Price: Pediatric Nursing, 11th Edition

Chapter 03: Pediatric Procedures

Testbank

MULTIPLE CHOICE

1. As part of the preparation for obtaining a throat swab from a toddler, the nurse will:
   a. Bring all equipment to the bedside prior to explaining the procedure to the child
   b. Tell the toddler several hours in advance
   c. Have the parent restrain the child
   d. Give a brief simple explanation to the child

   ANS: D
   The toddler should receive a simple explanation just before the procedure. The equipment should not be brought to the bedside until explanations have been given to the child and the parent. The parents can hold the child but should not be seen as the restrainer.

   DIF: Cognitive Level: Application REF: p. 33 OBJ: 2
   TOP: Preparation for Procedures KEY: Nursing Process Step: Intervention
   MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

2. The nurse is aware that the most effective form of comfort for an 11-year-old school-age child after a painful procedure is:
   a. Therapeutic holding by the parent
   b. Praise for cooperation
   c. A Mickey Mouse sticker
   d. A lollipop

   ANS: B
   The older school-age child responds well to praise. Therapeutic holding, candy, and colorful stickers are childish.

   DIF: Cognitive Level: Application REF: p. 33 OBJ: 2
   TOP: Preparation for Procedures KEY: Nursing Process Step: Intervention
   MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

3. In demonstrating technique for bathing an infant, the home health nurse stresses to the parents considerations such as:
   a. Always run hot water first to prevent chilling
   b. Wrap the circumcised penis in waterproof plastic
   c. Apply lotions, not powder, after the bath
   d. Mild bubble bath will lubricate the skin

   ANS: C

Use lotions rather than powder due to the risk of aspiration. Cold water should be run in the tub first. Circumcised infants should be sponged until circumcision is healed. Bubble baths may cause vaginitis in infants.

DIF: Cognitive Level: Application REF: pp. 34-35 OBJ: 3
TOP: Bathing an Infant or Small Child KEY: Nursing Process Step: Intervention
MSC: NCLEX: Health Promotion and Maintenance: Basic Care and Comfort

4. Prior to obtaining a clean-catch specimen from a 4-year-old, the nurse could best get the child to comply by:
   a. Telling the child to void in the cup
   b. Using the term the child uses for urination in explanations
   c. Gently washing the perineum, holding the cup in place, and asking the child to void
   d. Catheterizing the child

   ANS: B
   The child will not understand what a clean-catch urine specimen is, so the nurse should explain to the child what is needed. The nurse should discover what term the child uses for urination, because the other terms may also be meaningless. Catheterization is unnecessary.

   DIF: Cognitive Level: Application REF: pp. 36-37 OBJ: 4
   TOP: Collection of Specimens KEY: Nursing Process Step: Intervention
   MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

5. A child with spina bifida requires home catheterization. The child is now old enough to learn how to perform this procedure himself. The child is taught:
   a. Clean the tip of the penis with soap and water or Betadine
   b. Insert the catheter 3 inches
   c. Do not lubricate the catheter if reusing
   d. Never reuse the catheter

   ANS: A
   The tip of the penis should be cleaned with soap and water or Betadine. The catheter should be inserted until urine is returned. Always lubricate the catheter before insertion. The catheter can be cleaned, dried, and reused for 1 week without increasing the risk of infection.

   DIF: Cognitive Level: Application REF: p. 39 OBJ: 4
   TOP: Specimen Collection KEY: Nursing Process Step: Intervention
   MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

6. In order to lessen the discomfort of a venipuncture for a blood draw for a 3-year-old child, the nurse may apply EMLA (local anesthetic cream) to the antecubital fossa:
   a. Immediately prior to venipuncture
   b. 10 minutes prior to venipuncture

c. 30 minutes prior to venipuncture
d. 60 minutes prior to venipuncture

ANS: D
EMLA cream should be applied 60 minutes prior to venipuncture. Children older than 2 years of age usually have blood drawn from the antecubital fossa.

DIF: Cognitive Level: Application REF: p. 40 OBJ: 5
TOP: Collection of Blood Specimens KEY: Nursing Process Step: Intervention
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

7. After a blood draw from the antecubital fossa of a 5-year-old child, the child continues to cry and to press his hand against the puncture site. The nurse's best intervention would be to say:
   a. "Big kids don't cry. It is all over, and you are just fine. Let's go to the playroom."
   b. "This big band aid will fix that hole, and you won't have to hold it anymore. You were very brave!"
   c. "Tell this stuffed bear how much that needle sticking in your arm hurt."
   d. "Let's go get some ice to put on that hole in your arm."

   ANS: B
   Preschoolers may fear continuously losing blood from the puncture site. The placement of a large bandage reassures them that their body fluids will not leak out.

   DIF: Cognitive Level: Application REF: p. 40 OBJ: 5
   TOP: Collection of Blood KEY: Nursing Process Step: Intervention
   MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

8. The nurse while assisting the physician with a lumbar puncture of a small child will take special precaution to closely monitor the:
   a. Blood pressure
   b. Pulse
   c. Respiratory status
   d. Temperature

   ANS: C
   The nurse would monitor the respiratory status of the child during the procedure. Respiratory obstruction is a risk when the neck is flexed. The other vital signs would be monitored before the beginning of the procedure.

   DIF: Cognitive Level: Application REF: p. 42 OBJ: 6
   TOP: Assisting with Lumbar Puncture KEY: Nursing Process Step: Intervention
   MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

9. In order to prepare a child for a lumbar puncture, the nurse would place the child in which position?
   a. Supine
   b. Side-lying in the center of the table with knees flexed

c. Seated with legs dangling and neck flexed
d. Side-lying with neck and knees held in flexed position

ANS: D
The nurse can place the child in either a side-lying position with knees flexed, or a seated position with the back curved on the edge of the examination table.

DIF: Cognitive Level: Application REF: p. 42 OBJ: 6
TOP: Assisting with Lumbar Puncture KEY: Nursing Process Step: Intervention
MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

10. Following a successful lumbar puncture, in order to avoid post-procedure discomfort for the patient, the nurse should:
a. Ask the parents to keep the child flat for several hours
b. Encourage the child to begin ambulation as soon as possible
c. Place the child in the high Fowler's position for several hours
d. Place the child in the semi-Fowler's position with knees flexed for several hours

ANS: A
The child is instructed to lay flat for a certain amount of time in order to decrease the chance of developing a spinal headache. Ambulation and a high Fowler's position would increase the likelihood of having a spinal headache.

DIF: Cognitive Level: Application REF: p. 42 OBJ: 6
TOP: Assisting with Lumbar Puncture KEY: Nursing Process Step: Intervention
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

11. The nurse sees an order to give 500 mg of an oral suspension of Ampicillin to a child who weighs 22 pounds. After the nurse has calculated the dose based on the child's weight and sees that the dose should be 50 mg/kg/day, the nurse should:
a. Tell the charge nurse that the dose seems too high
b. Call the physician to clarify the order
c. Give the ordered dose
d. Ask the parents if the child has taken this much drug previously

ANS: C
The nurse should calculate the child's weight in kilograms and compare with the recommended dose. 22 pounds child weight = 10 kilograms; 10 kilograms multiplied by 50 mg = 500 mg. The ordered dose should be given.

DIF: Cognitive Level: Application REF: p. 42 OBJ: 7
TOP: Administering Medication KEY: Nursing Process Step: Intervention
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

12. The nurse has drawn up 5 units of insulin to give to an 8-year-old. As a safety precaution prior to giving the drug, the nurse should:
a. Ask the parent if the child has ever had an insulin reaction
b. Check the child's blood sugar

c. Verify the dose with another nurse
d. Chart the administration of the drug

ANS: D
Prior to giving drugs such as digoxin, insulin, heparin, and narcotics, the dose is verified by another nurse. There is no need to check the blood sugar at this time. Drugs are never charted until they are actually given.

DIF: Cognitive Level: Application REF: p. 44 OBJ: 7
TOP: Administering Medication KEY: Nursing Process Step: Intervention
MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

13. The nurse brings the medication into a child's room for administration. The intervention that will ensure safe administration of this medication is:
a. Call the child by name to verify the patient's identity
b. Verify the patient's identity with the hospital identification band for child's birth date
c. Inform the parent about the side effects of the drug
d. Ask another nurse to verify the child's identity

ANS: B
The nurse should not rely on the child for verification of identity. The identity should be confirmed by comparing the hospital identification band and a second identifier, such as birth date or room number.

DIF: Cognitive Level: Application REF: p. 44 OBJ: 7
TOP: Administering Medication KEY: Nursing Process Step: Intervention
MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

14. The nurse caring for a 2-month-old baby uses a(n) _____ to administer a very small dose of oral medication that is in a suspension.
a. Oral syringe
b. Calibrated cup
c. Teaspoon
d. Nipple

ANS: A
The nurse would use an oral syringe, because it is the most accurate. Teaspoons are often inaccurate and do not hold a standard amount. It is hard to be accurate with a small dose using a calibrated cup. The nipple is useful but does not have anything to do with accuracy.

DIF: Cognitive Level: Application REF: p. 44 OBJ: 7
TOP: Medication Administration KEY: Nursing Process Step: Intervention
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

15. An intramuscular (IM) injection is ordered for a 6-month-old child. The nurse should select the injection site of:

a. Dorsogluteal
b. Ventrogluteal
c. Vastus lateralis
d. Deltoid

ANS: C
The nurse would choose the vastus lateralis because it is well-developed at birth, it is the largest muscle mass, and it has the fewest vessels and nerves. The dorsogluteal is not fully developed until the child has walked for 1 to 2 years. The ventrogluteal should not be used until 18 months. The deltoid cannot be used for large volumes of medication or for medications that need to be administered into the deep muscle mass.

DIF: Cognitive Level: Application REF: p. 47 OBJ: 8
TOP: Intramuscular Injections KEY: Nursing Process Step: Intervention
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

16. The nurse giving an intramuscular (IM) dose of 2 mL to a 6-month-old child should:
a. Inject the entire amount in the ventrogluteal muscle
b. Give the medication in divided doses in each deltoid
c. Inject 1 mL into each vastus lateralis
d. Divide the dose, and give 1 mL injections 1 hour apart

ANS: C
The nurse should divide the dose and give the maximum 1 mL in each vastus lateralis.

DIF: Cognitive Level: Application REF: p. 47 OBJ: 8
TOP: Intramuscular Injections KEY: Nursing Process Step: Application
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

17. The nurse is aware that an IV antibiotic medication should infuse in no longer than:
a. 15 minutes
b. 30 minutes
c. 45 minutes
d. 60 minutes

ANS: D
An antibiotic medication should infuse in no longer than 60 minutes.

DIF: Cognitive Level: Comprehension REF: p. 49 OBJ: 9
TOP: Intravenous Medication KEY: Nursing Process Step: Intervention
MSC: NCLEX: Physiological Integrity: Pharmacological Therapies

18. An infant with diarrhea is dehydrated. IV fluids have been ordered to restore fluid balance. The most effective device used to prevent fluid overload is:
a. A precision-controlled syringe pump
b. A piggyback setup
c. A tunneled IV catheter
d. A 15-drop infusion set

ANS: A
A syringe or other in-line volume-control device is often used because they hold a limited amount of fluid. Only that fluid can be administered at one time. A piggyback setup would be used to infuse a dose of medication, not a continuous infusion. Neither a tunneled catheter nor a 15-drop infusion set would protect the child from fluid overload.

DIF: Cognitive Level: Application REF: p. 49 OBJ: 9
TOP: Parenteral Fluids KEY: Nursing Process Step: Intervention
MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

19. The nurse monitoring the TPN infusion for a small child assesses that the infusion is behind. The nurse should:
a. Speed up the infusion to catch up
b. Notify the charge nurse
c. Stop the infusion, and notify the charge physician
d. Give the child extra fluids to make up for the deficit

ANS: B
TPN must be monitored carefully. Speeding up an infusion can cause hyperglycemia. The infusion should not be stopped. The charge nurse should be notified.

DIF: Cognitive Level: Application REF: p. 50 OBJ: 9
TOP: Total Parenteral Nutrition KEY: Nursing Process Step: Intervention
MSC: NCLEX: Physiological Integrity: Pharmacological Therapies

20. Following a gavage feeding, a 4-year-old child should be positioned:
a. In a high Fowler's position to prevent aspiration
b. In a semi-Fowler's position with knees flexed to prevent cramping
c. On the right side to aid in stomach emptying
d. On the left side to slow stomach emptying

ANS: C
After a gavage feeding, the child is positioned on the right side to aid in stomach emptying.

DIF: Cognitive Level: Comprehension REF: p. 51 OBJ: 10
TOP: Gavage Feedings KEY: Nursing Process Step: Intervention
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

21. When the nurse is instilling drops into the ear of a 2-year-old, the nurse should:
a. Pull the earlobe up
b. Chill the drops prior to administration
c. Assist the child to sit upright after instillation
d. Draw the earlobe down and back to straighten the ear canal

ANS: D

For a child younger than 3 years of age, the earlobe is drawn down and back to straighten the ear canal and allow the drops to enter the ear canal. The child should be left in a supine or side-lying position while the drops are absorbed. The drops should be warmed.

DIF: Cognitive Level: Application REF: p. 46 OBJ: 7
TOP: Topic: Administration of Eardrops KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Pharmacological Therapies

22. The nurse modifies the technique of administering eyedrops for a 1-month-old infant by:
    a. Placing the drops in the nasal corner of the eyelid
    b. Asking assistance of a coworker to hold the lids open
    c. Grasping the eyelashes and placing the drops under the lid
    d. Applying the drops from a moistened cotton ball

    ANS: A
    Because infants clench their eyes shut, the drops can be placed in the nasal corner of the eye so when the child opens the eyes the medication flows onto the conjunctiva.

    DIF: Cognitive Level: Application REF: p. 47 OBJ: 7
    TOP: Topic: Infant Eyedrops KEY: Nursing Process Step: Implementation
    MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

COMPLETION

1. Carrying out procedures in the least stressful manner to the child is called _____.

    ANS:
    Atraumatic care
    Considering the least painful or stressful method to complete a procedure is classified as atraumatic care.

    DIF: Cognitive Level: Knowledge REF: p. 33 OBJ: 2
    TOP: Preparation for Procedures KEY: Nursing Process Step: Intervention
    MSC: NCLEX: Psychosocial Integrity: Basic Care and Comfort

2. When parenteral fluids have escaped into the surrounding tissue, the nurse would document and report that _____ had occurred.

    ANS:
    Extravasation or infiltration
    Extravasation is the term for escaped parenteral fluid that has entered the surrounding tissue.

    DIF: Cognitive Level: Knowledge REF: p. 50 OBJ: 1

TOP: Extravasation KEY: Nursing Process Step: Intervention
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

3. A catheter threaded into the superior vena cava for the purpose of parenteral nutrition (TPN) is referred to as a(n) _____.

ANS:
PICC or peripherally inserted central catheter
A PICC is inserted into the antecubital area and threaded into the superior vena cava, and it can be used for long-term parenteral therapy.

DIF: Cognitive Level: Knowledge REF: p. 50 OBJ: 9
TOP: PICC KEY: Nursing Process Step: N/A MSC: NCLEX: N/A

4. For a child who weighs 32 pounds, what is the maximum pediatric dose for a medication that is recommended to be given at 35 mg/kg/day?

ANS:
507.5 mg
RAT: 32 pounds divided by 2.2 = 14.5 kilograms; 14.5 kilograms multiplied by 35 = 507.5 mg.

DIF: Cognitive Level: Application REF: p. 42 OBJ: 7
TOP: Topic: Dose calculation KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Pharmacological Therapies

5. When selecting a cuff for a child, the nurse should confirm that the width of the cuff covers approximately _____ of the upper arm.

ANS:
Two thirds
A cuff that is too large will give an erroneously low reading.

DIF: Cognitive Level: Comprehension REF: p. 60 OBJ: 14
TOP: Blood Pressure Cuff Width KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

6. When preparing an enema solution for a child younger than 2 years of age, the total amount of fluid should not exceed _____.

ANS:
240 mL
Children younger than 2 years of age should not receive more than 240 mL of fluid in an enema solution.

DIF: Cognitive Level: Comprehension REF: p. 51 OBJ: 2
TOP: Enema Volume KEY: Nursing Process Step: N/A
MSC: NCLEX: N/A

MULTIPLE RESPONSE

1. The nurse giving an allergy desensitization injection to a well-fed 8-month-old child in a subcutaneous injection would: *(Select all that apply.)*
   a. Select a 23-gauge needle
   b. Inject at a 90-degree angle
   c. Gently aspirate before injecting the medicine
   d. Give a maximum of 1 mL
   e. Give the injection in the abdomen

   ANS: B, E
   A dose of no more than 0.05 mL can be delivered with a 25- to 27-gauge needle, usually in the abdomen at a 90-degree angle without aspiration.

   DIF: Cognitive Level: Application REF: p. 35 OBJ: 8
   TOP: Topic: Subcutaneous Injections KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

2. The nurse would assess a 5-year-old patient who had a lumbar puncture completed 30 minutes ago for: *(Select all that apply.)*
   a. Drainage at the puncture site
   b. Evidence of headache
   c. Elevation of temperature
   d. Allergic skin reaction
   e. Gastric distress

   ANS: A, B, C
   Following a lumbar puncture, the patient should be assessed for drainage at the puncture site, evidence of post-puncture headache, or elevation of temperature. Allergic skin reaction and gastric distress are not associated with post-lumbar puncture concerns.

   DIF: Cognitive Level: Application REF: p. 48 OBJ: 6
   TOP: Assisting with Lumbar Puncture KEY: Nursing Process Step: Intervention
   MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

3. Considerations about possible risk factors of giving medications to children include: *(Select all that apply.)*
   a. Smaller body mass of a child
   b. Immaturity of body systems
   c. Need for individuality of dose
   d. High toxicity of many modern drugs
   e. Unavailability of useful drug references

ANS: A, B, C, D
Medicating small children is hazardous because of their smaller body mass, the immaturity of their body systems, the need for individualizing doses, and the high toxicity of many modern drugs. Many drug references are available.

DIF: Cognitive Level: Comprehension REF: p. 42 OBJ: 7
TOP: Administering Medication KEY: Nursing Process Step: Intervention
MSC: NCLEX: Physiological Integrity: Pharmacological Therapies

4. The signs that indicate the need for tracheal suctioning in a 3-month-old child are:
   a. Coughing
   b. Crust around the tracheostomy tube
   c. A bubbling sound during respiration
   d. Noisy breathing
   e. Moisture on a dressing under the tracheostomy tube

ANS: A, C, D
Coughing, a bubbling sound during respiration, and noisy breathing are indicators of the need for tracheostomy suctioning. Crust on the tube and a moist dressing can be remedies when the tube is cleaned and are not indicators of obstruction.

DIF: Cognitive Level: Application REF: p. 42 OBJ: 11
TOP: Suctioning KEY: Nursing Process Step: Assessment
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

OTHER

1. Place the steps of the infant bath in the correct sequence:
   a. Apply water and shampoo to the head, and shampoo the hair/scalp
   b. Fill the tub, and test the water for appropriate warmth
   c. Remove secretions from the baby's eyes
   d. Bathe the trunk and limbs
   e. Wash the perineal area

ANS:
B, C, A, D, E
The water is run and tested for appropriate warmth (100° F). The eyes are cleansed using a separate cotton ball for each eye, the face is washed, the hair/scalp is shampooed, the trunk and limbs are washed, the perineum is washed, and the baby is wrapped in a towel to dry.

DIF: Cognitive Level: Analysis REF: p. 54 OBJ: 3
TOP: Topic: Bathing Infant KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort