of the normal angle between the nail and the nail bed.

E. Tachypnea: Tachypnea, or rapid breathing, can occur in children with tetralogy of Fallot, especially during episodes of increased activity or during cyanotic spells. The rapid breathing is an attempt to compensate for the decreased oxygen levels in the blood.

REMEMBER

- Notify the nursing supervisor: Notifying the nursing supervisor would delay immediate intervention for the infant in distress. During a hypercyanotic episode in an infant with tetralogy of Fallot, prompt action is necessary to relieve the symptoms and improve oxygenation. Contacting the nursing supervisor alone is not the priority action in this situation.

- Contact the respiratory therapist: While respiratory support may be needed during a hypercyanotic episode, contacting the respiratory therapist alone is not the priority action. The nurse should first take immediate actions to assist the infant and improve oxygenation before seeking additional support.

- Place the infant in a prone position: Placing the infant in a prone position is not the recommended priority action during a hypercyanotic episode in tetralogy of Fallot. The prone position may further compromise the infant's ability to breathe and can worsen their condition.

- Place the infant in a knee-chest position: This is the correct option. Placing the infant in a knee-chest position is the priority action during a hypercyanotic episode in tetralogy of Fallot. The knee-chest position increases systemic vascular resistance and reduces venous return to the heart, helping to improve pulmonary blood flow. It can alleviate the cyanosis and relieve the infant's difficulty in breathing.

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?

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Multiple Choice Exercise:

A client is diagnosed with lactose intolerance. Which of the following statements made by the client indicates an understanding of the condition?

A. "I can consume small amounts of lactose without experiencing symptoms."
B. "I need to completely eliminate all sources of lactose from my diet."
C. "I can take over-the-counter lactase supplements to aid digestion."
D. "Lactose intolerance is a permanent condition with no treatment options."

Multiple Selection Exercise:

Which of the following are common symptoms of lactose intolerance? Select all that apply.

A. Abdominal bloating
B. Diarrhea
C. Constipation
D. Weight gain
E. Flatulence
F. Nausea

ANSWER KEY

Multiple Choice Exercise:

The correct answer is C. Lactose intolerance is the inability to digest lactose, the sugar found in milk and dairy products, due to the deficiency or absence of the enzyme lactase. The severity of lactose intolerance varies among individuals, and different people have different thresholds for tolerating lactose. Therefore, the statement that indicates an understanding of the condition is the one about taking over-the-counter lactase supplements.

Multiple Selection Exercise:

A. Abdominal bloating: Abdominal bloating is a common symptom of lactose intolerance. It occurs due to the inability to digest lactose, resulting in the fermentation of lactose by bacteria in the colon, leading to gas production and bloating.

B. Diarrhea: Diarrhea is a common symptom of lactose intolerance. It occurs when undigested lactose in the intestine draws excess water into the colon, resulting in loose and watery stools.

E. Flatulence: Flatulence, or excessive gas production and passing of gas, is a common symptom of lactose intolerance. It occurs due to the fermentation of lactose by bacteria in the colon, resulting in gas formation.

F. Nausea: Nausea can be a symptom of lactose intolerance. It may occur due to the irritation of the digestive system or as a response to the discomfort caused by bloating and gas production.

REMEMBER

- Fats: While fats are an essential component of a healthy diet, they are not specifically necessary as a dietary supplement for a child with lactose intolerance. Lactose intolerance refers to the inability to digest lactose, the sugar found in milk and dairy products. It does not directly affect the body's ability to digest or utilize fats. However, it is important to ensure an adequate intake of dietary fats from various sources for overall health and nutrition.

- Zinc: Zinc is a micronutrient that plays various roles in the body, including supporting growth, immune function, and wound healing. While zinc is important for overall health, it is not specifically required as a dietary supplement for a child with lactose intolerance. Lactose intolerance does not impact the body's ability to absorb or utilize zinc.

- Protein: Protein is essential for growth, development, and repair of body tissues. While it is important to ensure an adequate intake of protein in the diet, it is not specifically necessary as a dietary supplement for a child with lactose intolerance. Lactose intolerance primarily affects the digestion of lactose, not the metabolism or utilization of protein.

- Calcium: This is the correct option. Lactose intolerance can pose a challenge in obtaining adequate dietary calcium since many dairy products are high in lactose. Calcium is important for bone health and various other functions in the body. To compensate for the potential shortfall in calcium intake due to lactose intolerance, it is necessary to provide alternative sources of calcium in the child's diet. These can include calcium-fortified non-dairy milk alternatives, green leafy vegetables, tofu, and fortified cereals or juices. In some cases, a calcium supplement may be recommended, depending on the severity of lactose intolerance and the child's specific nutritional needs.

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?

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Multiple Choice Exercise:

A nurse is providing education to parents about gastroschisis. Which of the following statements made by the parents indicates a need for further teaching?

A. "Gastroschisis is a congenital anomaly characterized by a defect in the abdominal wall."
B. "Surgical repair is usually performed shortly after birth."
C. "A protective sac covers the exposed abdominal contents in gastroschisis."
D. "Feeding and nutrition may be challenging for a baby with gastroschisis."

Multiple Selection Exercise:

Which of the following are true regarding gastroschisis? Select all that apply.

A. It is a congenital anomaly involving a defect in the abdominal wall.
B. A protective sac covers the exposed abdominal contents.
C. Surgical repair is typically performed shortly after birth.
D. Feeding and nutrition may be challenging for a baby with gastroschisis.
E. Gastroschisis is typically located to the right of the umbilical cord.
F. Gastroschisis is associated with chromosomal abnormalities.

ANSWER KEY

Multiple Choice Exercise:

The correct answer is C. Gastroschisis is a congenital anomaly characterized by a defect in the abdominal wall, typically to the right of the umbilical cord insertion, which leads to the extrusion of abdominal contents, such as intestines, outside of the abdominal cavity. Unlike in omphalocele, a protective sac is not present in gastroschisis. The abdominal contents are directly exposed to the external environment.

Multiple Selection Exercise:

A. It is a congenital anomaly involving a defect in the abdominal wall: This is correct. Gastroschisis is a congenital anomaly characterized by a defect in the abdominal wall, usually to the right of the umbilical cord, resulting in the extrusion of abdominal contents outside of the abdominal cavity.

C. Surgical repair is typically performed shortly after birth: This is correct. Surgical repair is usually performed shortly after birth to return the extruded abdominal contents to the abdominal cavity and close the abdominal wall defect.

D. Feeding and nutrition may be challenging for a baby with gastroschisis: This is correct. The exposed intestines in gastroschisis may not be able to function properly immediately after birth, making feeding and nutrition challenging. Parenteral nutrition (intravenous) or enteral feeds through a nasogastric tube may be initiated initially, followed by gradual introduction of oral feeding as tolerated by the baby.

E. Gastroschisis is typically located to the right of the umbilical cord: This is correct. In gastroschisis, the defect in the abdominal wall is usually to the right of the umbilical cord insertion.

REMEMBER

- Infection: This is the correct option. In the plan of care for a neonate with gastroschisis, the nurse would address the concern of infection. Gastroschisis is a congenital condition in which there is a defect in the abdominal wall, resulting in the extrusion of abdominal contents. The exposed intestines are vulnerable to infection due to the lack of protective covering. The nurse's focus would be on preventing and managing infection by adhering to strict aseptic technique, performing sterile dressing changes, administering antibiotics as prescribed, monitoring for signs of infection, and providing education to parents or caregivers on infection prevention measures.

- Poor body image: Poor body image is not a primary concern in the immediate plan of care for a neonate with gastroschisis. The focus of care initially is on addressing the physical health and well-being of the neonate, including the protection and management of the exposed abdominal contents. Body image concerns may be relevant in later stages of care as the neonate grows and develops, but they are not the primary concern at the time of delivery and initial care.

- Decreased urinary elimination: Decreased urinary elimination is not typically associated with gastroschisis unless there are additional complications or conditions present. Gastroschisis primarily affects the abdominal wall and does not directly impact urinary elimination. However, the nurse would monitor the neonate's urine output and assess for any signs of renal or urinary system involvement as part of the overall assessment.

- Cracking oral mucous membranes: Cracking oral mucous membranes is not directly related to gastroschisis. Gastroschisis primarily affects the abdominal wall, and its associated concerns involve the protection and management of the exposed abdominal contents. Cracking oral mucous membranes may be associated with other factors such as dehydration or dryness, but it is not the primary concern in the immediate care of a neonate with gastroschisis.

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.

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Multiple Choice Exercise:

A nurse is providing education to a client scheduled for an appendectomy. Which statement by the client indicates an understanding of the procedure?

A. "The surgeon will remove my gallbladder during the surgery."
B. "I should expect to have a small incision near my belly button."
C. "After the surgery, I can resume my regular diet immediately."
D. "The procedure will be performed under local anesthesia."

Multiple Selection Exercise:

Which of the following are important nursing considerations for a client undergoing an appendectomy? Select all that apply.

A. Monitoring vital signs and assessing for signs of infection.
B. Administering pain medication as prescribed.
C. Encouraging the client to resume regular activities immediately after surgery.
D. Assisting with early ambulation and deep breathing exercises.
E. Educating the client about wound care and signs of complications.
F. Allowing the client to eat a regular diet immediately after surgery.

ANSWER KEY

Multiple Choice Exercise:

The correct answer is B. An appendectomy is the surgical removal of the appendix, typically performed to treat appendicitis. The procedure can be performed using different techniques, including laparoscopic or open surgery. In a laparoscopic appendectomy, small incisions are made, including one near the belly button, through which instruments and a camera are inserted to remove the appendix. This technique allows for less invasive surgery and faster recovery compared to open surgery.

Multiple Selection Exercise:

A. Monitoring vital signs helps assess the client's physiological status and detect any early signs of complications, such as infection. Assessing the surgical incision site for redness, swelling, warmth, or purulent drainage is crucial to identify signs of infection.

B. The nurse should administer pain medication as prescribed by the healthcare provider to ensure the client's comfort and promote healing.

D. Early ambulation helps prevent complications such as deep vein thrombosis (DVT) and promotes bowel function. Deep breathing exercises help prevent respiratory complications and improve lung expansion.

E. The nurse should educate the client about proper wound care, including keeping the incision site clean and dry, observing for signs of infection or delayed healing, and reporting any concerning symptoms to the healthcare provider. This empowers the client to actively participate in their own recovery and seek timely medical attention if needed.

REMEMBER

- Initiate an IV line: This is a correct option. Prior to the appendectomy, it is common practice to initiate an IV line to ensure access for fluid administration, medication administration, and potential blood transfusion if needed during or after the surgery.

- Maintain an NPO status: This is a correct option. It is standard procedure to keep the child NPO (nothing by mouth) for a certain period of time before surgery. This helps prevent aspiration of stomach contents during the procedure and ensures the child's stomach is empty.

- Administer a Fleet enema: This is an incorrect option. The administration of a Fleet enema is not typically part of the preoperative preparation for an appendectomy. An enema is more commonly used for lower gastrointestinal procedures or in cases of severe constipation.

- Administer intravenous antibiotics: This is a correct option. Prior to the appendectomy, the child may receive intravenous antibiotics as a prophylactic measure to prevent surgical site infections. Antibiotics are typically administered before the surgery begins and may be continued postoperatively, depending on the surgeon's preference.

- Administer preoperative medications: This is a correct option. Preoperative medications, such as sedatives or anxiolytics, may be prescribed to help calm and relax the child before the surgery. These medications can help reduce anxiety and make the child more comfortable during the perioperative period.

- Place a heating pad on the abdomen to decrease pain: This is an incorrect option. Placing a heating pad on the abdomen is not a standard nursing intervention for pain management before or after an appendectomy. Heat application may not be suitable and can potentially increase the risk of infection or interfere with wound healing.

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?

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Multiple Choice Exercise:

A nurse is providing education to parents of a child with cerebral palsy. Which statement by the parents indicates an understanding of the condition?

A. "Cerebral palsy is caused by an infectious disease of the central nervous system."
B. "The severity of cerebral palsy symptoms typically worsens over time."
C. "Cerebral palsy is a chronic condition that affects muscle movement and posture."
D. "Intellectual disabilities are a common characteristic of cerebral palsy."

Multiple Selection Exercise:

Which of the following are true regarding cerebral palsy? Select all that apply.

A. Cerebral palsy is caused by an infectious disease of the central nervous system.
B. The severity of cerebral palsy symptoms typically worsens over time.
C. Cerebral palsy is a non-progressive condition.
D. It is characterized by impaired muscle movement and posture.
E. Intellectual disabilities are always present in individuals with cerebral palsy.
F. Cerebral palsy is caused by a congenital brain injury.

ANSWER KEY

Multiple Choice Exercise:

The correct answer is C. Cerebral palsy is a chronic condition characterized by impaired muscle movement and posture. It is caused by damage to the developing brain, typically occurring before or during birth. The specific areas of the brain affected and the severity of the condition can vary among individuals with cerebral palsy, leading to different motor impairments.

Multiple Selection Exercise:

C. Cerebral palsy is a non-progressive condition: This is correct. Cerebral palsy is a non-progressive neurological disorder. Once the brain injury or damage occurs, the condition does not progress or worsen over time. However, the functional limitations and symptoms may change as the individual grows and develops.

D. It is characterized by impaired muscle movement and posture: This is correct. Cerebral palsy is characterized by impaired muscle movement and posture. The specific areas of the brain affected and the severity of the condition can vary, resulting in difficulties with coordination, muscle tone, balance, and posture.

F. Cerebral palsy is caused by a congenital brain injury: This is correct. Cerebral palsy is typically caused by a brain injury or damage that occurs before or during birth. This injury can result from various factors, including oxygen deprivation, infections, trauma, or developmental abnormalities.

REMEMBER

- An infectious disease of the central nervous system: This option is incorrect. Cerebral palsy is not caused by an infectious disease of the central nervous system. It is a non-progressive neurological disorder that occurs due to damage to the developing brain, typically before or during birth.

- An inflammation of the brain as a result of a viral illness: This option is incorrect. While certain viral illnesses can cause inflammation of the brain (encephalitis), cerebral palsy is not directly caused by inflammation resulting from a viral illness. The causes of cerebral palsy are diverse and can include factors such as brain injury, developmental abnormalities, or oxygen deprivation to the brain.

- A chronic disability characterized by impaired muscle movement and posture: This option is correct. Cerebral palsy is a chronic disability that affects muscle movement and posture. It is caused by damage to the motor control centers of the developing brain, which can result in difficulties with coordination, muscle tone, balance, and posture. The specific areas of the brain affected and the severity of the condition can vary, leading to a range of motor impairments.

- A congenital condition that results in moderate to severe intellectual disabilities: This option is incorrect. While some individuals with cerebral palsy may also have intellectual disabilities, cerebral palsy primarily affects motor function, not intellectual ability. Intellectual disabilities are not an inherent characteristic of cerebral palsy. The severity and presence of intellectual disabilities can vary among individuals with cerebral palsy, and many individuals with cerebral palsy have normal or above-average intelligence.

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?

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Multiple Choice Exercise:

A nurse is caring for a client with a suspected basilar skull fracture. Which assessment finding would the nurse expect to observe in this client?

A. Clear fluid draining from the ears.
B. Bruising around the eyes (raccoon eyes).
C. Severe headache and neck pain.
D. Decreased level of consciousness.

Multiple Selection Exercise:

Which of the following are characteristic findings in a client with a basilar skull fracture? Select all that apply.

A. Clear fluid draining from the ears.
B. Bruising around the eyes (raccoon eyes).
C. Severe headache and neck pain.
D. Decreased level of consciousness.
E. Numbness and tingling in the extremities.
F. Ecchymosis behind the ears (Battle's sign).

ANSWER KEY

Multiple Choice Exercise:

The correct answer is A. A basilar skull fracture is a fracture of the bones at the base of the skull. When the fracture extends into the area around the middle ear, it can cause a disruption in the membranes, resulting in the leakage of cerebrospinal fluid (CSF) through the ears. Therefore, observing clear fluid draining from the ears is a characteristic finding in a client with a suspected or confirmed basilar skull fracture.

Multiple Selection Exercise:

A. Clear fluid draining from the ears: This is a characteristic finding in a client with a basilar skull fracture. When the fracture extends into the area around the middle ear, it can cause a disruption in the membranes, resulting in the leakage of cerebrospinal fluid (CSF) through the ears.

B. Bruising around the eyes (raccoon eyes): This is a characteristic finding in a client with a basilar skull fracture. Bruising around the eyes, also known as raccoon eyes, is commonly associated with fractures involving the orbital bones, which can occur in conjunction with a basilar skull fracture.

F. Ecchymosis behind the ears (Battle's sign): This is a characteristic finding in a client with a basilar skull fracture. Ecchymosis, or bruising, behind the ears, known as Battle's sign, is commonly observed in basilar skull fractures and indicates bleeding under the skin in that area.

REMEMBER

- Obtain daily weight: This prescription is appropriate for a child with a basilar skull fracture. Daily weight monitoring helps assess fluid balance and can be useful in detecting any significant changes that may require further evaluation or adjustment in the treatment plan. This prescription does not need to be questioned.

- Provide clear liquid intake: This prescription is appropriate for a child with a basilar skull fracture. Clear liquid intake is often recommended initially to prevent dehydration and provide adequate hydration while minimizing the risk of complications related to swallowing difficulties. This prescription does not need to be questioned.

- Nasotracheal suction as needed: This prescription is the correct option to question. Basilar skull fractures can be associated with cerebrospinal fluid (CSF) leakage, and nasotracheal suctioning has the potential to introduce organisms into the CSF, increasing the risk of meningitis. Therefore, the nurse should question this prescription to clarify the need for nasotracheal suctioning and discuss alternative methods of airway clearance, such as oral suctioning or non-invasive techniques.

- Maintain a patent intravenous line: This prescription is appropriate for a child with a basilar skull fracture. Maintaining a patent intravenous (IV) line is important for administering fluids, medications, and other necessary interventions. It ensures that access is readily available if the child's condition deteriorates or if specific treatments are required. This prescription does not need to be questioned.

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.

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Multiple Choice Exercise:

A nurse is providing education to a group of parents regarding seizure management in children. Which statement by a parent indicates an understanding of seizure first aid?

A. "I should restrain my child during a seizure to prevent injury."
B. "Placing a padded tongue blade in my child's mouth will protect their airway."
C. "I will time the duration of my child's seizures to provide important information to the healthcare provider."
D. "Moving furniture away from my child during a seizure will reduce the risk of injury."

Multiple Selection Exercise:

Which of the following are appropriate actions for seizure management and first aid? Select all that apply.

A. Restraining the person during a seizure to prevent injury.
B. Placing a padded tongue blade in the person's mouth.
C. Timing the duration of the seizure.
D. Moving furniture away from the person.
E. Keeping the person in a prone position.
F. Administering antiseizure medication during the seizure.

ANSWER KEY

Multiple Choice Exercise:

The correct answer is D. Moving furniture away from the child during a seizure is an appropriate action to reduce the risk of injury. Children experiencing seizures may have uncontrolled movements, and removing nearby furniture or objects helps create a safer environment by minimizing the risk of accidental injury.

Multiple Selection Exercise:

C. Timing the duration of the seizure: This is a correct action. Timing the duration of seizures is important as it provides valuable information for healthcare providers. It helps determine if the seizure is prolonged or requires immediate medical attention. Timing the seizure assists in the management and treatment of seizures.

D. Moving furniture away from the person: This is a correct action. Moving furniture away from the person during a seizure is an appropriate action. It helps create a safer environment by minimizing the risk of accidental injury. People experiencing seizures may have uncontrolled movements, and removing nearby furniture or objects reduces the risk of harm.

F. Administering antiseizure medication during the seizure: This is a correct action. If the person has a known seizure disorder and prescribed antiseizure medication, administering the medication during the seizure may be appropriate. However, the exact timing and administration of medication should be based on the individual's specific treatment plan and healthcare provider's instructions.

REMEMBER

- Time the seizure: This is a correct intervention. Timing the duration of the seizure helps to monitor the length of the seizure activity. It provides important information for healthcare professionals and assists in determining if the seizure is prolonged or requires immediate medical attention.

- Restrain the child: This is an incorrect option. Restraint is not recommended during a seizure. It can potentially cause harm to the child or interfere with the seizure activity. Restraining the child may also increase the risk of injury to both the child and the caregiver.

- Stay with the child: This is a correct intervention. It is important for the nurse or caregiver to stay with the child during a seizure to provide supervision, ensure safety, and offer emotional support. Staying with the child allows for immediate response and assessment of any changes in the seizure activity or the child's condition.

- Place the child in a prone position: This is an incorrect option. Placing the child in a prone position (lying face down) during a seizure is not recommended. It can obstruct the airway and increase the risk of aspiration. The child should be placed on their side (recovery position) to facilitate drainage of secretions and reduce the risk of choking.

- Move furniture away from the child: This is a correct intervention. During a seizure, the child may have uncontrolled movements, which can pose a risk of injury if they come into contact with nearby furniture or objects. Moving furniture away from the child's immediate vicinity helps to create a safe environment and reduces the risk of injury.

- Insert a padded tongue blade in the child's mouth: This is an incorrect option. It is no longer recommended to insert anything, including a padded tongue blade, into the child's mouth during a seizure. This action can cause injury to the child's teeth, gums, or jaw and can potentially obstruct the airway. It is important to maintain a patent airway by allowing the child's mouth to remain open and clear during the seizure.

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?

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Multiple Choice Exercise:

A nurse is providing care for a child with leukemia. Which statement accurately describes leukemia?

A. Leukemia is a type of infectious disease.
B. Leukemia is a cancer of the lymphatic system.
C. Leukemia is characterized by abnormal production of white blood cells.
D. Leukemia primarily affects the liver and gastrointestinal system.

Multiple Selection Exercise:

Which of the following statements accurately describe leukemia? Select all that apply.

A. Leukemia is a type of infectious disease.
B. Leukemia is a cancer of the lymphatic system.
C. Leukemia is characterized by abnormal production of white blood cells.
D. Leukemia primarily affects the liver and gastrointestinal system.
E. Chemotherapy is a common treatment for leukemia.
F. Leukemia is a genetic disorder.

ANSWER KEY

Multiple Choice Exercise:

The correct answer is C. Leukemia is a type of cancer that affects the blood and bone marrow. It involves the abnormal production of immature or dysfunctional white blood cells. These abnormal cells, called leukemic cells, accumulate in the bone marrow and interfere with the production of normal blood cells.

Multiple Selection Exercise:

C. Leukemia is characterized by abnormal production of white blood cells: This is a correct statement. Leukemia involves the abnormal production of immature or dysfunctional white blood cells in the bone marrow. These abnormal cells, called leukemic cells, accumulate and interfere with the production of normal blood cells.

E. Chemotherapy is a common treatment for leukemia: This is a correct statement. Chemotherapy is a common treatment modality for leukemia. It involves the use of medications to destroy or control cancer cells, including the abnormal leukemic cells in the bone marrow.

F. Leukemia is a genetic disorder: This is a correct statement. Some forms of leukemia have a genetic component, meaning they are associated with specific genetic mutations. These genetic mutations can increase the risk of developing leukemia. However, not all cases of leukemia are caused solely by genetic factors, and other factors, such as environmental exposures or certain medical conditions, can also contribute to the development of leukemia.

REMEMBER

- Initiate bleeding precautions: This is the correct intervention based on the low platelet count of 19,500 mm3 (19.5 × 109/L). Platelets play a crucial role in blood clotting, and a low platelet count (thrombocytopenia) increases the risk of bleeding and bruising. Initiating bleeding precautions involves minimizing the risk of injury and promoting a safe environment. This may include avoiding invasive procedures, using gentle handling techniques, promoting fall prevention, avoiding the use of blood-thinning medications, and using soft-bristle toothbrushes. The nurse should closely monitor for signs of bleeding and promptly report any abnormal bleeding or symptoms to the healthcare team.

- Monitor closely for signs of infection: Monitoring for signs of infection is an important aspect of care for a child with leukemia who is receiving chemotherapy. Chemotherapy can suppress the immune system, making the child more susceptible to infections. While monitoring for signs of infection is important, it is not the most appropriate intervention in this situation where the primary concern is the low platelet count.

- Monitor the temperature every 4 hours: While monitoring the temperature is an important aspect of assessing for signs of infection, it is not the priority intervention in this situation. The low platelet count is more directly related to the risk of bleeding, and therefore, initiating bleeding precautions would take precedence.

- Initiate protective isolation precautions: Protective isolation precautions are typically implemented for clients with compromised immune systems to minimize the risk of exposure to infections. While a child with leukemia receiving chemotherapy may be at increased risk of infections, the specific laboratory value of a low platelet count does not directly indicate a need for protective isolation precautions. The primary concern in this scenario is the risk of bleeding associated with the low platelet count.

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STUDENT WORKBOOK

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.

Next Gen PASSERS NCLEX

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			

Next Gen PASSERS NCLEX

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 Scattered lung crackles Chest pain and shortness of breath
Erythema multiforme	Integumentary	Sores in the mouth Round red patches noted on the back and abdomen
Dehydration	Cardiovascular, respiratory, integumentary	Rapid respirations Concentrated urine Capillary refill 4 seconds 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 2. Topical antibiotic cream 3. Antihistamines
Respiratory	1. Oxygen 2. Respiratory treatments 3. Head elevation at 30 to 45 degrees
Fluid and Electrolyte Balance	1. Intravenous fluids 2. Monitor body weight 3. Oral potassium chloride

Next Gen PASSERS NCLEX

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.

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.

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

Next Gen PASSERS NCLEX

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.

Next Gen PASSERS NCLEX

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.

Next Gen NCLEX PASSERS

- Fundamentals
- Adult Health
- Mental Health
- Pharmacology
- Maternity
- Child Health ✅
- Critical Care
- Skills
- Leadership and Management

EXAM DATE AND TIME

__/__/____

__:__ **AM | PM**

Study Calendar - Phase 1

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
	SAMPLE WEEK - CATEGORY - SATURDAYS					
	QUIZ # 2		QUIZ # 3		**LIVE CLASS**	QUIZ # 1
QUIZ # 3	SAMPLE WEEK - CATEGORY - WEDNESDAY					
		LIVE CLASS	QUIZ # 1		QUIZ # 2	

Study Calendar - Phase 2

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
	SAMPLE WEEK - FINAL PREPARATION					
EXAM SIMULATOR		CONTENT REVIEW		**EXAM SIMULATOR**		CONTENT REVIEW