Wong's Essentials of Pediatric Nursing 12th edition Hockenberry Test Bank

SKU: 9780443123528-TEST-BANK

Test Bank - Chapter 01

Q1: The nurse would include which associated risk when planning a teaching session about childhood obesity?

A. Type I diabetes
B. Respiratory disease
C. Celiac disease
D. Type II diabetes (Correct)

Rationale: Childhood obesity has been associated with the rise of type II diabetes in children. Type I diabetes is not associated with obesity and has a genetic component. Respiratory disease is not associated with obesity, and celiac disease is the inability to metabolize gluten in foods and is not associated with obesity.

Q2: Which second-leading cause of death topic would the nurse emphasize to a group of boys ranging in age from 15 to 19 years?

A. Suicide
B. Cancer
C. Homicide (Correct)
D. Occupational injuries

Rationale: Homicide is the second overall cause of death in this age group and the leading cause of death in 15- to 19-year-old teenagers. Suicide is the third-leading cause of death in this population. Cancer, although a major health problem, is the fourth-leading cause of death in this age group. Occupational injuries do not contribute to a significant death rate for this age group.

Q3: During a community safety event, the nurse cites this as a major cause of death for children older than 1 year:

A. Cancer
B. Heart disease
C. Unintentional injuries (Correct)
D. Congenital anomalies

Rationale: Unintentional injuries (accidents) are the leading cause of death after age 1 year through adolescence. Congenital anomalies are the leading cause of death in those younger than 1 year. Cancer ranks either second or fourth, depending on the age group, and heart disease ranks fifth in the majority of the age groups.

Q4: Which factor most impacts the type of injury a child is susceptible to, according to the child's age?

A. Physical health of the child
B. Developmental level of the child (Correct)
C. Educational level of the child

D. Number of responsible adults in the home

Rationale: The child's developmental stage determines the type of injury that is likely to occur. The child's physical health may facilitate the child's recovery from an injury but does not impact the type of injury. Educational level is related to developmental level, but it is not as important as the child's developmental level in determining the type of injury. The number of responsible adults in the home may affect the number of unintentional injuries, but the type of injury is related to the child's developmental stage.

Q5: Which is most descriptive of the care the nurse is delivering when practicing family-centered care?

A. Taking over total care of the child to reduce stress on the family
B. Encouraging family dependence on health care systems
C. Recognizing that the family is the constant in a child's life (Correct)
D. Excluding families from the decision-making process

Rationale: The three key components of family-centered care are respect, collaboration, and support. Family-centered care recognizes the family as the constant in the child's life. Taking over total care does not include the family in the process and may increase stress instead of reducing stress. The family should be enabled and empowered to work with the health care system. The family is expected to be part of the decision-making process.

Q6: Which intervention would the nurse include when providing atraumatic care?

A. Prepare the child for separation from parents during hospitalization by reviewing a video.
B. Prepare the child before any unfamiliar treatment or procedure. (Correct)
C. Help the child accept the loss of control associated with hospitalization.
D. Help the child accept pain that is connected with a treatment or procedure.

Rationale: Preparing the child for any unfamiliar treatments, controlling pain, allowing privacy, providing play activities for expression of fear and aggression, providing choices, and respecting cultural differences are components of atraumatic care. In the provision of atraumatic care, the separation of children from parents during hospitalization is minimized. The nurse should promote a sense of control for the child. Preventing and minimizing bodily injury and pain are major components of atraumatic care.

Q7: Which suggests that a nurse has a nontherapeutic relationship with a patient and family?

A. Staff are concerned about the nurse's closeness with the patient and family. (Correct)
B. Staff assignments allow the nurse to care for the same patient and family over an extended time.
C. Nurse is able to withdraw emotionally when emotional overload occurs but still remains committed.
D. Nurses use teaching skills to instruct the patient and family rather than doing everything for them.

Rationale: A clue to a nontherapeutic staff-patient relationship is concern by other staff members. Allowing the nurse to care for the same patient over time would be therapeutic for the patient and family. Nurses who are able to somewhat withdraw emotionally can protect themselves while providing therapeutic care. Nurses using teaching skills to instruct patient and family will assist in transitioning the child and family to self-care.

Q8: Which is descriptive of clinical reasoning?

A. A simple developmental process
B. A cognitive process used to analyze data (Correct)
C. Based on deliberate actions
D. Assists individuals in guessing which is most appropriate

Rationale: Clinical reasoning is a complex, developmental process based on rational and deliberate thought. Clinical reasoning is not a developmental process. Clinical reasoning is not action based. Clinical reasoning is not a guessing process.

Q9: Which action by the nurse demonstrates use of evidence-based practice (EBP)?

A. Gathering equipment for a procedure
B. Documenting changes in a patient's status
C. Questioning the practice of daily central line dressing changes (Correct)
D. Clarifying a physician's prescription for morphine

Rationale: The nurse who questions the daily central line dressing change is ascertaining whether clinical interventions result in positive outcomes for patients. This demonstrates EBP, which implies questioning why something is effective and whether a better approach exists. Gathering equipment for a procedure and documenting changes in a patient's status are practices that follow established guidelines. Clarifying a physician's prescription for morphine constitutes safe nursing care.

Q10: A nurse is admitting a toddler to the hospital and the parents state they will need to leave for a brief period. Which type of nursing diagnosis would the nurse formulate for this child?

A. Risk for anxiety (Correct)
B. Anxiety
C. Readiness for enhanced coping
D. Ineffective coping

Rationale: A potential problem is categorized as a risk. The toddler has a risk of becoming anxious when the parents leave. Nursing interventions will be geared toward reducing the risk. The child is not showing current anxiety or ineffective coping. The child is not at a point for readiness for enhanced coping, especially because the parents will be leaving.

Q11: A nurse is planning a class on accident prevention for parents of toddlers. Which safety topic is the priority for this class?

A. Correct use of car seat restraints (Correct)
B. Safety crossing the street

C. Helmet use when riding a bicycle
D. Poison control numbers

Rationale: Motor vehicle accidents (MVAs) continue to be the most common cause of death in children older than 1 year, therefore the priority topic is appropriate use of car seat restraints. Safety crossing the street and bicycle helmet use are topics that should be included for preschool parents but are not priorities for parents of toddlers. Information about poison control is important for parents of toddlers and would be a safety topic to include but is not the priority over appropriate use of car seat restraints.

Q12: A nurse is collecting subjective and objective information about target populations to diagnose problems based on community needs. This describes which step in the community nursing process?

A. Planning
B. Diagnosis
C. Assessment (Correct)
D. Establishing objectives

Rationale: Assessment is a continuous process that operates at all phases of problem solving and is the foundation for decision making. Assessment involves multiple nursing skills and consists of the purposeful collection, classification, and analysis of data from a variety of sources. Diagnosing is the next step of the nursing process when the problem is identified. The nurse should establish objectives for the activity before starting the nursing process.

Q13: A nurse has established several health programs, such as bicycle safety, to improve the health status of a target population. This describes which step in the community nursing process?

A. Planning
B. Evaluation
C. Assessment
D. Implementation (Correct)

Rationale: The nurse working with the community to put into practice a program to reach community goals is the implementation phase of the community nursing process. Planning involves designing the program to meet community-centered goals. The evaluation stage would determine the effectiveness of the program. During the assessment phase, the nurse would identify the resources necessary and the barriers that would interfere with implementation.

Q14: When communicating with other health care professionals, which is important for the nurse to do?

A. Ask others what they want to know.
B. Share everything known about the family.
C. Restrict communication to clinically relevant information. (Correct)
D. Recognize that confidentiality is not possible.

Rationale: The nurse will need to share, through both oral and written communication, clinically relevant information with other involved health professionals. Asking others what they want to know and sharing everything known about the family is inappropriate. Patients have a right to confidentiality. The nurse is not permitted to share information about clients, except clinically relevant information that pertains to the child's care. Confidentiality permits the disclosure of information to other health professionals on a need-to-know basis.

Q15: A nurse is formulating a clinical question for evidence-based practice. Place in sequential order the steps the nurse should use to clarify the scope of the problem and clinical topic of interest: 1. Intervention 2. Outcome 3. Population 4. Time 5. Comparison

A. 4, 5, 1, 2, 1
B. 5, 2, 3, 4, 1
C. 3, 1, 5, 2, 4 (Correct)
D. 2, 3, 1, 5, 4

Rationale: When formulating a clinical question for evidence-based practice, the nurse would follow a concise, organized way that allows for clear answers. Good clinical questions should be asked in the PICOT (population, intervention, comparison, outcome, time) format to assist with clarity and literature searching. PICOT questions assist with clarifying the scope of the problem and clinical topic of interest.

Q16: The nurse is performing an assessment on a 28-month-old toddler in the clinical and finds he is in the 98th percentile in weight. What is important to include in parent teaching?

A. Children establish lifelong eating habits in the first three years of life. (Correct)
B. Screen time should be limited to one hour during the week.
C. Mother should consider switching to human milk for nutrition.
D. Encourage parents to continue their current nutritional diet.

Rationale: Nutrition is an essential component for healthy growth and development and children establish lifelong eating habits during the first three years of life. The nurse is instrumental in educating parents on the importance of nutrition.

Q17: The nurse decides to use a topical anesthetic prior to an intravenous catheter insertion on a 5-year-old child. This action by the nurse demonstrates:

A. Evidence based practice
B. Atraumatic Care (Correct)
C. Time-saving strategies
D. Family-Centered Care

Rationale: The overriding goal in providing atraumatic care is: First, do no harm. One goal of this is to prevent or minimize bodily injury or pain. The nurse will likely take more time, but the topical anesthetic will minimize the pain when inserting the IV catheter.

Q18: The following account for the most common causes of deaths in infants younger than 1 year? (Select all that apply.) *(Select all that apply.)*

A. Congenital anomalies (Correct)

B. Sudden infant death syndrome (Correct)

C. Respiratory distress syndrome

D. Bacterial sepsis of the newborn

E. Disorders relating to short gestation (Correct)

Rationale: Congenital anomalies, disorders relating to short gestation and unspecified LBW, newborn affected by maternal complications of pregnancy, and sudden infant death syndrome—are the leading causes of deaths in infants younger than 1 year old (Centers for Disease Control and Prevention, 2017a).

Q19: Which behaviors by the nurse indicate a therapeutic relationship with children and families? (Select all that apply.) *(Select all that apply.)*

A. Spending off-duty time with children and families

B. Asking questions if families are not participating in the care (Correct)

C. Clarifying information for families (Correct)

D. Buying toys for a hospitalized child

E. Learning about the family's religious preferences (Correct)

Rationale: Asking questions if families are not participating in the care, clarifying information for families, and learning about the family's religious preferences are positive actions and foster therapeutic relationships with children and families. Spending off-duty time with children and families and buying toys for a hospitalized child are negative actions and indicate overinvolvement with children and families, which is nontherapeutic.

Q20: Which behaviors by the nurse indicate a non-therapeutic relationship with the child and family? (Select all that apply.) *(Select all that apply.)*

A. Visits family on days off. (Correct)

B. Provides a calming influence

C. Purchases clothes and toys for the child. (Correct)

D. Communication is open and two-way.

E. Strives to empower families.

Rationale: A home care nurse can establish therapeutic nurse-family boundaries by negotiating house rules and ensuring that communication is open and two-way. Visiting the family of off-duty days and buying gifts for the child would be boundary crossing and non-therapeutic.

Review Questions - Chapter 01

Q1: The role of the pediatric nurse is influenced by trends in health care. Which is an influential trend in pediatric health care based on Healthy People 2030 goals?

A. Primary focus on the pediatric age range.
B. Engaging key partnerships in design of healthcare policies. (Correct)
C. Focusing educational materials for the bilingual population.
D. Focus on the unification of the population to meet one common standard.

Rationale: Trends in health care are impacted on the population level. The pediatric nurse should be involved in partnerships as they relate to the development of healthcare policies. This is considered to be an important trend. Although the pediatric nurse is focused on the delivery of healthcare to the pediatric population, the pediatric nurse must be aware of the impact on health and diversity at the population level which is more global in nature and doesn't relate to one common standard.

Q2: The etiology component of the nursing diagnosis describes the

A. projected changes in an individual's health status, clinical conditions, or behavior.
B. individual's responses to health pattern deficits in the child, family, or community.
C. cluster of cues and/or defining characteristics that are derived from patient assessment and indicate actual health problems.
D. physiologic, situational, and maturational factors that cause the problem or influence its development. (Correct)

Rationale: The etiology component of the nursing diagnosis, the second component of the nursing diagnosis, describes the physiologic, situational, and maturational factors that cause the problem or influence its development. Projected changes in an individual's health status, clinical conditions, or behavior are the outcomes or goals that are established. An individual's responses to health pattern deficits in the child, family, or community is the definition of the problem statement, the first component of the nursing diagnosis. The cluster of cues and/or defining characteristics that are derived from patient assessment and indicate actual health problems is the third part of the nursing diagnosis, the signs and symptoms.

Q3: Nurses play an important role in current issues and trends in health care. Which is a current trend in pediatric nursing and health care today?

A. The patient is the unit of care for the health care provider.
B. Discharge planning begins when the physician writes the order.
C. Health promotion resources enable children to achieve their full potential. (Correct)
D. The focus of pediatric health care is trending toward acute hospital care.

Rationale: Health promotion provides opportunities to reduce differences in current health status among members of different groups and provides a better chance to achieve the fullest health potential. The patient and family is the unit of care for the health care provider. Discharge planning begins when the patient is admitted. The focus of pediatric health care is trending away from acute

hospital settings.

Q4: The nurse is providing education to a group of parents at a health fair in a local kindergarten school. The nurse describes the most common cause of death for children age 5 to 9 years is

A. inappropriate use of bike helmets and seat belts. (Correct)

B. childhood immunizations.

C. lack of hand washing in the prevention of communicable diseases.

D. the obesity epidemic.

Rationale: The most common cause of death in children age 5 to 9 years is accidents. Education on safety is important to help prevent accidental deaths. Accidents are the most common cause of death for children age 5 to 9 years, not childhood immunizations or obesity. Hand washing helps to prevent communicable diseases.

Q5: The nurse demonstrates understanding of family-centered care by

A. encouraging family visitation. (Correct)

B. assuming total care for the child.

C. limiting visitation to three time periods per day.

D. expecting the child to perform self-care in activities of daily living.

Rationale: Family-centered care recognizes the family as the constant in a child's life and visitation supports this philosophy in addition to developing trusting relationships with families. Family-centered care does not assume total care for the child. Limiting visitation is the exact opposite of family-centered care. Family-centered care involves more than expectations for the child.

Q6: A child is admitted to the hospital with a diagnosis of possible meningitis. Which information is the most important to ask at the time of admission?

A. "Are there any pets in the household?"

B. "Is anyone else in the household ill?"

C. "Are the immunizations up to date?" (Correct)

D. "Has the child had a recent injury?"

Rationale: Immunizations are one of two public health interventions that have had the greatest impact on world health, with clean public drinking water being the other. Nurses should review individual immunization records at every clinical visit and/or hospitalization. In addition, nurses are responsible for keeping current in changes in immunization schedules, recommendations, and research related to childhood vaccines.

Q7: Which nursing intervention would be most effective in decreasing mortality from unintentional injury?

A. Teaching children the dangers of contact sports

B. Encouraging potential parents to obtain genetic counseling

C. Educating parents-caretakers about the benefits of immunizations

D. Teaching parents-caretakers about proper use of vehicle restraint seats (Correct)

Rationale: The most common cause of death for the age group 1-19 years is unintentional injuries such as motor vehicle accidents, drowning, and firearms. Teaching the dangers of contact sports will not decrease mortality from unintentional injuries such as motor vehicle accidents. Genetic counseling does not decrease mortality from unintentional injuries. Immunization education is not most effective.

Q8: A nurse is preparing an educational workshop on atraumatic care in pediatric patient care. The most appropriate nursing intervention to include in the workshop is to

A. prepare the child that their parents will not be able stay during hospitalization by watching a video.
B. help the child to accept the pain associated with any treatments, procedures, or surgery.
C. tell the child that the loss of control and privacy in the hospital is temporary.
D. provide the child play activities for expression of fear and aggression. (Correct)

Rationale: Allowing the child play activities for the expression of fear and aggression are principles of atraumatic care. Atraumatic care is to prevent or minimize the child's separation from the family. Minimizing or preventing bodily injury and pain are principles of atraumatic care. Promoting a sense of control and privacy are components of atraumatic care.

Q9: Which represents the most likely cause of death for children greater than 1 year of age?

A. Homicide
B. Unintentional injuries (Correct)
C. Violent death
D. Congenital diseases

Rationale: The most common cause of death for children over 1 year of age is unintentional injuries. Homicide and violent deaths do occur but are not the most common cause. Congenital disease can contribute to morbidity and mortality but it is not the most common cause of death in children over 1 year of age.

Q10: With regard to the nutritional well-being, at what age should the nurse instruct the parents that lifelong learning habits have been fostered?

A. By 1 year of age
B. When the child enters kindergarten
C. At 6 months of age when solid food introduction takes place
D. By 18 months of age (Correct)

Rationale: Lifelong eating habits are typically in place by 18 months of age. It is important for both the parents, nurse and health care provider to be cognizant of this fact in order to prevent possible eating disorders and/or food aversions.

Q11: A nurse has been working with a family who has 2 children, ages 5 and 7 years of age, to provide health teaching related to healthy nutritional patterns. Which observation if noted would

indicate that additional instruction should be given related to health teaching in this area?

A. The children demonstrate application of skills by identifying healthy food snacks.
B. The parents are able to identify which foods are poor examples of “healthy food snacks.”
C. In response to the family’s identification of healthy food snacks, the nurse provides limited feedback since the answers are correct. (Correct)
D. The nurse provides an interactive learning environment using age appropriate learning strategies.

Rationale: The nurse, in the role of health teaching, should provide generous feedback and evaluation responses in order to facilitate the learning environment. Parents and children who can successfully identify and apply information provides evidence of effective teaching. Use of age appropriate learning strategies is a critical part of health teaching.

Q12: The nurse in considering ethical dilemmas that may affect delivery of care with regard to pediatric patients, must consider that the patient’s well-being is of paramount importance. This concept is best described by

A. fairness.
B. applying equity.
C. beneficence. (Correct)
D. prevention of harm.

Rationale: Beneficence is the moral principle of promotion of a patient’s well-being. Fairness is the application of justice. Providing equity relates to the equality of provided services. Prevention of harm is defined by the ethical principle of maleficence.

Q13: When comparing the nursing process to the Clinical Judgment Measurement and Action model, which options are aligned with analysis (Select all that apply.) *(Select all that apply.)*

A. recognize cues.
B. evaluate outcomes.
C. take action.
D. generate solutions.
E. analyze cues. (Correct)
F. prioritize hypotheses. (Correct)

Rationale: The analysis phase of nursing process is correlated with analyze cues and prioritize hypotheses of the Clinical Judgment Measurement and Action model.

Q14: Bright Futures program provides initiatives that focus on health promotion of children by focusing on (Select all that apply.) *(Select all that apply.)*

A. encouraging use of community resources. (Correct)
B. focus on after school activities as a source of engagement.
C. promotion of healthy eating habits. (Correct)
D. limitations on introduction of health and sexuality teaching so as to assure parental support.

E. providing a safe environment. (Correct)
F. providing limited mental health services. (Correct)

Rationale: Bright Futures focuses on promoting community resources, nutritional/healthy eating habits, focusing on a safe environment to avoid injury and providing mental health services as needed. After school activities are not a part of the available services and health and sexuality teaching is an offered service, not a restricted service.

Q15: Arrange in sequential order the steps of the nursing process in relationship to evidenced based practice (EBP). (Answer with a letter followed by a comma and a space (e.g., A, B, C, D).) *(Select all that apply.)*

A. Collecting research based on the question of interest (Correct)
B. Integrating evidence with clinical expertise to implement care (Correct)
C. Development of the research question (Correct)
D. Evaluation of the effectiveness of the care plan (Correct)
E. Development of the care plan (Correct)

Rationale: EBP process can be correlated with nursing process to incorporate critical thinking and clinical judgment. During assessment and diagnosis phases, the research question is developed as research is collected to support the query of interest. Development of the care plan is then established as research evidence is integrated with clinical expertise in the implementation phase. Lastly, the overall effectiveness of the care plan is examined during the evaluation phase.