Chapter 24: Review Questions

* Multiple Choice
1. A 5-month-old infant is admitted to the hospital’s pediatric unit with a history of Bronchopulmonary Dysplasia (BPD). What are the nurse’s priority nursing actions? (*Select all that apply*.)
2. Administer Albuterol (Ventolin) nebulizer as ordered.
3. Monitor the infant’s oxygen saturation levels.
4. Calculate the infant’s intake and output.
5. Administer antibiotic therapy as ordered.
6. The pediatric nurse is aware that the child with cystic fibrosis (CF) has discharge planning needs. Which of the following is important to include in the discharge-teaching plan?
7. Communicating to the family about a well balanced, low-protein, high-calorie diet
8. Communicating to the family about when to administer pancreatic enzymes
9. Communicating to the family that vitamin supplements are not necessary
10. Communicating to the family that cystic fibrosis (CF) a self limiting illness
11. A 2-year-old child is discharged from the out-patient surgical unit after having had a tonsillectomy. The pediatric nurse knows that the discharge teaching is effective after the parents verbalize which of the following statements as the most important aspect of the teaching?
12. “I will administer cherry flavored acetaminophen (Children’s Tylenol) for pain.”
13. “It’s important to have my child to gargle to prevent an infection.”
14. “I will bring my child to the emergency room if I see excessive swallowing.”
15. “I will offer my child ice cream to help soothe the pain in the throat.”
16. When caring for the pediatric patient, the nurse is aware that there are differences in the anatomy and physiology between the child’s and the adult’s airway that predispose the child to contracting a respiratory condition. *(Select all that apply.)*
17. Infants are obligatory nose breathers until about 4 weeks of age so it is essential to maintain nasal patency.
18. The trachea of the adult is shorter and narrower in diameter than the trachea of the child.
19. The epiglottis of the child is more fl accid and does not close properly, which can lead to airway obstruction.
20. The increased amount of soft tissue in the child’s neck makes the child more susceptible to edema and infections.
21. Which assessment must the pediatric nurse include when evaluating the respiratory status of a child? *(Select all that apply.)*
22. Skin turgor
23. Oxygen saturation levels
24. Skin color and moisture
25. Respiratory rate and depth
* True or False
1. The best time for the pediatric nurse to assess the child’s respiratory status is when the child is awake and active. (True)
2. Excessive drooling in the newborn with a history of polyhydramnios in the mother’s obstetrical history may be indicative of a diaphragmatic hernia. (False)
3. The pediatric nurse understands that two primary goals in caring for a child with cystic fi brosis are to control infection and improve aeration. (True)
* Fill-in-the-Blank
1. In the newborn diagnosed with a congenital diaphragmatic hernia (CDH), the nurse understands that there is an opening between the thoracic and abdominal cavities through which the abdominal organs can herniate into the thoracic cavity and present with symptoms of respiratory distress.
* Matching

Match the appropriate signs and/or symptoms the nurse would observe in each of the following respiratory conditions. Write the letters on the blank provided before the item number.

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| Answer | Column A | Column B |
| D | 10. Croup | A. Dry, hacking cough |
| E | 11. Pharyngitis | B. Facial pain, headache, and fever |
| B | 12. Sinusitis | C. Rigor, chills, and myalgia |
| A | 13. Bronchitis | D. Hoarse, barky cough |
| F | 14. Asthma | E. Pain on swallowing |
| C | 15. Severe acute respiratory distress syndrome (SARS) | F. An irritating, nonproductive cough, nasal flaring, retractions |