# Emergency Nursing Pediatric Course (ENPC) Practice Test (Sample)

## Study Guide


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# Questions

1. **A 16-year-old male arrives intubated after a dirt bike accident. What is the priority intervention?**
   - **A. Assess the oropharynx**
   - **B. Assess endotracheal tube placement**
   - **C. Insert an orogastric tube**
   - **D. Insert a second intravenous access**

2. **When should you be concerned about a fever in pediatric patients?**
   - **A. When the fever exceeds 100.4°F**
   - **B. When they are immunocompromised or ill-appearing**
   - **C. When they have a rash**
   - **D. When they complain of a headache**

3. **What is the recommended fluid bolus dosage for infants and children in an emergency situation?**
   - **A. 10 ml/kg**
   - **B. 15 ml/kg**
   - **C. 20 ml/kg**
   - **D. 25 ml/kg**

4. **Which symptom is critical when evaluating a child's risk for dehydration?**
   - **A. Increased thirst**
   - **B. Normal urination**
   - **C. Consistent energy levels**
   - **D. Decreased skin turgor**

5. **Which of the following is a true statement about the A-E part of the initial assessment?**
   - **A. Assessments and interventions cannot be done simultaneously**
   - **B. Order of step completion is crucial for prioritization**
   - **C. Assessments prioritize life-threatening conditions**
   - **D. Assessments do not affect treatment decisions**

**6. What are the key components to assess for disability in a pediatric emergency case?**

**A. Heart rate and blood pressure**

**B. GCS and pupils**

**C. Respiratory rate and skin color**

**D. Temperature and hydration status**

**7. What is the first step in the preparation and triage for a pediatric trauma patient?**

**A. Prepare the room with necessary equipment**

**B. Don personal protective equipment (PPE)**

**C. Activate the team and assign roles**

**D. Assess for signs of hemorrhage**

**8. What is the initial step in assessing the chest in a head-to-toe examination?**

**A. Inspect and palpate**

**B. Listen for lung sounds**

**C. Check for open wounds**

**D. Palpate for tenderness**

**9. What should be considered as a potential cause of altered mental status in pediatric patients?**

**A. Dehydration or fever**

**B. Decreased cerebral perfusion or hypoglycemia**

**C. Medication side effects**

**D. Recent injury**

**10. What is the first-line treatment for neonatal resuscitation?**

**A. Medications**

**B. Cardiac compressions**

**C. Ventilating**

**D. Defibrillation**

# Answers

1. B
2. B
3. C
4. D
5. C
6. B
7. C
8. A
9. B
10. C

# Explanations

## 1. A 16-year-old male arrives intubated after a dirt bike accident. What is the priority intervention?

**A. Assess the oropharynx**

**B. Assess endotracheal tube placement**

**C. Insert an orogastric tube**

**D. Insert a second intravenous access**

**In an emergency situation involving a 16-year-old male who has arrived intubated after a dirt bike accident, assessing the placement of the endotracheal tube is the most critical intervention. Confirming correct tube placement is vital to ensure that the airway is secured and that the patient is receiving adequate ventilation. Misplacement of the tube, such as into the esophagus instead of the trachea, can lead to severe hypoxia and potentially fatal complications, especially in a trauma setting where time is of the essence. While assessing the oropharynx can provide information about the airway and any potential obstructions, it does not directly address the immediate need to ensure that the intubation was successful. Inserting an orogastric tube may be indicated later for decompression and feeding but is not a priority in this critical moment. Additionally, while having a second intravenous access is important for medication administration and fluid resuscitation, ensuring the airway is secure takes precedence in an emergency context where respiratory failure is a risk. Therefore, confirming the endotracheal tube placement is the appropriate first step in managing this patient's airway to ensure proper ventilation.**

## 2. When should you be concerned about a fever in pediatric patients?

**A. When the fever exceeds 100.4°F**

**B. When they are immunocompromised or ill-appearing**

**C. When they have a rash**

**D. When they complain of a headache**

**Concerns about a fever in pediatric patients are heightened specifically in cases where the child is immunocompromised or appears ill. This is crucial because these children have a reduced ability to fight infections due to their compromised immune systems or underlying medical conditions. In such scenarios, a fever can signal a serious infection that may progress rapidly and requires prompt medical evaluation and intervention. Additionally, an ill-appearing child may demonstrate systemic signs of infection, such as lethargy or difficulty in waking, which indicates that the child's condition is potentially dangerous. Therefore, vigilant assessment and appropriate management of fever in these children is essential. While fever exceeding 100.4°F is commonly a threshold used to define fever, in the context of a pediatric patient who is otherwise healthy, it may not be as pressing a concern. A rash alone, although it can indicate certain conditions, does not inherently escalate the urgency without additional context. Complaints of headache could suggest various issues but are not as immediately crucial as the overall appearance and immune status of the child.**

## 3. What is the recommended fluid bolus dosage for infants and children in an emergency situation?

**A. 10 ml/kg**

**B. 15 ml/kg**

**C. 20 ml/kg**

**D. 25 ml/kg**

**In emergency situations involving infants and children, the recommended fluid bolus dosage is 20 ml/kg. This dosage is based on current pediatric resuscitation guidelines and is designed to ensure rapid volume replacement to stabilize a child who may be experiencing dehydration or shock due to various causes such as trauma or illness. Using 20 ml/kg allows healthcare providers to effectively increase intravascular volume, thereby improving perfusion and blood pressure in the child. This dosage is also well-established in clinical practice and studies, reflecting a balance between providing sufficient fluid and avoiding potential complications from fluid overload. The other suggested dosages, although they may have their own contexts, do not align with the standard recommendation for initial fluid resuscitation in pediatric emergencies. For example, dosages of 10 ml/kg may be suitable in less severe situations or for maintenance, while larger boluses like 25 ml/kg may not be appropriate due to the risk of fluid overload, especially in smaller patients. The 20 ml/kg guideline is thus widely accepted as effective and safe for emergency fluid resuscitation in pediatric care.**

## 4. Which symptom is critical when evaluating a child's risk for dehydration?

**A. Increased thirst**

**B. Normal urination**

**C. Consistent energy levels**

**D. Decreased skin turgor**

**Decreased skin turgor is a critical symptom when evaluating a child's risk for dehydration. Skin turgor refers to the skin's elasticity and its ability to return to its normal position after being pinched. In a well-hydrated child, the skin quickly returns to its original position; however, in a dehydrated child, the skin tends to remain tented when pinched, indicating reduced fluid levels in the body. This physical examination finding is a key indicator of the body's hydration status. While increased thirst is a common response to dehydration, it is a subjective symptom and not necessarily measurable, making it less reliable than objective signs like skin turgor. Normal urination suggests that the child is adequately hydrated, which contradicts the assessment of dehydration risk. Consistent energy levels can vary for many reasons and may not specifically indicate hydration status; children can still maintain energy levels despite being dehydrated until it reaches a more severe stage. Thus, decreased skin turgor stands out as a definitive and measurable sign in assessing dehydration risk in a child.**

## 5. Which of the following is a true statement about the A-E part of the initial assessment?

**A. Assessments and interventions cannot be done simultaneously**

**B. Order of step completion is crucial for prioritization**

**C. Assessments prioritize life-threatening conditions**

**D. Assessments do not affect treatment decisions**

**The statement that assessments prioritize life-threatening conditions is true and reflects the critical nature of the A-E approach in emergency nursing. In the initial assessment of a pediatric patient, the aim is to quickly identify and address any conditions that could pose an immediate threat to life. By applying this structured framework, emergency nurses ensure that the most pressing issues—such as airway obstruction, breathing difficulties, or circulation problems—are prioritized and managed effectively. This approach is essential because swift recognition and intervention can significantly impact patient outcomes. For instance, if a child's airway is compromised, immediate action is necessary before addressing other concerns, such as their history or any non-life-threatening issues. Therefore, assessments are not merely observational; they guide the immediate interventions required to stabilize the patient and prevent deterioration. The incorrect options present ideas that do not align with the fundamental principles of emergency assessment. For example, the idea that assessments and interventions cannot be done simultaneously contradicts the reality of emergency care, where actions often occur concurrently. Similarly, while order of completion is important, the flexibility in prioritizing assessments based on the patient's condition illustrates that it is not always strictly sequential. Lastly, it is incorrect to suggest that assessments do not affect treatment decisions, as they are foundational in guiding the interventions that follow**

## 6. What are the key components to assess for disability in a pediatric emergency case?

**A. Heart rate and blood pressure**

**B. GCS and pupils**

**C. Respiratory rate and skin color**

**D. Temperature and hydration status**

**In the assessment of disability during a pediatric emergency, the key components focus on evaluating the neurological status of the child. This is primarily done through the Glasgow Coma Scale (GCS) and examination of the pupils. The GCS provides a standardized method to assess a patient's level of consciousness and responsiveness, which is critical when evaluating potential neurological impairment. Additionally, pupil size and reactivity offer valuable insights into brain function and can indicate the presence of increased intracranial pressure or other neurological concerns. Changes in pupils, such as unequal size or non-reactivity to light, can signal significant issues that may require immediate intervention. Assessing heart rate and blood pressure, respiratory rate and skin color, or temperature and hydration status pertains more to other areas of emergency care, such as cardiovascular stability or respiratory function, rather than focusing specifically on the neurological aspect designated by the term "disability."**

## 7. What is the first step in the preparation and triage for a pediatric trauma patient?

**A. Prepare the room with necessary equipment**

**B. Don personal protective equipment (PPE)**

**C. Activate the team and assign roles**

**D. Assess for signs of hemorrhage**

**The first step in the preparation and triage for a pediatric trauma patient is activating the team and assigning roles. This step is crucial because it ensures that all team members understand their responsibilities and can respond quickly to the situation. In a trauma scenario, especially involving children, time is of the essence, and effective communication and coordination among the team can be the difference between life and death. By activating the team, the lead nurse or healthcare provider is able to gather a multidisciplinary response that includes physicians, nurses, respiratory therapists, and possibly social workers. Assigning specific roles helps streamline the approach to care, ensuring that someone is focused on airway management, another on assessing circulation, and others on diagnostic imaging or parental accompaniment. This organized response is vital in a high-stress and high-stakes environment. While preparing the room with necessary equipment, donning PPE, and assessing for signs of hemorrhage are all important steps in the triage process, they follow the establishment of a coordinated team. The initial focus should be on mobilizing resources effectively, which enhances the overall preparation for the patient's immediate care.**

## 8. What is the initial step in assessing the chest in a head-to-toe examination?

**A. Inspect and palpate**

**B. Listen for lung sounds**

**C. Check for open wounds**

**D. Palpate for tenderness**

**The initial step in assessing the chest during a head-to-toe examination is to inspect and palpate the area. Inspection allows the examiner to visually assess thoracic symmetry, respiratory effort, and any visible abnormalities such as deformities, cyanosis, or signs of respiratory distress. Following inspection, palpation helps assess for any irregularities beneath the surface, such as tenderness, masses, or crepitus. These two steps are fundamental in establishing a baseline for further assessments. By starting with inspection and palpation, the healthcare provider can gather crucial information prior to moving on to auscultation or checking for open wounds. The other options, while relevant to a comprehensive assessment, are typically performed after the initial inspection and palpation steps. Listening for lung sounds is part of a thorough evaluation but comes after the initial observations. Checking for open wounds or palpating for tenderness may be warranted based on findings from the inspection phase but does not precede it in the assessment sequence.**

## 9. What should be considered as a potential cause of altered mental status in pediatric patients?

**A. Dehydration or fever**

**B. Decreased cerebral perfusion or hypoglycemia**

**C. Medication side effects**

**D. Recent injury**

**Altered mental status in pediatric patients can result from various underlying conditions, and decreased cerebral perfusion or hypoglycemia is a significant consideration. Decreased cerebral perfusion can occur due to a multitude of reasons, such as dehydration, shock, or significant blood loss, leading to inadequate blood flow and oxygen to the brain, which negatively impacts mental status. Hypoglycemia, or low blood sugar, is another common cause of altered mental status and can lead to confusion, lethargy, or even loss of consciousness in children, who may not always exhibit classic symptoms of low blood sugar. Both conditions require prompt recognition and intervention to prevent further neurological impairment. While dehydration or fever, medication side effects, and recent injury are also important factors to evaluate, the immediate physiological effects of decreased cerebral perfusion and hypoglycemia directly compromise brain function and can be life-threatening if not addressed swiftly. Recognizing these conditions as potential causes emphasizes the need for timely assessment and treatment to safeguard the child's cognitive and overall health.**

## 10. What is the first-line treatment for neonatal resuscitation?

**A. Medications**

**B. Cardiac compressions**

**C. Ventilating**

**D. Defibrillation**

**The first-line treatment for neonatal resuscitation involves ensuring adequate ventilation. When a newborn is not breathing or not breathing adequately at birth, providing effective ventilation is critical to establish adequate oxygenation and prevent hypoxia. Positive pressure ventilation is usually initiated with a bag-mask ventilation device. Successful ventilation helps to stimulate the baby's respiratory drive and aids in maintaining effective circulation. Adequate ventilation can often restore normal heart rate and breathing patterns without the need for further interventions. Other options like medications, cardiac compressions, or defibrillation are employed only if the infant remains unresponsive to initial resuscitation efforts. They are not considered first-line treatments in the immediate management of a newborn who requires resuscitation. Thus, starting with effective ventilation is the correct approach for neonatal resuscitation.**