

Nursing

*AACN CCRN-Pediatric
Acute/Critical Care Nursing*



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Question: 1

A nurse is caring for a 12-year-old trauma patient in the PICU. The patient sustained multiple fractures as a result of a motor vehicle accident, including a closed fracture of the left femur, which has been cast. The nurse includes monitoring for complications of the femoral fracture in the daily plan of care. Which of the following signs and/or symptoms would likely indicate the formation of fat emboli?

- A. Dark, reddish-brown urine and extreme muscle cramping
- B. Fever and tachycardia
- C. Swelling and severe pain in the cast leg
- D. Hypoxia and petechial rash

Answer: D

Explanation:

Correct answer: Hypoxia and petechial rash

Although rare, fat embolism syndrome (FES) is a dangerous complication of fractures and is more commonly seen in closed versus open fractures of the long bones and pelvis of major trauma victims. It can also be a complication of orthopedic surgery. It is postulated to be the result of a disruption to blood supply caused by fat globules that enter the venous channels at the fracture site, leading to embolization.

FES may manifest within 12 hours post-injury or surgery with symptoms peaking within 48 to 72 hours. Although this syndrome can be difficult to diagnose, respiratory distress symptoms manifest in up to 90% of cases. Other common symptoms include a petechial rash seen on the anterior torso, axillary regions, and conjunctiva (usually appears 3-5 days after the onset of symptoms) and altered mental status (particularly confusion).

Swelling and severe pain are indicative of compartment syndrome. Fever and tachycardia could signal osteomyelitis. Muscle cramping and dark urine are symptoms of rhabdomyolysis.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 717-718.

Question: 2

What is the preferred method of debriding a painful wound?

- A. Surgical debridement
- B. Enzymatic debridement
- C. Mechanical debridement
- D. Autolytic debridement

Answer: D

Explanation:

Correct answer: Autolytic debridement

Autolytic debridement uses the body's enzymes and moisture to rehydrate, soften, and ultimately liquefy hard eschar and slough with the use of occlusive or semi-occlusive dressings. It is best for use on clean wounds with slight to moderate exudate. There is little to no pain for the patient with this form of wound debridement.

Surgical, mechanical, and enzymatic debridement methods usually increase pain during the procedures.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 807-808.

Question: 3

Which of the following cerebrospinal fluid (CSF) analysis findings in a child could indicate bacterial meningitis?

- A. Decreased CSF glucose level
- B. Decreased CSF protein level
- C. CSF that is clear in color
- D. Decreased CSF white blood cell count

Answer: A

Explanation:

Correct answer: Decreased CSF glucose level

CSF analysis is the gold standard for diagnosing bacterial meningitis and should be performed on any child suspected of having meningitis. CSF analysis in bacterial meningitis usually demonstrates the following:

- elevated white blood count (WBC) with predominately polymorphonuclear cells
- elevated protein content (normal 10-30 mg/dL)
- decreased glucose content (normal 40-80 mg/dL)
- positive results from gram stain
- positive results from culture for organism
- turbid or cloudy color

Results may vary in neonates, as the WBC count may be normal, glucose content may be normal (it should be compared to serum), and protein levels are normally higher in neonates (20-170 mg/dL).

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 417.

Question: 4

Which of the following signs is indicative of patent ductus arteriosus (PDA) in a newborn?

- A. Narrow pulse pressure
- B. Profound cyanosis
- C. Bounding peripheral pulses
- D. Clubbed fingers and toes

Answer: C

Explanation:

Correct answer: Bounding peripheral pulses

Assessment findings of a newborn with PDA reveal a machine-like continuous murmur that is heard best at the left upper sternal border. Poor feeding, irritability, tachypnea, tachycardia, and poor weight gain are often present. The pulse pressure is wide (not narrow), and peripheral pulses may be strong and collapse suddenly because of low diastolic pressure resulting from ductal shunting of blood into the low-pressure pulmonary artery. This is referred to as a water-hammer pulse.

No cyanosis or clubbing of the digits is present in PDA.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 253.

Question: 5

What is the Coombs test, or indirect antiglobulin test (DAT), used to detect?

- A. Human leukocyte (HLA) antigens
- B. IgG-positive antibodies in maternal and newborn blood
- C. Any acute inflammatory response
- D. Autoimmune hemolytic anemia (AIHA)

Answer: D

Explanation:

Correct answer: Autoimmune hemolytic anemia (AIHA)

The Coombs test, or DAT, is used to detect antibodies that act against the surface of the patient's RBCs, indicating a condition known as AIHA. In this condition, the RBCs are prematurely destroyed, so the body's RBC store is constantly being depleted, resulting in anemia. Clumping of RBCs occurs if the RBCs are coated with antibodies or complement. The greater the number of antibodies against the RBCs is, the more clumping will occur. Any clumping is read as a positive result using a scale of 1 to 4+. Coombs test differentiates types of hemolytic anemia and detects immune antibodies.

Indirect Coombs testing is a type of antibody screening that detects specific serum antibodies (IgG) to RBC antigens that are in the serum but not attached to the RBCs. It is used to detect IgG-positive antibodies in maternal blood and newborns and is performed before RBC transfusions to detect incompatibilities other than major ABO groups.

Erythrocyte sedimentation rate (ESR) is a nonspecific indicator of an acute inflammatory response and is often used in conjunction with other laboratory values to assess inflammation.

Histocompatibility testing identifies HLA antigens.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 605.

Question: 6

A child with diastolic left heart failure (HF) secondary to pediatric cardiomyopathy has developed pulmonary edema. When a nurse performs this patient's head-to-toe assessment, which of the following signs and symptoms would be an expected finding?

- A. Tachypnea and tachycardia
- B. Machine-like murmur
- C. Muffled heart sounds
- D. Jaundice

Answer: A

Explanation:

Correct answer: Tachypnea and tachycardia

Cardiomyopathy is myocardial dysfunction associated with mechanical and/or electrical problems with ventricular dilation or hypertrophy. Symptoms of cardiomyopathy reflect the variable degrees of HF. Tachycardia, tachypnea, increased work of breathing, diaphoresis, loss of appetite, feeding intolerance, poor weight gain, abdominal pain, and exercise intolerance are often seen.

A machine-like murmur is not associated with congestive heart failure (CHF). Jaundice is the result of liver dysfunction and subsequently elevated bilirubin levels. Muffled heart sounds are indicative of cardiac tamponade.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 225-226, 227.

Question: 7

A nurse is caring for a 17-year-old patient with appendicitis who is scheduled for a laparoscopic appendectomy. The patient voices concern about the surgical procedure and is fearful of anesthesia. How should the nurse address these concerns initially?

- A. Give detailed explanations about the processes involved in the surgery
- B. Ask the patient to discuss what they currently know about the planned surgery
- C. Explain any possible discomfort or pain that could result from the surgery
- D. Tell the patient that preoperative fear is normal

Answer: B**Explanation:**

Correct answer: Ask the patient to discuss what they currently know about the procedure

Most children experience some fear and anxiety when hospitalized. Fears may be reality-based, related to past experiences, or the result of an overly active imagination. The information the patient may have gotten could be incorrect, or the child could have heard comments made by others that are scary or out of context.

It's most important to first ask the teenager what they currently know about the planned surgical procedure to guide the remainder of the conversation. If the nurse has a baseline of what information the teenager currently knows, they can add information as needed or correct any misinformation to help alleviate the patient's stress.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 6, 8-9.

Question: 8

A 12-year-old patient with sickle cell disease (SCD) has been prescribed hydroxyurea for management of the condition. Which of the following outcomes would indicate this medication is therapeutic?

- A. The patient will experience a decrease in hemoglobin S
- B. The patient will experience diuresis
- C. The patient will require fewer blood transfusions over time
- D. The patient will experience a decrease in fetal hemoglobin (HbF)

Answer: C**Explanation:**

Correct answer: The patient will require fewer blood transfusions over time

Hydroxyurea enhances the production of HbF, thereby decreasing the ability of the RBCs with HbSS to sickle. The patient will experience an increase in HbF. Indications for hydroxyurea therapy are limited to severe complications such as frequent pain crises, acute chest syndrome, severe and symptomatic anemia, or other vaso-occlusive events. Because it helps with severe anemia, a therapeutic outcome of hydroxyurea therapy would be fewer blood transfusions required.

Frequent monitoring for toxicities is essential for patients receiving this medication (due to a risk of low white blood cell counts), as well as guidance regarding contraception methods since it is a teratogen.

Diuresis is not an outcome of successful hydroxyurea therapy.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 632.

Question: 9

Which of the following is NOT considered to be a physiologic cause of respiratory failure in a child?

- A. Ventilation-perfusion (V/Q) mismatch
- B. Intrapulmonary shunting
- C. Hyperventilation
- D. Diffusion abnormalities

Answer: C

Explanation:

Correct answer: Hyperventilation

Respiratory failure is defined as an insufficient exchange of oxygen and carbon dioxide to meet the body's needs. This results in hypoxemia, hypercarbia, or both.

Causes include hypoventilation (not hyperventilation), V/Q mismatch, intrapulmonary shunting, and diffusion abnormalities.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 91-93.

Question: 10

A nurse is providing care to an intubated and mechanically ventilated child for the treatment and management of pediatric acute respiratory distress syndrome (PARDS). The child's respiratory function has continued to deteriorate over the past 24 hours, and the physician has ordered arterial blood gases (ABGs) for reassessment.

The ABG results that are expected with this diagnosis will correlate with which of the following acid-base imbalances?

- A. Metabolic acidosis
- B. Metabolic alkalosis
- C. Respiratory alkalosis
- D. Respiratory acidosis

Answer: D

Explanation:

Correct answer: Respiratory acidosis

ARDS is respiratory failure due to diffuse alveolar-capillary membrane injury, causing permeability or elevated protein pulmonary edema. Management may include high positive end-expiratory pressure (PEEP) with low tidal volume, high-frequency oscillation ventilation (HFOV), permissive hypercapnia, and hemodynamic monitoring.

Respiratory acidosis occurs in later stages of PARDS when CO₂ levels rise high enough to lower the serum pH below 7.35. Increased CO₂ can be the result of CNS depression, intrinsic airway disease, chest wall instability, a compromised diaphragm, compromised upper airway muscle function, or alveolar disease.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 93-94.

Question: 11

Which of the following types of respiratory patterns is indicative of damage to the respiratory center within the medulla?

- A. Apneustic respirations
- B. Central neurogenic hyperventilation
- C. Ataxic respirations
- D. Cheyne-Stokes respirations

Answer: C

Explanation:

Correct answer: Ataxic respirations

This breathing pattern is abnormal and refers to a complete irregularity of breathing, consisting of both deep and shallow breaths with irregular pauses and increasing periods of apnea. It is due to damage to the medulla oblongata from trauma or strokes.

Cheyne-Stokes respirations are described as periodic breathing with phases of hyperpnea alternating with apnea. It is often associated with Cushing's triad, indicating increasing intracranial pressure (ICP).

Central neurogenic hyperventilation is a sustained, rapid, and deep pattern of hyperpnea. It is unclear which mechanism in the brain causes this type of breathing.

Apneustic respirations are characterized by a prolonged inspiration with a pause at full inspiration lasting 2 to 3 seconds. They are indicative of damage to the brainstem near the level of the fifth cranial nerve nucleus.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 380.

Question: 12

A nurse is caring for an infant admitted for increased lethargy, jaundice, and hepatosplenomegaly. Cholestatic jaundice is suspected. What is another hallmark sign of cholestasis?

- A. Laboratory values reveal increasing platelet counts
- B. Petechiae is present
- C. The infant is experiencing bilious vomiting
- D. An increase in direct bilirubin is present

Answer: D

Explanation:

Correct answer: An increase in direct bilirubin is present

Cholestatic jaundice results from failure of biliary excretion. Elevated direct bilirubin levels are present.

A direct bilirubin level of greater than 2 mg/dL is indicative of cholestasis.

Petechiae, bilious vomiting, and increasing platelet counts are not indicative of cholestatic jaundice.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 565.

Question: 13

Which of the following types of skin grafts is considered to be a permanent wound-closure method for pediatric burn-wound management?

- A. Allograft
- B. Homograft
- C. Heterograft
- D. Autograft

Answer: D

Explanation:

Correct answer: Autograft

Once a burn wound has been debrided, a skin graft that is taken from the patient's unburned or healed skin can be transferred to the injured area. This is referred to as an autograft and is utilized for permanent wound coverage. Autografts can be described based on the thickness of the graft as well as the meshing ratio (i.e., full-thickness or split-thickness grafts).

An allograft (also known as a homograft) is a biological skin graft dressing from a human donor (often cadaver skin). It provides a temporary wound covering until the area is able to be covered with a permanent wound-closure method. A heterograft is a temporary skin graft from a different species (usually pig); it is often used to cover a superficial partial-thickness burn while the underlying wound heals.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 810.

Question: 14

A nurse is caring for an infant with DiGeorge syndrome and associated coarctation of the aorta. Surgical intervention is scheduled for closure of the patient's ventricular septal defect (VSD) and aortic arch reconstruction. Which interventions are necessary for this patient before the OR?

- A. Send type and screen for blood for the OR and ensure the blood bank is aware the infant meets the criteria for irradiated blood products

- B. Place a consult with craniofacial surgery for discussion of cleft palate
- C. Ensure an MRI of the head has been completed and is in the patient's chart
- D. Perform a newborn screen and a newborn hearing screen prior to any surgical procedure

Answer: A

Explanation:

Correct answer: Send type and screen for blood for the OR and ensure the blood bank is aware the infant meets the criteria for irradiated blood products

Surgical repair of aortic coarctation is accomplished via thoracotomy with one of the several methods. Sternotomy and cardiopulmonary bypass are used if complete arch reconstruction is required or associated lesions are to be repaired (i.e., VSD). Blood is required when bypass is used in infants. Because patients with DiGeorge syndrome are at risk for immune deficiency, irradiated blood products should be used to avoid graft-versus-host reactions.

A head MRI is not indicated at this point but may be necessary if there are neurologic complications postoperatively. A craniofacial surgery consult will be obtained after the initial phase of illness to plan treatment and management for cleft lip and palate. The newborn screen is performed at 24 hours of age, and a hearing screen will not be performed until the infant is no longer requiring oxygen.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 277.

Question: 15

An infant is being treated with inhaled nitric oxide (iNO) for hypoxic respiratory failure secondary to pulmonary hypertension. The nurse should be aware of which of the following potential side effects while providing care to an infant receiving iNO therapy?

- A. Methemoglobinemia
- B. Rebound pulmonary hypertension
- C. Significant GI distress
- D. Hepatic dysfunction

Answer: A

Explanation:

Correct answer: Methemoglobinemia

Nitric oxide (NO) is an inhaled pulmonary vasodilator. A potential side effect of iNO is methemoglobinemia, which can reduce the oxygen-carrying capacity of the hemoglobin. For this reason, weaning the patient as quickly as possible is vital. Methemoglobin levels should be closely monitored while the child is receiving iNO therapy.

Use iNO with caution in patients with left-sided obstructive heart lesions. Rebound pulmonary hypertension may occur with discontinuation; do not abruptly discontinue but rather wean the patient. GI distress and hepatic dysfunction are not considered to be side effects of iNO.

Reference:

Question: 16

A 15-year-old female is admitted to the ED with a suspected overdose after her mother found her unconscious in her bedroom and rushed her to the hospital. She had a prescription bottle of her father's nortriptyline at her bedside table.

Which of the following signs and symptoms would the nurse expect to observe in this type of toxicity?

- A. Dysrhythmias and hypotension
- B. Respiratory distress and drooling
- C. Hypothermia and tachycardia
- D. Profound hypertension and diaphoresis

Answer: A

Explanation:

Correct answer: Dysrhythmias and hypotension

The toxicity of tricyclic antidepressants (TCAs) is related to the effects of the following:

- anticholinergic effects
- direct alpha-adrenergic blockage
- inhibition of norepinephrine and serotonin reuptake
- blockade of fast sodium channels in myocardial cells

The most serious adverse effects of TCA toxicity are CNS effects and cardiovascular instability. A classic presentation of overdose poisoning includes profound hypotension, metabolic acidosis, and numerous dysrhythmias (especially ventricular dysrhythmias, conduction delays, and potentially the rapid onset of grand mal seizures and coma shortly after ingestion). In addition, sinus tachycardia on ECG is common.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 747.

Question: 17

A child with acute respiratory distress syndrome (ARDS) is intubated and mechanically ventilated via high-frequency oscillation ventilation (HFOV). In addition to hemodynamic monitoring, which of the following is a priority in the management of this child?

- A. Targeted sedation
- B. Inhaled nitric oxide (iNO) therapy
- C. Chest physiotherapy
- D. Corticosteroid administration

Answer: A

Explanation:

Correct answer: Targeted sedation

Treating pediatric patients with ARDS involves supportive measures to maintain adequate oxygenation and pulmonary perfusion, treatment of infection source or the precipitating cause, and maintaining adequate cardiac output. Patients should receive minimal yet targeted sedation to facilitate their tolerance to mechanical ventilation and to optimize oxygen delivery, VO₂, and work of breathing.

Nursing care should include maintaining a clear airway and close monitoring of respiratory frequency, heart rate/rhythm, pulse oximetry, and noninvasive blood pressure. Hemodynamic monitoring is recommended to guide volume expansion. The patient's response to ventilator assistance must be closely monitored. Chest imaging is indicated for initial diagnosis and to detect complications.

Corticosteroids, chest physiotherapy, and iNO therapy are not recommended for routine use in pediatric ARDS.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 93-94.

Question: 18

Which of the following behaviors portrays developmental activities in a 13-year-old child?

- A. Reading an exciting book
- B. Exploring career opportunities
- C. Volunteering at a local food shelter
- D. Going with a group of friends to the movies

Answer: D

Explanation:

Correct answer: Going with a group of friends to the movies

During their adolescent years (12-18 years), teens are often searching for a sense of self and personal identity. They are becoming more independent, and socialization is the most important aspect of life at this age. As they begin to examine their identity, a teen's peer group will be of the greatest significance and will become a major source of the child's self-esteem. Therefore, spending time with friends best exemplifies developmentally appropriate activities.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 4-5.

Question: 19

A physician orders a hemoglobin level, complete blood count (CBC), reticulocyte count, and peripheral blood smear for a patient in the PICU with suspected anemia. What finding is considered consistent with anemia?

- A. Hemoglobin less than four standard deviations below the mean for the normal population
- B. Hemoglobin less than one standard deviation below the mean for the normal population
- C. Hemoglobin less than two standard deviations below the mean for the normal population
- D. Hemoglobin less than three standard deviations below the mean for the normal population

Answer: C

Explanation:

Correct answer: Hemoglobin less than two standard deviations below the mean for the normal population

Anemia is defined as a hemoglobin level two standard deviations below the mean for age. The most significant problems seen in PICU patients with anemia include altered tissue perfusion, altered fluid volume, and decreased oxygen-carrying capacity. Nursing assessment and management are targeted at these three critical issues.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 624.

Question: 20

A nurse is preparing a child for cardiac catheterization. Which of the following is an early and common complication of this procedure?

- A. Arrhythmia from catheter manipulation
- B. Perforation of the heart, valves, or vessels
- C. Allergic reaction to contrast dye
- D. Infection

Answer: A

Explanation:

Correct answer: Arrhythmia from catheter manipulation

While all the choices are potential complications of cardiac catheterization, cardiac arrhythmias secondary to catheter manipulation during the procedure are the most common (and early) complications of this procedure. These are generally sporadic and transient, resolving without treatment. In rare cases, more serious arrhythmias may develop.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 181.

Question: 21

A 10-month-old infant is brought into the emergency department via ambulance and stops breathing. The nurse confirms the infant still has a pulse by checking the brachial artery in the infant's upper arm. The nurse ensures the infant's airway is open and immediately begins rescue breaths using a bag valve mask (BVM).

How frequently should the nurse provide breaths to the infant?

- A. Every 5-7 seconds
- B. Every 1-2 seconds
- C. Every 10 seconds
- D. Every 3-5 seconds

Answer: D

Explanation:

Correct answer: Every 3-5 seconds

Infants and children typically go into cardiac arrest after they have experienced respiratory failure; prolonged hypoxemia from inadequate oxygenation, ventilation, and circulation leads to cardiac arrest. Respiratory arrest in the pediatric population is associated with a higher survival rate than cardiac arrest.

If an infant stops breathing and still has a pulse, the rescuer may decide to do rescue breathing only (not compressions). In this case, breathing via the rescuer's mouth (which should completely cover the infant's nose and mouth) or using a BVM is acceptable and should be performed every 3-5 seconds, with each breath lasting 1 second.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 112-113.

Question: 22

A nurse has received an order to administer IV ondansetron to a child prior to a surgical procedure. This medication is given prophylactically for the prevention of which of the following conditions?

- A. Incisional pain
- B. Paralytic ileus
- C. Nausea and vomiting
- D. Urinary retention

Answer: C

Explanation:

Correct answer: Nausea and vomiting

Ondansetron (Zofran) is an antiemetic and can be used to treat postoperative nausea and vomiting; it is best used prior to the anticipated stimulus (e.g., operating room). Other medications used for nausea in children include metoclopramide (Reglan) and droperidol (Inapsine).

Ondansetron does not treat incisional pain, urinary retention, or paralytic ileus.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 65.

Question: 23

A pediatric nurse is educating the parents of a child with pulmonary stenosis about the pathophysiology of this condition. The nurse should explain that this disorder involves which of the following?

- A. Absence of blood flow from the right atrium to the right ventricle
- B. Obstruction to blood flow from the right ventricle to the pulmonary artery
- C. Restriction of blood flow from the left atrium to the left ventricle
- D. Obstruction of blood flow from the left ventricle to the pulmonary artery

Answer: B

Explanation:

Correct answer: Obstruction to blood flow from the right ventricle to the pulmonary artery

Pulmonary stenosis (PS) involves a narrowed pulmonary valve obstructing flow from the right ventricle to the pulmonary artery, resulting in right ventricular hypertrophy. This defect involves a stiff pulmonic valve, further contributing to the obstruction of blood flow. PS is most often a congenital heart defect, resulting from an embryologic error in the formation of pulmonary leaflets.

In noncritical PS, conservative management and monitoring are recommended. Intervention is required for moderate or greater PS, with balloon valvuloplasty as the currently accepted treatment modality, providing excellent short- and long-term results.

Tricuspid atresia involves an absence of blood flow from the RA to the RV, due to a lack of tricuspid valve formation. Survival of this condition is contingent upon the placement of an obligatory right-to-left atrial shunt. Mitral stenosis (not pulmonary stenosis) involves narrowing of the mitral valve orifice, restricting blood flow from the LA to the LV.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 284-285.

Question: 24

Among hospitalized pediatric patients, which age group is most likely to view illness as a punishment for bad behavior?

- A. Toddlers
- B. School-age children
- C. Adolescents
- D. Preschoolers

Answer: D

Explanation:

Correct answer: Preschoolers

Hospitalization of preschoolers interrupts and challenges children at a time when they are learning to control their bodies and the environment around them. To gain control, they may refuse food and not cooperate with caregivers. They hold onto security items and may regress to the toddler stage during hospitalization for an illness.

Preschoolers may project feelings of sadness, anger, or guilt onto others; view illness as a punishment for misdeeds and/or bad behavior; and not understand how their caregivers could not have protected them from this illness. They may withdraw from interaction with others if they are angry, sad, or in pain. Preschoolers may be able to express their anxieties through dramatic play and drawing.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 7-8.

Question: 25

What blood type is known as the "universal donor?"

- A. Type A
- B. Type B
- C. Type O
- D. Type AB

Answer: C

Explanation:

Correct answer: Type O

For blood transfusions, the donor's blood and the recipient's blood must be tested for compatibility. If the blood is not compatible, a life-threatening transfusion reaction can occur.

However, the universal red blood cell donor is type O negative; O-negative unmatched blood may be given to patients with an urgent, life-threatening need for a blood transfusion. Type AB positive is known as the universal recipient. All other blood types must be tested for compatibility before administering.

Reference:

AACN Core Curriculum for Pediatric High Acuity, Progressive, and Critical Care Nursing, 3rd Edition. Pg 616.

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