

Learning System RN 3.0 Nursing Care of Children Practice Test (Sample)

Study Guide



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SAMPLE

Questions

- 1. What is an important poisoning prevention tip for parents of toddlers?**
 - A. Leave cleaning supplies on a low shelf**
 - B. Use child-safe products for cleaning**
 - C. Put all cleaning supplies in a locked cabinet**
 - D. Store medications in a visible area**
- 2. What statement by a parent after an umbilical hernia repair indicates understanding of post-operative care?**
 - A. I will keep the incision covered with a bandage**
 - B. I will fold my baby's diaper away from the incision**
 - C. I will not change the diaper for a week**
 - D. I will give my baby a bath to clean the area**
- 3. What vital sign is particularly important to monitor in a child with pneumonia?**
 - A. Temperature**
 - B. Pulse**
 - C. Respiratory rate**
 - D. Blood pressure**
- 4. When admitting a child with acute lymphocytic leukemia, which lab value should the nurse prepare for?**
 - A. RBC count of 4.5 million/uL**
 - B. RBC count of 8 million/uL**
 - C. RBC count of 2.5 million/uL**
 - D. RBC count of 5 million/uL**
- 5. Which method is considered effective for teaching diabetic management to school-aged children?**
 - A. Using puppets to demonstrate**
 - B. Providing lengthy lectures**
 - C. Handing out printed materials only**
 - D. Involving interactive games**

- 6. How should a nurse prepare a pediatric patient for a magnetic resonance imaging (MRI) scan?**
- A. Explain the procedure in age-appropriate terms and provide comfort measures**
 - B. Perform a physical assessment before the scan**
 - C. Obtain informed consent from the parents only**
 - D. Limit the child's fluid intake before the procedure**
- 7. Which sign is often associated with respiratory issues such as croup?**
- A. Wheezing**
 - B. Stridor and barking cough**
 - C. Persistent sneezing**
 - D. Sudden weight loss**
- 8. When caring for a child with cystic fibrosis, which lab finding should alert the nurse to report to the provider?**
- A. Heart rate of 110 bpm**
 - B. Oxygen saturation of 95%**
 - C. Oxygen saturation of 85%**
 - D. RBC count of 6 million/uL**
- 9. How should the nurse respond if a child expresses fear about a lumbar puncture?**
- A. Advise the child that they need to be brave**
 - B. Explain the importance of the procedure in simple terms**
 - C. Tell them there is no reason to be afraid**
 - D. Dismiss the fear as being childish**
- 10. Which condition is characterized by a "cherry-red spot" on the macula in infants?**
- A. Cystic fibrosis**
 - B. Down syndrome**
 - C. Tay-Sachs disease**
 - D. Spinal muscular atrophy**

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. What is an important poisoning prevention tip for parents of toddlers?

- A. Leave cleaning supplies on a low shelf**
- B. Use child-safe products for cleaning**
- C. Put all cleaning supplies in a locked cabinet**
- D. Store medications in a visible area**

An important poisoning prevention tip for parents of toddlers is to put all cleaning supplies in a locked cabinet. This measure is crucial because toddlers are naturally curious and tend to explore their environment, often reaching for items that can be hazardous, such as cleaning supplies. By securing these products in a locked cabinet, parents can significantly reduce the risk of accidental poisoning. This practice ensures that harmful substances are out of the child's reach, thereby promoting a safer home environment. While using child-safe products and keeping cleaning supplies on a high shelf or out of sight can contribute to safety, they do not provide the same level of security as a locked cabinet. It's essential to prioritize complete accessibility prevention given the active and exploratory nature of toddlers. Storing medications in a visible area, on the other hand, increases the risk of accidental ingestion—contradicting the goal of safeguarding children.

2. What statement by a parent after an umbilical hernia repair indicates understanding of post-operative care?

- A. I will keep the incision covered with a bandage**
- B. I will fold my baby's diaper away from the incision**
- C. I will not change the diaper for a week**
- D. I will give my baby a bath to clean the area**

The statement that reflects an understanding of post-operative care for a child who has undergone an umbilical hernia repair is the decision to fold the baby's diaper away from the incision. This is important because it helps to prevent irritation and pressure on the surgical site, which can promote healing and minimize discomfort for the child. Proper diapering techniques are crucial following surgery to ensure that the surgical area remains clean and dry while providing a barrier against urine and stool that could lead to infection or complications. Additionally, avoiding direct contact with the incision site reduces the risk of trauma to the area during the diaper change. In contrast, keeping the incision covered with a bandage can vary based on the healthcare provider's instructions and may not always be necessary once the area is clean and healing. Not changing the diaper for a week is not advisable, as it's essential to keep the area clean, and changing the diaper regularly helps to maintain hygiene and comfort. Giving the baby a bath to clean the area may introduce moisture and lead to complications, as the surgical site needs to remain dry and untouched for optimal healing in the early post-operative period.

3. What vital sign is particularly important to monitor in a child with pneumonia?

- A. Temperature**
- B. Pulse**
- C. Respiratory rate**
- D. Blood pressure**

Monitoring the respiratory rate is crucial for a child with pneumonia due to the condition's direct impact on breathing and lung function. Pneumonia is an infection that inflames the air sacs in the lungs, which can fill with fluid or pus, leading to difficulty in breathing and reduced oxygenation of the blood. An elevated respiratory rate can indicate increased work of breathing or hypoxia, while a significantly decreased rate might suggest respiratory failure. Children may exhibit changes in their respiratory patterns, including tachypnea (increased breathing rate) as they try to compensate for impaired gas exchange. By closely observing the respiratory rate, healthcare providers can assess the severity of the pneumonia, monitor for any worsening of the child's condition, and determine the effectiveness of the treatments being administered. While temperature, pulse, and blood pressure are important vital signs to monitor in general, the respiratory rate provides more specific insight into the child's respiratory status and the immediate impact of pneumonia on their health.

4. When admitting a child with acute lymphocytic leukemia, which lab value should the nurse prepare for?

- A. RBC count of 4.5 million/uL**
- B. RBC count of 8 million/uL**
- C. RBC count of 2.5 million/uL**
- D. RBC count of 5 million/uL**

In a child with acute lymphocytic leukemia (ALL), a common finding is a reduced red blood cell (RBC) count, leading to anemia. This condition occurs due to the bone marrow's inability to produce sufficient healthy cells due to the proliferation of leukemic cells. A RBC count of 2.5 million/uL reflects significant anemia, which is consistent with the pathophysiology of ALL. This lower RBC count points toward the body's inability to compensate for the decreased production of red blood cells as a result of the leukemic process. Other counts presented, such as 4.5 million/uL, 8 million/uL, and 5 million/uL, indicate normal or elevated RBC levels, which are not typically observed in children with acute lymphocytic leukemia. Consequently, being prepared for the lower RBC count aligns with the expected laboratory findings in this diagnosis, highlighting the significance of understanding the condition's impact on hematological values.

5. Which method is considered effective for teaching diabetic management to school-aged children?

- A. Using puppets to demonstrate**
- B. Providing lengthy lectures**
- C. Handing out printed materials only**
- D. Involving interactive games**

Involving interactive games is considered an effective method for teaching diabetic management to school-aged children because it engages them in a fun and enjoyable manner, promoting active participation in their learning process. Children are more likely to retain information when they can interact with the content rather than passively receive it through lectures or printed materials. Interactive games can also present real-life scenarios that require children to apply their knowledge and make decisions regarding their diabetes management. This hands-on experience helps reinforce important concepts such as blood sugar monitoring, recognizing symptoms of hypo- or hyperglycemia, and making healthy food choices. Furthermore, interactive methods cater to various learning styles and help maintain the children's interest and motivation, which is crucial in teaching them life-long management skills for their condition.

6. How should a nurse prepare a pediatric patient for a magnetic resonance imaging (MRI) scan?

- A. Explain the procedure in age-appropriate terms and provide comfort measures**
- B. Perform a physical assessment before the scan**
- C. Obtain informed consent from the parents only**
- D. Limit the child's fluid intake before the procedure**

Preparing a pediatric patient for an MRI scan involves providing support and understanding to help alleviate the child's anxiety and fear associated with the procedure. Using age-appropriate language is crucial because it ensures the information shared is relatable and understandable for the child. This approach helps demystify the process, allowing the child to know what to expect, which can significantly reduce anxiety. In addition to a clear explanation, incorporating comfort measures—such as allowing a favorite toy or blanket, or having the presence of a parent or caregiver—can further enhance a child's experience and cooperation during the procedure. Creating a supportive environment not only helps the child feel safe but also enables the MRI staff to perform the procedure more efficiently. While physical assessments and informed consent are important aspects of overall patient care, the primary focus for preparing a pediatric patient for an MRI is to ensure they feel informed and comfortable with the process. Similarly, restrictions on fluid intake might not be necessary unless specified for a specific case or procedure, and obtaining consent should involve caregivers but is not the primary focus of preparation for the child.

7. Which sign is often associated with respiratory issues such as croup?

- A. Wheezing**
- B. Stridor and barking cough**
- C. Persistent sneezing**
- D. Sudden weight loss**

The presence of stridor and a barking cough is often associated with respiratory issues such as croup, particularly in children. Croup, which is typically caused by viral infections, leads to inflammation of the larynx and upper airway, resulting in these characteristic symptoms. Stridor is a high-pitched, wheezing sound made during inhalation, caused by turbulent airflow through narrowed airways, and the barking cough resembles the sound of a seal or a barking dog. These clinical signs are crucial for healthcare providers to identify croup and differentiate it from other respiratory conditions. In contrast, while wheezing might occur in various respiratory issues, it is more typically associated with conditions like asthma or bronchospasm rather than croup specifically. Persistent sneezing is generally linked to allergic reactions or upper respiratory infections, and sudden weight loss is not a typical symptom associated with respiratory issues but may indicate other underlying health concerns. Hence, the combination of stridor and a barking cough is the hallmark indicator of croup, making it the correct choice in this context.

8. When caring for a child with cystic fibrosis, which lab finding should alert the nurse to report to the provider?

- A. Heart rate of 110 bpm**
- B. Oxygen saturation of 95%**
- C. Oxygen saturation of 85%**
- D. RBC count of 6 million/uL**

In a patient with cystic fibrosis, oxygen saturation is a critical parameter for monitoring respiratory function. An oxygen saturation level of 85% indicates significant hypoxemia, which is concerning and should prompt immediate intervention. In children with cystic fibrosis, the lungs can become significantly compromised due to thick mucus build-up, leading to reduced oxygen exchange and potentially life-threatening conditions. An oxygen saturation below 90% is generally considered indicative of respiratory distress or failure, often requiring additional supportive measures or medical intervention. This situation necessitates prompt reporting to the healthcare provider to address the child's respiratory status and ensure appropriate care is initiated to optimize oxygenation and pulmonary function. In contrast, a heart rate of 110 bpm could be considered within a normal range for a child, depending on age and activity level. An oxygen saturation of 95% is within acceptable limits for most pediatric patients, as is an RBC count of 6 million/uL, which often falls within the normal range for children. Thus, while these findings may warrant monitoring, they do not present the same urgent concern as an oxygen saturation of 85%.

9. How should the nurse respond if a child expresses fear about a lumbar puncture?

- A. Advise the child that they need to be brave**
- B. Explain the importance of the procedure in simple terms**
- C. Tell them there is no reason to be afraid**
- D. Dismiss the fear as being childish**

When a child expresses fear about a lumbar puncture, the most appropriate response is to explain the importance of the procedure in simple terms. This approach is effective because it acknowledges the child's feelings and provides them with a clear understanding of what to expect. Using age-appropriate language helps demystify the procedure, making it less intimidating for the child. It can also increase their sense of control and cooperation, which often leads to a more positive experience. Explaining the procedure can help alleviate anxiety by encouraging the child to ask questions and express further concerns. This open line of communication is crucial in pediatric care, as it fosters trust between the child and the healthcare provider. Understanding the reason behind the lumbar puncture can also help the child feel more involved in their own care, which is an essential aspect of pediatric nursing.

10. Which condition is characterized by a "cherry-red spot" on the macula in infants?

- A. Cystic fibrosis**
- B. Down syndrome**
- C. Tay-Sachs disease**
- D. Spinal muscular atrophy**

Tay-Sachs disease is characterized by a "cherry-red spot" on the macula in infants. This condition is a genetic disorder caused by a deficiency in the enzyme hexosaminidase A, leading to the accumulation of GM2 gangliosides in the brain and nervous system. As a result, affected infants typically demonstrate developmental delays and neurodegeneration. The "cherry-red spot" appears in the retina due to the contrast between the pale surrounding retina and the area of the macula, which remains intact while other areas of the retina are affected by the disease. This clinical finding is a pivotal diagnostic indicator, often prompting further evaluation for Tay-Sachs disease, especially in populations with higher carrier rates for this genetic condition. Other choices do not present with a cherry-red spot in the macula. For example, cystic fibrosis primarily affects the respiratory and digestive systems; Down syndrome may exhibit various physical traits but is not associated with this specific ocular manifestation; while spinal muscular atrophy affects motor neurons and muscle function without causing characteristic retinal findings like a cherry-red spot.