

Silvestri: Saunders Comprehensive Review for the NCLEX-RN® Examination, 6th Edition

Child Health

Test Bank

MULTIPLE CHOICE

1. The nurse is caring for an infant with a diagnosis of hydrocephalus and is monitoring the infant for signs of increased intracranial pressure (ICP). The nurse suspects increased ICP if which of the following is noted?
 1. Proteinuria
 2. Bradycardia
 3. A drop in blood pressure
 4. A bulging anterior fontanel

ANS: 4

Rationale: An elevated or bulging anterior fontanel indicates an increase in cerebrospinal fluid collection in the cerebral ventricle. Proteinuria, bradycardia, and a drop in blood pressure are not specific signs of increased ICP. Changes in the level of consciousness and a widened pulse pressure are additional signs of increased ICP.

Test-Taking Strategy: Use the principles associated with excessive fluid buildup in the cranial cavity when answering the question. Fluid accumulation in the cranial cavity will exert pressure on the soft brain tissue. This will cause the anterior fontanel to expand. A method of assessing fluid collection in the cranial cavity is to palpate this anterior fontanel. A full or bulging fontanel will indicate increasing amounts of fluid accumulation. Additionally, correlate the strategic word “hydrocephalus” in the question with “anterior fontanel” in “a bulging anterior fontanel,” the correct option. If you had difficulty with this question, review the symptoms associated with hydrocephalus.

PTS: 1

DIF: Level of Cognitive Ability: Analyzing

REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Child Health

MSC: Integrated Process: Nursing Process—Assessment

2. The nurse is caring for a child who has sustained a head injury in an automobile accident and is monitoring the child for signs of increased intracranial pressure (ICP). The nurse monitors for the earliest sign of increased ICP by assessing for:
 1. Apnea
 2. Posturing
 3. Tachycardia
 4. Changes in level of consciousness (LOC)

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ANS: 4

Rationale: An altered level of consciousness is an early sign of increased ICP. Late signs of increased ICP include tachycardia, leading to bradycardia, apnea, systolic hypertension, widening pulse pressure, and posturing.

Test-Taking Strategy: Note the strategic words “earliest sign” in the question. “Apnea” and “posturing” can be eliminated first because they are clearly late signs of increased ICP. Recalling that changes in LOC are an indication of concern in any client will assist in directing you to “changes in level of consciousness (LOC).” Review the early signs of increased ICP if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Child Health

MSC: Integrated Process: Nursing Process—Assessment

3. The nurse is providing instructions to the parents of an infant with a ventriculoperitoneal shunt. The nurse includes which of the following instructions?
1. Call the physician if the infant is fussy.
 2. Expect an increased urine output from the shunt.
 3. Call the physician if the infant has a high-pitched cry.
 4. Position the infant on the side of the shunt when the infant is put to bed.

ANS: 3

Rationale: If the shunt is malfunctioning, the fluid from the ventricle part of the brain will not be diverted to the peritoneal cavity. The cerebrospinal fluid will build up in the cranial area. The result is increased intracranial pressure, which then causes a high-pitched cry in the infant. The infant should not be positioned on the side of the shunt because this will cause pressure on the shunt and skin breakdown. This type of shunt affects the gastrointestinal system, not the genitourinary system, and an increased urinary output is not expected. “Call the physician if the infant is fussy” is a concern only if other signs indicative of a complication are occurring.

Test-Taking Strategy: Knowledge about a ventriculoperitoneal shunt is required to answer the question. Remember that a high-pitched cry in an infant indicates a concern or problem. If you had difficulty with this question, review assessment findings and home care instructions for the parents of a child with a shunt.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Child Health

MSC: Integrated Process: Teaching and Learning

4. The nurse reviews the plan of care for a child with Reye's syndrome. The nurse prioritizes the nursing interventions included in the plan and prepares to monitor for:
1. Signs of hyperglycemia
 2. Signs of a bacterial infection
 3. The presence of protein in the urine
 4. Signs of increased intracranial pressure

ANS: 4

Rationale: Intracranial pressure and encephalopathy are major symptoms of Reye's syndrome. Protein is not present in the urine. Reye's syndrome is related to a history of viral infections, and hypoglycemia is a symptom of this disease.

Test-Taking Strategy: This question asks you to select a priority nursing intervention for the child with Reye's syndrome. Recalling that Reye's syndrome is related to a history of viral infection and that hypoglycemia is associated with this syndrome will assist in eliminating "signs of hyperglycemia" and "signs of increased intracranial pressure." Use prioritizing skills to select "signs of increased intracranial pressure" over "the presence of protein in the urine." If you had difficulty with this question, review care of the child with Reye's syndrome.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). Maternal child nursing care (4th ed.). St. Louis: Mosby.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Child Health

MSC: Integrated Process: Nursing Process—Planning

5. The nurse is providing home care instructions to the mother of a child who is recovering from Reye's syndrome. Which of the following home instructions should the nurse provide to the mother?
1. Increase the stimuli in the environment.
 2. Give the child frequent small meals, if vomiting occurs.
 3. Avoid daytime naps so that the child will sleep at night.
 4. Check the child's skin and eyes every day for a yellow discoloration.

ANS: 4

Rationale: If vomiting occurs in Reye's syndrome, it is caused by cerebral edema and is a sign of intracranial pressure. Decreasing stimuli and providing rest decrease stress on the brain tissue. Checking for jaundice will assist in identifying the presence of liver complications, which are characteristic of Reye's syndrome.

Test-Taking Strategy: Read each option carefully, and think about the manifestations and complications associated with Reye's syndrome. Recalling that increased intracranial pressure is a concern will assist in eliminating "give the child frequent small meals, if vomiting occurs." Eliminate "increase the stimuli in the environment" and "avoid daytime naps so that the child will sleep at night" because they are comparable or alike in that they do not promote a restful environment for the child. Review care of the child with Reye's syndrome if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Child Health

MSC: Integrated Process: Teaching and Learning

6. The nurse working in the day care center is told that a child with autism will be attending the center. The nurse collaborates with the staff of the day care center and assists in planning activities that will meet the child's needs. The nurse understands that the priority consideration in planning activities for the child is to ensure:
1. Safety with activities
 2. Activities providing verbal stimulation
 3. Social interactions with other children in the same age group
 4. Familiarity with all activities and providing orientation throughout the activities

ANS: 1

Rationale: Safety with all activities is a priority in planning activities with the child. The child with autism is unable to anticipate danger, has a tendency for self-mutilation, and has sensoriperceptual deficits. Although providing social interactions, verbal communications, and familiarity and orientation are also appropriate interventions, the priority is safety.

Test-Taking Strategy: Use Maslow's Hierarchy of Needs theory to answer this question. Physiological needs take priority. When a physiological need does not exist, safety needs are the priority. None of the options addresses a physiological need. "Safety with activities" addresses the safety need. "Activities providing verbal stimulation," "social interactions with other children in the same age group," and "familiarity with all activities and providing orientation throughout the activities" address psychosocial needs. Review care to the child with autism if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.

OBJ: Client Needs: Safe and Effective Care Environment

TOP: Content Area: Child Health

MSC: Integrated Process: Nursing Process—Planning

7. The nurse is providing instructions to an adolescent who is taking phenytoin (Dilantin) for the control of seizures. Which of the following statements, if made by the adolescent, indicates a need for further teaching regarding the medication?
1. "The medication may cause oily skin."
 2. "Drinking alcohol may affect the medication."
 3. "If my gums become sore I need to stop the medication."
 4. "Birth control pills may not be effective when I take this medication."

ANS: 3

Rationale: The adolescent should not stop taking antiseizure medications suddenly or without discussing it with a physician or nurse. Acne or oily skin may be a problem for the adolescent, and the adolescent is advised to call a physician for skin problems. Alcohol will lower the seizure threshold, and it is best to avoid the use of alcohol. Birth control pills may be less effective when the client is taking antiseizure medication.

Test-Taking Strategy: Note the strategic words "need for further teaching." These words indicate a negative event query and the need to select the incorrect statement. Use general principles related to the administration of medication to assist in answering this question. The adolescent needs to be instructed not to stop the medication suddenly without discussing it with a physician or nurse. Review client teaching points related to the administration of medications if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Evaluating

REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Child Health

MSC: Integrated Process: Teaching and Learning

8. The nurse is collecting data on a 7-year-old child who is suspected of having episodes of absence seizures. Which of the following questions to the mother will assist in providing information that will identify the symptoms associated with these types of seizures?
1. "Does twitching occur in the face and neck?"
 2. "Does the muscle twitching occur on one side of the body?"
 3. "Does the muscle twitching occur on both sides of the body?"
 4. "Does the child have a blank expression during these episodes?"

ANS: 4

Rationale: Absence seizures are very brief episodes of altered awareness. There is no muscle activity except eyelid fluttering or twitching. The child has a blank facial expression. These seizures last only 5 to 10 seconds but may occur one after another several times a day. Myoclonic seizures are brief, random contractions of a muscle group that can occur on one or both sides of the body. Simple partial seizures consist of

twitching of an extremity, the face, or the neck, or the sensation of twitching or numbness in an extremity, the face, or the neck.

Test-Taking Strategy: Knowledge of the characteristics of the various types of seizures is required to answer this question. Focusing on the type of seizure identified in the question—absence seizures—may assist in directing you to “Does the child have a blank expression during these episodes?” Review the characteristics of the various types of seizures if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Analyzing

REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). *Maternal-child nursing* (3rd ed.). St. Louis: Saunders.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Child Health

MSC: Integrated Process: Nursing Process—Assessment

9. The nurse is reviewing the record of a child with increased intracranial pressure and notes that the child has exhibited signs of decerebrate posturing. On assessment of the child, the nurse would expect to note which of the following if this type of posturing were present?
1. Rigid extension and tremors of all extremities
 2. Flaccid paralysis of all extremities
 3. Flexion of the upper extremities and extension of the lower extremities
 4. Abnormal extension of the upper and lower extremities with some internal rotation

ANS: 4

Rationale: Decerebrate (extension) posturing is an abnormal extension of the upper extremities, with internal rotation of the upper arm and wrist and extension of the lower extremities with some internal rotation. “Flexion of the upper extremities and extension of the lower extremities” describes decorticate posturing. “Rigid extension and tremors of all extremities” and “flaccid paralysis of all extremities” are incorrect and not characteristics of decerebrate posturing.

Test-Taking Strategy: Knowing the clinical manifestations associated with posturing is required to answer this question. Focusing on the subject, decerebrate, will direct you to “abnormal extension of the upper and lower extremities with some internal rotation.” Also recalling that decerebrate posturing indicates extension posturing will assist in answering correctly. If you are unfamiliar with these findings, review the types and characteristics of posturing.

PTS: 1

DIF: Level of Cognitive Ability: Analyzing

REF: Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). *Maternal child nursing care* (4th ed.). St. Louis: Mosby.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Child Health

MSC: Integrated Process: Nursing Process—Assessment

10. The nurse is assisting in developing a plan of care for a child who will be returning from the operating room following a tonsillectomy. The nurse plans to place the child in which of the following positions on return from the operating room?
1. Supine
 2. Side-lying
 3. High-Fowler's and on the left side
 4. Trendelenburg's and on the right side

ANS: 2

Rationale: The child should be placed in a prone or side-lying position following tonsillectomy to facilitate drainage. "Supine," "High-Fowler's and on the left side," and "Trendelenburg's and on the right side" will not facilitate drainage.

Test-Taking Strategy: Visualize each of the positions described in the options. Keeping in mind that the goal is to facilitate drainage will easily direct you to "side-lying." Review positioning procedures following tonsillectomy if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Child Health

MSC: Integrated Process: Nursing Process—Planning

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118. A child is being discharged from the hospital following heart surgery. Prior to discharge, the nurse reviews the discharge instructions with the mother. Which of the following statements if made by the mother indicates a need for further education?
1. "Quiet activities are allowed."
 2. "The child should play inside for now."
 3. "Visitors are not allowed for at least 1 month."
 4. "The regular schedule regarding naps should be resumed."

ANS: 3

Rationale: Visitors without signs of any infection are allowed to visit the child. The mother should be instructed, however, that the child needs to avoid large crowds of people for 1 week following discharge. "Quiet activities are allowed." "The child should play inside for now." and "The regular schedule regarding naps should be resumed." are accurate instructions regarding activity following heart surgery.

Test-Taking Strategy: Note the strategic words "need for further education" in the question. These words indicate a negative event query and the need to select the incorrect statement. Use the process of elimination, considering the effects of the surgery on the child. Also noting the lengthy time period in "Visitors are not allowed for at least 1 month." will direct you to this option. Review child activity guidelines following heart surgery if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Evaluating

REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.

OBJ: Client Needs: Health Promotion and Maintenance

TOP: Content Area: Child Health

MSC: Integrated Process: Teaching and Learning

MULTIPLE RESPONSE

1. Cerebral palsy (CP) is a term applied to a disorder that impairs movement and posture. The effects on perception, language, and intellect are determined by the type that is diagnosed. What are the potential warning signs of CP? **Select all that apply.**
 1. The infant's arms or legs are stiff or rigid.
 2. By 8 months of age, the infant can sit without support.
 3. A high risk factor for CP is very low birth weight.
 4. The child has strong head control but a limp body posture.
 5. If the infant is able to crawl, only one side is used to propel himself or herself.
 6. The infant has feeding difficulties, such as poor sucking and swallowing.

ANS: 1, 3, 5, 6

Rationale: “The infant’s arms or legs are stiff or rigid,” “a high risk factor for CP is very low birth weight,” “if the infant is able to crawl, only one side is used to propel himself or herself,” and “the infant has feeding difficulties, such as poor sucking and swallowing” are potential warning signs of CP. By 8 months of age, if the infant cannot sit up without support, this would be considered a potential warning sign, because this developmental task should be completed by this time. The infant with a potential diagnosis of CP has poor head control by 3 months of age, when head control should be strong.

Test-Taking Strategy: Focus on the subject, the potential warning sign of CP. By reading each option carefully and using knowledge of the characteristics of cerebral palsy, you will be able to select the correct warning signs of CP. If you are unfamiliar with the warning signs and characteristics of CP, review this content.

PTS: 1

DIF: Level of Cognitive Ability: Analyzing

REF: Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). Maternal child nursing care (4th ed.). St. Louis: Mosby.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Child Health

MSC: Integrated Process: Nursing Process—Assessment

2. A child is brought to the emergency department, and a fracture of the left lower arm is suspected. The mother states that the child was rollerblading and attempted to break a fall with an outstretched arm. Diagnostic x-rays of the child reveal that a fracture is present. A plaster of Paris cast is applied to the arm, and the nurse provides instructions to the mother regarding cast care at home. Which teaching points would the nurse provide the mother? **Select all that apply.**
1. The cast should be dry in about 6 hours.
 2. The cast is water-resistant, so the child is able to take a bath or a shower.
 3. The cast will mold to the body part.
 4. The cast needs to be kept dry, because when wet it will begin to disintegrate.
 5. Keep the cast elevated for the first day on pillows.
 6. Make sure that the child can frequently wiggle the fingers.

ANS: 3, 4, 5, 6

Rationale: “The cast will mold to the body part,” “the cast needs to be kept dry, because when wet it will begin to disintegrate,” “keep the cast elevated for the first day on pillows,” and “make sure that the child can frequently wiggle the fingers” are all important components of a teaching plan for a parent. Plaster of Paris is a heavier material than that used in a synthetic cast. It molds easily to the extremity and is less expensive than a synthetic cast. It takes about 24 hours to dry, but drying time could be longer, depending on the size of the cast. Plaster of Paris is not water-resistant and, when wet, will begin to disintegrate. The cast should be elevated on a pillow for the first day to decrease swelling as the cast begins to mold to the arm. As the cast molds, it is imperative that the child can wiggle the fingers, because the extremity continues to swell.

If the child can wiggle the fingers, adequate motion is present. Color and sensation of the fingers should also be assessed.

Test-Taking Strategy: Focus on the strategic word “plaster” in the question and use knowledge regarding the differences between plaster casts and synthetic casts to answer this question. Using the process of elimination, you will easily select “the cast will mold to the body part,” “the cast needs to be kept dry, because when wet it will begin to disintegrate,” “keep the cast elevated for the first day on pillows,” and “make sure that the child can frequently wiggle the fingers.” If you had difficulty with this question, review nursing care of the child with a plaster cast.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). Maternal child nursing care (4th ed.). St. Louis: Mosby.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Child Health

MSC: Integrated Process: Teaching and Learning

3. The clinic nurse is assessing a child suspected of having juvenile rheumatoid arthritis (JRA). Which of the following assessment items would the nurse expect to find in a child who has been diagnosed with JRA? **Select all that apply.**
1. Hematuria
 2. Morning stiffness
 3. Painful, stiff, and swollen joints
 4. Limited range of motion of the joints
 5. Stiffness that develops later in the day
 6. History of late afternoon temperature, with temperature spiking up to 105° F

ANS: 2, 3, 4, 6

Rationale: Clinical manifestations associated with JRA include intermittent joint pain that lasts longer than 6 weeks and painful, stiff, and swollen joints that are warm to the touch, with limited range of motion. The child will complain of morning stiffness and may protect the affected joint or refuse to walk. Systemic symptoms include malaise, fatigue, lethargy, anorexia, weight loss, and growth problems. A history of a late afternoon fever with temperature spiking up to 105° F will also be part of the clinical manifestations.

Test-Taking Strategy: Knowledge regarding the clinical manifestations associated with JRA is required to answer this question. Thinking about the pathophysiology associated with this disorder and careful reading of each option will direct you to the correct ones. If you are unfamiliar with these manifestations, review this content.

PTS: 1

DIF: Level of Cognitive Ability: Analyzing

REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Child Health

MSC: Integrated Process: Nursing Process—Assessment

4. Which of the following interventions are appropriate for a child placed in protective isolation for neutropenia? **Select all that apply.**
1. Placing the child on a low-bacteria diet
 2. Changing dressings using sterile technique
 3. Peeling fruits and vegetables before allowing the child to eat them
 4. Allowing fresh-cut flowers in the room as long as they are kept in a vase with water
 5. Allowing individuals who are ill to visit as long as they wear a mask

ANS: 1, 2, 3

Rationale: For the hospitalized neutropenic child, flowers or plants should not be kept in the room because standing water and damp soil harbor *Aspergillus* and *Pseudomonas* species, to which these children are very susceptible. Fruits and vegetables not peeled before being eaten harbor molds and should be avoided until the white blood cell count rises. The child is placed on a low-bacteria diet. Dressings are always changed using sterile technique. Individuals who are ill are not allowed to visit the client.

Test-Taking Strategy: Knowledge regarding protective isolation procedures required in a neutropenic child will assist in answering this question. Noting the strategic words “low-bacteria” in “placing the child on a low-bacteria diet,” “sterile” in “changing dressings using sterile technique,” and “peeling” in “peeling fruits and vegetables before allowing the child to eat them” will assist in selecting these options. Review protective isolation procedures for the neutropenic child if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). Maternal-child nursing (3rd ed.). St. Louis: Saunders.

OBJ: Client Needs: Safe and Effective Care Environment

TOP: Content Area: Child Health

MSC: Integrated Process: Nursing Process—Implementation

COMPLETION

1. Augmentin 500 mg orally every 6 hours is prescribed for a child with an upper respiratory infection. The medication is supplied as 200 mg/5 mL. How many milliliters will be administered in each dose? **(Enter the answer in the space provided.)**
Answer: _____ mL

ANS: 12.5

Rationale: Use the ratio and proportion medication calculation formula.

$$500 \text{ mg} : X \text{ mL} = 200 \text{ mg} : 5 \text{ mL}$$

$$2500 = 200X$$

$$X = 12.5 \text{ mL}$$

Test-Taking Strategy: Use the medication calculation formula to answer the question and verify the answer with a calculator. Make sure that the answer makes sense. Review the formula for medication calculations if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: Potter, P., & Perry, A. (2009). Fundamentals of nursing (7th ed.). St. Louis: Mosby.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Child Health

MSC: Integrated Process: Nursing Process—Implementation

SHORT ANSWER

1. A mother brings her child to the emergency department. Based on the child's sitting position, drooling, and apparent respiratory distress, a diagnosis of epiglottitis is suspected. In anticipation of the physician's prescriptions, number the following actions in the appropriate order for delivering nursing interventions for this child. (Number 1 is the first action, and number 6 is the last action.)
 - 1 Prepare for assisted ventilation and have necessary equipment available.
 - 2 Obtain a pulse oximetry reading.
 - 3 Obtain an axillary temperature.
 - 4 Assess breath sounds by auscultation.
 - 5 Obtain weight for correct antibiotic dose infusion.
 - 6 Ask the mother about the precipitating events related to the child's condition.

ANS: 1, 3, 4, 2, 5, 6

Rationale: The highest priority with epiglottitis is to have assisted ventilation available, because the highest risk with this child is complete airway obstruction. Physiological interventions continue to have the highest priority, with assessment of breath sounds and then obtaining pulse oximetry being next highest in priority. Once the airway is stabilized, the temperature can be obtained. At this time, the child should be stabilized and the weight can be obtained. The last priority is asking about precipitating events, which is done once physiological needs are met.

Test-Taking Strategy: In prioritizing the options, consider Maslow's Hierarchy of Needs theory. Basic needs must be met first. Assisted ventilation is necessary. In addition to this, consider the ABCs—airway, breathing, and circulation—in prioritizing interventions. The lowest priority is asking the mother about precipitating events. If you had difficulty with this question, review the important treatment measures for the child with epiglottitis.

PTS: 1

DIF: Level of Cognitive Ability: Applying








REF: Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). Maternal child nursing care (4th ed.). St. Louis: Mosby.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Child Health

MSC: Integrated Process: Nursing Process—Planning

LIST OF AVAILABLE FILES

Name	Date modified	Type	Size
 Adult_Health	2015-04-16 02:57 ...	Rich Text Format	1,026 KB
 Child_Health	2015-04-16 02:57 ...	Rich Text Format	1,157 KB
 Fundamentals	2015-04-16 02:57 ...	Rich Text Format	1,024 KB
 Maternity	2015-04-16 02:57 ...	Rich Text Format	908 KB
 Mental_Health	2015-04-16 02:57 ...	Rich Text Format	495 KB
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