# TEST BANK CHILD HEALTH NURSING 3RD EDITION BY BALL

**Ball, Child Health Nursing, 3/E**
**Chapter 7**

**Question 1**

**Type:** MCSA

During the newborn examination, the nurse assesses the infant for signs of developmental dysplasia of the hip. Which finding would strongly suggest this disorder?

1. Asymmetric thigh and gluteal folds
2. Positive Babinski'sflex re
3. A negative Moro reflex
4. Flat soles with prominent fat pads

**Correct Answer:** 1

**Rationale 1**: Asymmetric thigh and gluteal folds are a positive finding for developmental dysplasia of the hip and require follow-up with an ultrasound.

**Rationale 2**: A positive Babinski's reflex is a normal finding i

**Rationale 3**: The Moro reflex involves both arms and legs. A positive Moro reflex is normal in the newborn. The absence of the Moro can indicate a brain or tissue injury.

**Rationale 4**: Flat soles are normal in newborns.

**Global Rationale:**

**Cognitive Level:** Analyzing

**Client Need:**
**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Assessment

**Learning Outcome:** 7-1

**Question 2**

**Type:** MCSA

The nurse is taking a health history from the family of a three-year-old child. Which statement or question by the nurse would be most likely to establish rapport and elicit an accurate response from the family?

1. "Tell me about the concerns that brought you to th
2. "Does any memberofyour family have a history of asthma, heart disease, or diabetes?"
3. "Hello, I would like to talk with you and get some and your child."
4. "You will need to fill out these forms; make sure as complete as possible."

**Correct Answer:** 1

**Rationale 1**: Asking the parents to talk about their concerns is an open-ended question and one that is more likely to establish rapport and an understanding of the parents' perceptions.

**Rationale 2**: Asking about a number of items at once might be confusing to the family.

**Rationale 3**: Giving an introduction before asking the parents for information is likely to establish rapport, but giving an explanation of why the information would be needed will be even more effective at establishing rapport and also getting more accurate, pertinent information.

**Rationale 4**: Simply asking the parents to fill out forms is very impersonal, and more information is likely to be obtained and clarified by the nurse directing the interview.

**Global Rationale:**

**Cognitive Level:** Analyzing

**Client Need:**

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Assessment

**Learning Outcome:** 7-1

**Question 3**

**Type:** MCSA

A nurse working in the newborn nursery notes that an infant is having frequent episodes of apnea lasting 10 to15 seconds without any changes in color or decreases in heart rate. Which intervention would be the most appropriate?

1. Continue to observe the infant and call the physician if the apnea lasts longer than 20 seconds.
2. Suction the infant's mouth and nares.
3. Call the physician immediately.
4. Turn the infant on its right side.

**Correct Answer:** 1

**Rationale 1**: Apnea lasting less than 20 seconds is a normal finding in newborns as long as there is no associated cyanosis or bradycardia, so continued observation is the most appropriate intervention.

**Rationale 2**: There is no indication that suctioning is needed.

**Rationale 3**: It is unnecessary to inform the physician, as apnea lasting 10 to 15 seconds is normal in a newborn.

**Rationale 4**: Turning the baby is not necessary, as apnea lasting 10 to 15 seconds in a newborn is normal.

**Global Rationale:**
**Cognitive Level:** Analyzing

**Client Need:**

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Implementation

**Learning Outcome:** 7-3

**Question 4**

**Type:** MCSA

The nurse is completing a physical examination of a four-year-old child. The best position in which to place the child for assessment of the genitalia would be:

1. Supine, with legs at a 50-degree angle.
2. Right side-lying.
3. In prone position, with knees drawn up under the body.
4. Frog-leg position.

**Correct Answer:** 4

**Rationale 1**: The child will not tolerate the legs at a 50-degree angle for long.

**Rationale 2**: There is no reason for a side-lying position, and the child will not tolerate holding the top leg up for long.

**Rationale 3**: Prone with knees drawn up will allow assessment of the anus, but it will not allow for visualization of the vaginal area.

**Rationale 4**: Having the child lie supine, flexing her knees and pulling them up to a frog-legged position, allows for accurate assessment of the genitalia and is well tolerated by the majority of children.

**Global Rationale:**

**Cognitive Level:** Applying
**Client Need:**

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Assessment

**Learning Outcome:** 7-5

**Question 5**

**Type:** SEQ

Put the following nursing assessments of a toddler in the best order for the nurse to proceed (from first assessment to last assessment).

**Standard Text:** Click and drag the options below to move them up or down.

**Choice 1.** Auscultation of chest

**Choice 2.** Examination of eyes, ears, and throat

**Choice 3.** Palpation of abdomen

**Choice 4.** General appearance

**Correct Answer:** 4,1,3,2

**Rationale 1**: Auscultation usually is less threatening to the toddler than is palpation, especially if the nurse first demonstrates using the stethoscope on a parent or a toy.

**Rationale 2**: The most uncomfortable, most invasive exam for the toddler is most likely to be the examination of the eyes, ears, and throat; therefore, this assessment should be performed last.

**Rationale 3**: Palpation can be more threatening than is observing or listening, so it should be completed after both.

**Rationale 4**: The nurse will begin the assessment by looking at the child. This can be done while the mother is holding the child and the nurse is talking to the mother. This environment will be neutral for the child and will not cause anxiety.
**Global Rationale:**

**Cognitive Level:** Applying

**Client Need:**

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Planning

**Learning Outcome:** 7-5

**Question 6**

**Type:** MCSA

A very concerned 14 -year-old boy presents to the clinic because of an enlargement of his left breast. Except for the breast enlargement, the client's history and physical are normal. The most appropriate intervention for the nurse to implement next would be to inform the child that:

1. This is a normal finding in adolescent males and that the breast tissue generally regresses by the time of full sexual maturity.
2. His condition is related to a high-fat diet and that limiting fat intake usually will resolve the enlargement over a period of a couple of months.
3. A pediatric endocrine consult is being arranged.
4. The healthcare provider is arranging a surgical consult for him.

**Correct Answer:** 1

**Rationale 1**: Gynecomastia, or breast enlargement, is a normal finding in adolescent males as they develop toward sexual maturity.

**Rationale 2**: The breast enlargement is not related to fat content but is normal in developing adolescent males.

**Rationale 3**: This is a normal finding, and an endocrine consult is not required.
**Rationale 4**: There is no reason for a surgical consult, as this is normal for adolescent males.

**Global Rationale:**

**Cognitive Level:** Analyzing

**Client Need:**

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Implementation

**Learning Outcome:** 7-6

**Question 7**

**Type:** MCSA

A nurse caring for a nine-year-old notices some swelling in the child's a The nurse presses against the ankle bone for five seconds, then releases the pressure, noticing a markedly slow disappearance of the indentation. Based
on these physical findings, the nurse would be most concerned with assessing:

1. Skin integrity, especially in the lower extremities.
2. Level of consciousness.
3. Urine output.
4. Range of motion and ankle mobility.

**Correct Answer:** 3

**Rationale 1**: While ankle edema could lead to both decreased ankle mobility and compromise in skin integrity, diagnosing and treating the underlying cause of the edema is most important.

**Rationale 2**: While there may be an underlying condition causing the edema that could later result in changes in level of consciousness, assessing level of consciousness based on these findings is unlikely to elicit the cause of the child's edema.

**Rationale 3**: Dependent, pitting edema, especially in the lower extremities, can be a symptom of kidney and cardiac disorders. Decreases in urine output also can indicate compromise in the renal and cardiac systems.

**Rationale 4**: While ankle edema could lead to both decreased ankle mobility and compromise in skin integrity, diagnosing and treating the underlying cause of the edema is most important.

**Global Rationale:**

**Cognitive Level:** Analyzing

**Client Need:**

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Assessment

**Learning Outcome:** 7-7

**Question 8**

**Type:** MCSA

The nurse is caring for an infant diagnosed with “fai observes the physician taking blood pressures in all four extremities and recognizes that the physician suspects which congenital cardiac defect?

1. Tetralogy of Fallot
2. Ventricular septal defect
3. Pulmonary atresia
4. Coarctation of the aorta

**Correct Answer:** 4

**Rationale 1**: There are minimal differences between upper and lower blood pressure readings in tetralogy of Fallot.

**Rationale 2**: There are minimal differences between upper and lower blood pressure readings in ventricular septal defect.
**Rationale 3**: There are minimal differences between upper and lower blood pressure readings in pulmonary atresia.

**Rationale 4**: Normally, blood pressures in the lower extremities are the same or higher than upper-extremity blood pressures. But in coarctation of the aorta, the narrowing of the aorta causes decreased blood flow to the lower extremities, and

so lower extremity blood pressure readings are significantly lower than upperextremity readings.

**Global Rationale:**

**Cognitive Level:** Applying

**Client Need:**

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Assessment

**Learning Outcome:** 7-7

**Question 9**

**Type:** MCMA

A seven-year-old presents to the clinic with an exacerbation of asthma symptoms. On physical exam, the nurse would expect which of the following findings?

**Standard Text:** Select all that apply.

1. Increased tactile fremitus
2. Decreased vocal resonance
3. Bronchophony
4. Decreased tactile fremitus
5. Wheezing

**Correct Answer:** 2,4,5

**Rationale 1**: An increase in tactile fremitus is indicative of pneumonia.

**Rationale 2**: Asthma causes a decreased vocal resonance, as edema makes it more difficult for the sound to project.

**Rationale 3**: Bronchophony is an increase in the intensity and clarity of transmitted sounds that also is indicative of pneumonia.

**Rationale 4**: The air trapping in the lungs that occurs with asthma causes a decrease in the sensation of vibrations or a decreased tactile fremitus.

**Rationale 5**: Wheezing is caused by air passing through mucus or fluids in a narrowed lower airway, and it is a condition frequently present in asthma exacerbations.

**Global Rationale:**

**Cognitive Level:** Analyzing

**Client Need:**

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Assessment

**Learning Outcome:** 7-7

**Question 10**

**Type:** MCSA

While inspecting a five-year-old child's ears with an otoscope, th that the right membrane is red and there is an absence of light reflex. In view of these findings, which vital sign parameter would most concern the nurse?

1. Heart rate
2. Temperature

3. Blood pressure
4. Respirations

**Correct Answer:** 2
**Rationale 1**: Although there could be changes in heart rate, respiratory rate, and blood pressure, these are not indicators specific to the presence of infection.

**Rationale 2**: The red finding indicates that there is probably infection in the middle ear while the absence of life reflex indicates a bulging tympanic member, which is also associated with infection.

**Rationale 3**: Although there could be changes in heart rate, respiratory rate, and blood pressure, these are not indicators specific to the presence of infection.

**Rationale 4**: Although there could be changes in heart rate, respiratory rate, and blood pressure, these are not indicators specific to the presence of infection.

**Global Rationale:**

**Cognitive Level:** Analyzing

**Client Need:**

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Assessment

**Learning Outcome:** 7-7

**Question 11**

**Type:** MCSA

While assessing a 10-month-old African American infant, the nurse notices that the sclerae have a yellowish tint. Which organ system would the nurse suspect as having an ongoing disease process?

1. Genitourinary
2. Cardiac
3. Gastrointestinal
4. Respiratory

**Correct Answer:** 3

**Rationale 1**: Tenting of the skin and dry mucous membranes could be signs of dehydration, and edema could be a sign of fluid overload. Both of these conditions could be secondary to problems with functioning of the genitourinary system.

**Rationale 2**: Cyanosis of the skin and mucous membranes is generally a sign of problems with the cardiac and/or respiratory system.

**Rationale 3**: This infant's sclerae are showing signs of j likely is secondary to a failure or malfunction of the liver in the gastrointestinal system.

**Rationale 4**: Cyanosis of the skin and mucous membranes is generally a sign of problems with the cardiac and/or respiratory system.

**Global Rationale:**

**Cognitive Level:** Analyzing

**Client Need:**

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Assessment

**Learning Outcome:**

**Question 12**

**Type:** SEQ

While evaluating development of children, the nurse notes that the development of secondary sexual characteristics follows a typical pattern. Place the appearance of secondary sexual characteristics in the female in order of appearance from earliest to latest.

**Standard Text:** Click and drag the options below to move them up or down.

**Choice 1.** Appearance of pubic hair
**Choice 2.** Menarche

**Choice 3.** Breast budding

**Choice 4.** Breast Tanner stage 5, areola strongly pigmented

**Correct Answer:** 3,1,2,4

**Rationale 1**: Pubic hair is the second stage of Tanner development occurring around 11 years of age.

**Rationale 2**: The onset of menstruation usually occurs after the appearance of the first pubic hair.

**Rationale 3**: According to Tanner stages, the first stage of pubertal development in girls is the development of palpable glandular tissue of the breasts. Breast buds usually develop between 9 and 14 years of age.

**Rationale 4**: This is the final stage of breast development according to Tanner stage. It usually occurs between 12 and 18 years of age.

**Global Rationale:**

**Cognitive Level:** Applying

**Client Need:**

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Assessment

**Learning Outcome:** 7-6

**Question 13**

**Type:** MCMA

The policy of the pediatric clinic is that head circumferences are performed at each visit, if appropriate. The nurse should plan to check head circumferences on which of the children being seen today?

**Standard Text:** Select all that apply.

1. One-month-old child who is coming for his first well-child visit
2. Two-month-old child with failure to thrive
3. Nine-month-old child with otitis media
4. 18-month-old well-child visit for a child with Down's syn

**Correct Answer:** 1,2,3,4

**Rationale 1**: The fontanels are open and the head will increase in size until two years of age.

**Rationale 2**: The posterior fontanel is closed or closing. The anterior fontanel is open and head circumference will increase. The head circumference should be monitored to make sure the failure to thrive is not affecting brain development.

**Rationale 3**: The anterior fontanel is still open, and the head circumference is still increasing slightly. Failure to see the increase could indicate the sutures have closed prematurely. The otitis media diagnosis is unrelated to the general assessment findings.

**Rationale 4**: The anterior fontanel is closed or closing. The head circumferences should be evaluated until the child is two years old. The

diagnosis of Down's syndrome does not change the need child's progress.

**Global Rationale:**

**Cognitive Level:** Analyzing

**Client Need:**

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Assessment

**Learning Outcome:** 7-8

**Question 14**

**Type:** MCSA
The nurse wants to do a quick evaluation of a one-month-old infant's hearin Which assessment will provide the best information?

1. Examining the ear canal with an otoscope
2. Using a vibratingtuning fork placed against the child
3. Using tympanometry
4. Using a noisemaker in the infant's presence to eva response

**Correct Answer:** 4

**Rationale 1**: Inspection of the ear canal and membrane will not provide any information on the infant's hearing ability.

**Rationale 2**: In a school-age child, this will test bone conduction, but it is not appropriate for an infant.

**Rationale 3**: Tympanometry is a tool to evaluate the movement of the tympanic membrane. Although related to sound transmission, it is not the best response.

**Rationale 4** : This is a quick, simple evaluation of the ch
sounds. The child's response can bewideningastoppingofthe of act eyes, or turning toward the sound.

**Global Rationale:**

**Cognitive Level:** Analyzing

**Client Need:**

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Planning

**Learning Outcome:** 7-5

**Question 15**

**Type:** MCSA
To accurately access blood pressure on a child, the nurse would select a cuff:

1. By the cuff label— infant, child, adult.
2. That covers 2/3 of the upper arm with a bladder that wraps around at least 80% of the circumference of the arm.
3. Based on availability as the size of the cuff will not influence the blood pressure.
4. That extends up to 50 % of the upper arm and the bladder covers 1/4 of the circumference of the arm.

**Correct Answer:** 2

**Rationale 1**: This does not determine the size of the cuff by the size of the child. In addition, the arm may not be used for the blood pressure assessment.

**Rationale 2**: This is an accurate measurement to determine cuff size.

**Rationale 3**: Blood pressure readings will be inaccurately high or low based on whether the cuff is too large or too small.

**Rationale 4**: This is incorrect and will result in a cuff that is too small.

**Global Rationale:**

**Cognitive Level:** Applying

**Client Need:**

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Assessment

**Learning Outcome:** 7-5

**Question 16**

**Type:** MCSA

While assessing a seven-year-old girl, the nurse notices a regular— irregular heartbeat. The nurse listens carefully and notes that the heart rate increases on inspiration and decreases on expiration. What is the most appropriate action for the nurse to take next?

1. Record the finding as normal.
2. Notify the physician.
3. Schedule an EKG.

4. Ask the mother if a murmur has been detected before.

**Correct Answer:** 1

**Rationale 1**: This is sinus arrhythmia and is a normal finding in children but not in adults.

**Rationale 2**: This is a normal finding. It should be recorded, not reported.

**Rationale 3**: Nurses do not order tests, including EKGs.

**Rationale 4**: There is no evidence of a murmur in the stem. This is a normal finding.

**Global Rationale:**

**Cognitive Level:** Analyzing

**Client Need:**

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Implementation

**Learning Outcome:** 7-3

**Question 17**

**Type:** MCSA

While assessing the blood pressure of an eight-year-old child, the nurse notes the following: Systolic sound is heard at 98, but the sound continues until it reaches 0. There is a distinct sound softening at 48. How should the nurse record this finding?

1. 98/48

2. 98/48/0
3. 98/0
4. 48/0

**Correct Answer:** 2

**Rationale 1**: This is not the correct documentation. Korotkoff sounds were heard down to 0 mmHg.

**Rationale 2**: This documentation correctly records the nur

**Rationale 3**: This is not the correct documentation as it does not include the qualitative change at 48.

**Rationale 4**: This reading eliminates the systolic sound.

**Global Rationale:**

**Cognitive Level:** Applying

**Client Need:**

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Implementation

**Learning Outcome:** 7-5

**Question 18**

**Type:** MCMA

While assessing newborns, the nurse should differentiate normal findings from findings which require further evaluation and intervention. Which would be normal newborn findings?

**Standard Text:** Select all that apply.

1. Swelling over the occiput that crosses suture lines
2. Tiny white papules located primarily on the nose and chin
3. Tiny red macules and pustules that come and go, primarily on the trunk and extremities
4. When the Moro reflex is elicited, the right arm extends and returns to the body. The left arm remains resting against the chest.
5. Greenish discoloration of skin over the entire body that is not removed by the initial bath

**Correct Answer:** 1,2,3

**Rationale 1**: By crossing suture lines, this finding indicates it is caput succedaneum, a normal finding after vaginal delivery. No further evaluation or treatment is needed.

**Rationale 2**: This is a description of milia, a normal finding. No further care is required.

**Rationale 3**: This is a description of erythema toxicum, a normal newborn finding that requires no further treatment.

**Rationale 4**: This Moro reflex is incomplete. Further evaluation is necessary to determine if there has been injury to the right arm and/or shoulder.

**Rationale 5**: This is a description of a meconium-stained newborn. The passage of meconium has occurred at a more distant time, leading to the staining. The child will need to be evaluated for meconium aspiration.

**Global Rationale:**

**Cognitive Level:** Analyzing

**Client Need:**

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Assessment

**Learning Outcome:** 7-3

**Question 19**

**Type:** MCSA

The nurse is assessing a newborn while the new parents watch. The nurse uses an ophthalmoscope to examine the back of the eye (the retina) and notes a positive red reflex. The nurse would explain to the parents that the red reflex indicates:

1. The absence of congenital cataracts.
2. The presence of intraocular hemorrhage.
3. The optic nerve has been traumatized during delivery.
4. Presence of amblyopia.

**Correct Answer:** 1

**Rationale 1**: The light of the ophthalmoscope is reflecting off the retina producing the red reflex. This indicates there is nothing preventing the transfer of light.

**Rationale 2**: The red reflex is a normal finding.

**Rationale 3**: The optic nerve is behind the retina and not visible.

**Rationale 4**: Amblyopia cannot be diagnosed at this time and is not evaluated with an ophthalmoscope.

**Global Rationale:**

**Cognitive Level:** Applying

**Client Need:**

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Assessment

**Learning Outcome:** 7-7

**Question 20**

**Type:** MCMA

The nurse is assessing a new admission to the newborn nursery. Which physical findings suggest the infant was preterm? **Standard Text:** Select all that apply.

1. The ear pinna quickly returns to original position after being bent manually.
2. The infant's resting position is tightly flexed.
3. Labia widely separated with clitoris prominent.
4. Breast area barely perceptible with flat areola, no bud.
5. Sole creases do not extend the length of the foot.