Setting Priorities When Caring for Clients

1. The main sign of colic is intense crying; therefore, this is expected and would not warrant the nurse’s assessing the child first.
2. A human bite is dangerous, but it is not life threatening.
3. The child hit by a car should be assessed first because he or she may have life-threatening injuries that must be assessed and treated promptly.
4. This client is not priority over a client with a physiologic problem.

2.1. Administering oxygen may help decrease the sickling of the cells, but this should not be the first intervention to address the client’s headache.
2.2. Because the client is complaining of a headache, the nurse should first rule out cerebrovascular accident (CVA) by assessing the client’s neurologic status and then determine whether it is a headache that can be treated with medication.
3. Prior to administering any pain medication to a client, the nurse must first assess the client to determine whether the pain is what is expected with the disease process or whether it is a complication that requires further nursing intervention.
4. Only after CVA has been ruled out should the nurse medicate the client. Adequate hydration will help decrease sickling of the cells, but this is not the first intervention to address the client’s pain.

3.1. The nurse should always praise the child for attempts at cooperation even if the child did not accomplish what the nurse asked.
2. This action can be taken by the nurse after praising the child for the attempt.
3. This action is appropriate and should be implemented, but not before the nurse praises the child for the attempt.
4. The nurse can demonstrate the correct technique for the child but not before praising the child for the attempt.

4.1. A 180 mg/dL glucose level for a child with type 1 diabetes is not life threatening, and the nurse would not assess this child first.
2. The nurse would expect the child with pneumonia to have these signs and symptoms; therefore, the nurse would not assess this child first.
3. This is a normal potassium level; therefore, the nurse would not assess this child first.
4. A pulse oximeter reading of less than 93% is significant and indicates hypoxia, which is life threatening; therefore, this child should be assessed first.

MAKING NURSING DECISIONS: When deciding which client to assess first, the test taker should determine whether the signs/symptoms the client is exhibiting are normal or expected for the client situation. After eliminating the expected options, the test taker should determine which situation is more life threatening.

5.1. The third dose of an antibiotic would not be priority over sliding scale insulin because insulin must be administered prior to the breakfast meal.
2. Routine medications have a 1-hour leeway before and after the scheduled time; therefore, this medication does not have to be administered first.
3. Sliding scale insulin is ordered ac, which is before meals; therefore, this medication must be administered first after receiving the A.M. shift report.
4. Routine medications have a 1-hour leeway before and after the scheduled time; therefore, this medication does not have to be administered first.

4. The nurse must first determine the infant’s responsiveness by thumping the baby’s feet.
5. The nurse should then open the child’s airway using the head-tilt chin-lift technique, with care taken not to hyperextend the neck. Then the nurse should look, listen, and feel for respirations.
3. The nurse then administers quick puffs of air while covering the child’s mouth and nose, preferably with a rescue mask.
2. The nurse should determine whether the infant has a pulse by checking the brachial artery.
1. If the infant has no pulse, the nurse should begin chest compressions using two fingers at a rate of 30:2.
7. 1. The first intervention after the child is admitted to the unit is to orient the parents and child to the room, the call system, and the hospital rules, such as not leaving the child alone in the room.
2. This task is within the scope of the UAP, but it is not priority over orienting the child/parents to the room.
3. The height/weight should be posted in case the client codes, but this can be done after the child/parents are oriented to the room.
4. The child should receive a meal tray, but not before orientation to the room.

8. 1. The nurse should immobilize the child’s leg, but it is not the first intervention.
2. The nurse must explain any procedure in words the child can understand. It does not matter how old the child is.
3. This is an appropriate intervention, but it is not the first intervention.
4. This is an appropriate intervention, but it is not the first intervention.

9. 1. This is not the priority problem because lack of fluids is more life threatening to a child than lack of food.
2. The child diagnosed with gastroenteritis is at high risk for hypovolemic shock resulting from vomiting and diarrhea; therefore, maintaining fluid and electrolyte homeostasis is priority.
3. Knowledge deficit is a psychosocial diagnosis, and although it is important to teach the parents and child, it is not priority over a physiologic problem.
4. The child already has an infection; thus there is no risk.

MAKING NURSING DECISIONS: The test taker should use Maslow’s Hierarchy of Needs to determine the client’s priority problem. Physiologic problems are priority.

10. 1. The child diagnosed with nephrotic syndrome would be expected to have proteinuria.
2. The child diagnosed with leukemia would be expected to have petechiae.
3. Drooling indicates the child is having trouble swallowing, and the epiglottis is at risk of completely occluding the airway. This warrants immediate intervention. The nurse should notify the HCP and obtain an emergency tracheostomy tray for the bedside.
4. A child with an ear infection would be expected to have an elevated temperature.

MAKING NURSING DECISIONS: When deciding which client to assess first, the test taker should determine whether the signs/symptoms the client is exhibiting are normal or expected for the client situation. After eliminating the expected options, the test taker should determine which situation is more life threatening.

Delegating and Assigning Nursing Tasks

11. 1. It is appropriate for the nurse to perform ROM exercises to help prevent contractures, specifically, scissoring of the legs. This action would not require intervention.
2. Safety issues should always be addressed, and keeping the bed in the lowest position may prevent injury to the child.
3. Taking the child to the activity room is being a client advocate and would not warrant intervention.
4. The child should be positioned upright to prevent aspiration during meals; therefore, this action would require the charge nurse to intervene.

12. 1. The UAP cannot assess a client; therefore, this is an inappropriate delegation.
2. The child with a cleft palate repair is at risk for choking or damaging the incision site; therefore, this task should not be delegated to a UAP.
3. Demonstrating is teaching, and the UAP cannot teach a client.
4. The last step of delegating to a UAP is for the nurse to evaluate and determine whether the delegated tasks have been completed and performed correctly. This indicates the nurse has delegated appropriately.

MAKING NURSING DECISIONS: When delegating to a UAP, the nurse must follow the four rights of clinical delegation: the right task, to the right person, using the right communication, and providing the right feedback. The right feedback includes determining whether the delegated tasks were performed correctly.

13. 1. Communication to the UAP must be clear, concise, correct, and complete. The nurse must determine why there was a lack of communication, which resulted in the child’s receiving food; therefore, this action should be implemented first.
2. The nurse retains ultimate accountability for any delegated tasks and cannot blame the UAP for the child’s being fed by the mother. The HCP needs to be notified to cancel the procedure.

3. The nurse should talk to the mother about why the child was being fed, but the nurse must first determine whether the UAP told the mother not to feed the child and that the child was to be given nothing by mouth.

4. This action is too late to take care of the situation.

14. 1. The scrub technician is assigned to perform daily whirlpool dressing changes, which is a lengthy procedure. Therefore, assigning the one RN to this task would be inappropriate because he or she cannot be unavailable for an extended period of time.

2. **One of the responsibilities of the unit secretary is to transcribe the HCP’s orders, but the licensed nurse retains total responsibility for the correctness and accuracy of the transcribed orders.**

3. The scrub technician cannot administer medications.

4. The unit secretary and laboratory personnel are responsible for posting laboratory data into the client’s charts. The UAP should be on the unit taking care of the clients.

15. 1, 2, 4, and 5 are correct.

1. The UAP can pass the dietary trays to the clients because it does not require judgment.

2. **One of the responsibilities of the UAP is taking routine vital signs on clients.**

3. The nurse must complete the preoperative check list because it requires nursing judgment to determine whether the client is ready for surgery.

4. **One of the responsibilities of the UAP is changing bed linens.**

5. The UAP can document the client’s intake and output, but the UAP cannot evaluate the numbers.

16. 1. The administration of blood products does not require the most experienced nurse.

2. Preparing a child for a routine procedure does not require the most experienced nurse.

3. The child recovering from a sickle cell crisis would not require the most experienced nurse.

4. The child newly diagnosed with a chronic disease, which will have acute exacerbations, requires extensive teaching; therefore, the most experienced nurse should be assigned to this child and family.

17. 1. Only a nurse can withdraw blood from a central line.

2. The social worker or case manager is responsible for referring clients to support groups. This is not an expected responsibility of a floor nurse/LPN.

3. **Only chemotherapy certified RNs can administer antineoplastic, chemotherapeutic medications.** This is a national minimal standard of care according to the Oncology Nursing Society.

4. The dietitian is responsible for ensuring that the proper food is provided along with evaluating the child’s nutritional intake, not checking the amount of food eaten—this is the responsibility of the nursing staff.

18. 1. A 6-year-old child on bed rest needs an appropriate activity to help with distraction; a cartoon video would be an age-appropriate activity.

2. The child life therapist is responsible for recreational and developmental activity for the hospitalized child, but any staff member should address the child’s psychosocial needs.

3. **Part of the delegation process is to evaluate the UAP’s performance of duties, and the nurse should praise any initiative on the part of the UAP in being a client advocate.**

4. Videos are one of the few age-appropriate activities to occupy a 6-year-old on bed rest; therefore, there is no reason to notify the charge nurse.

19. 1. The newborn with the myelomeningocele is a portion of the spinal cord and membranes protruding through the back and is at risk for hydrocephalus and meningitis and should be assigned to a more experienced nurse.

2. The new graduate who has completed the NICU internship should be able to care for a premature infant because care is primarily supportive.

3. Esophageal atresia, a congenital anomaly in which the esophagus does not completely develop, is a clinical and surgical emergency. It puts the newborn at risk for aspiration because the upper esophagus ends in a blind pouch with the lower part of the esophagus connected to the trachea.
This newborn should be assigned to a more experienced nurse.

4. Tetralogy of Fallot is a cyanotic, congenital anomaly. It includes a combination of four defects of the heart, all of which result in unoxygenated blood’s being pumped into the systemic circulation. This newborn must be assigned to an experienced nurse.

**MAKING NURSING DECISIONS:** The test taker must determine which client is the most stable, which makes this an “except” question. Three clients are either unstable or have potentially life-threatening conditions.

20. 1. Weighing the diaper is the procedure for determining the infant’s urinary output and is not part of the procedure for obtaining a urine specimen.

2. The NCSBN position paper in 1995 defined delegation as transferring to a competent individual the authority to perform a selected nursing task in a selected situation. The nurse retains the accountability for the delegation. The nurse must determine whether the UAP has the ability and knowledge to perform a task. This question clarifies whether the UAP has the ability to obtain a urine specimen.

3. Obtaining a urine specimen with an indwelling catheter on an 11-month-old infant would require more expertise than a UAP would have on the pediatric unit. Furthermore, it does not determine whether the UAP understands how to do the procedure.

4. This statement does not determine whether the UAP understands how to perform the procedure of obtaining a urine specimen from an 11-month-old infant.

**Managing Clients and Nursing Staff**

21. 1. The nurse should offer the child choices that ensure cooperation with the therapeutic regimen. The choices are when the child will ambulate, not whether the child will ambulate.

2. The nurse could ask the parents for help in making sure the client ambulates, but this may cause a rift in the nurse/parent/child relationship. This is not the most appropriate intervention.

3. The child development therapist could assist with activities that would encourage the client to ambulate, but the nurse should take control of the situation and ensure the client ambulates. This is not the most appropriate intervention.

4. This is bribery, and the nurse should not use this technique to ensure cooperation with the therapeutic regimen.

22. 1. The nurse must take action or the child will be afraid of the nurse.

2. The nurse should discuss the inappropriate comment with the mother, not with the child.

3. If every nurse who overheard this type of comment reported it to Child Protective Services, it would only unnecessarily increase the workload in an already overloaded system. Furthermore, reporting perceived potential abuse to Child Protective Services is a very serious accusation.

4. The nurse should explain to the mother that threatening the child with a shot will cause the child to be frightened of health-care professionals. This type of comment is inappropriate and should not be used to discipline a child.

23. 1. There is a Web site to obtain information about Down syndrome, but this type of referral would not be the most appropriate for parents who need to deal with emotional aspects of having a child with special needs.

2. The hospital chaplain is an important part of the multidisciplinary health-care team but would not have specialized knowledge regarding caring for a special needs child.

3. According to the NCSBN NCLEX-RN test plan, referrals are included in management of care. The most appropriate referral would be to a support group where other parents who have special needs children can share their feelings and provide advice on how to care for their child in the home.

4. Although Down syndrome results from a trisomy chromosome 21, it is primarily associated with maternal age over 35 years. Furthermore, a geneticist would not have specialized knowledge regarding caring for a special needs child.

24. 1. The newborn nursery does not need any more people in the area. Personnel are needed to monitor any and all exits.

2. The purpose of using code names to alert hospital personnel of emergency situations is to avoid panic among the clients and visitors; therefore, the nurse should not
explain the situation to the clients and visitors.

3. Any time there is an overhead emergency announcement, the charge nurse is responsible for following the hospital emergency plan.

4. **Code Pink** means an infant has been abducted from the newborn nursery. The priority intervention is to prevent the abductor from taking the child from the hospital, which can be prevented by placing a staff member at all the unit exits.

**MAKING NURSING DECISIONS:** The nurse must be knowledgeable of hospital emergency preparedness. Students as well as new employees receive this information in hospital orientations and are responsible for implementing procedures correctly. The NCSBN NCLEX-RN blueprint includes questions on safe and effective care environment.

25. 1. Even though case management is a strategy to ensure coordination of care while reducing costs, the nurse should not share this with the mother.

2. The case manager is not responsible for ensuring that the client receives the correct medication; it is the responsibility of the HCP.

3. According to the NSCBN NCLEX-RN test blueprint, questions on case management are included. The case manager will coordinate the care for a client with a chronic illness with other members of the multidisciplinary health-care team. This attempts to prevent duplication of services and allows the mother to have a specific individual to coordinate services to meet the child’s needs.

4. The life expectancy of a child with Duchenne’s muscular dystrophy is approximately 25 years. The case manager is not responsible for helping the child have a normal life expectancy.

26. 1. Although this would not be the first step in investigating a problem, this action may be initiated if it is determined to be the cause for the increase in infection rates.

2. The nurse should utilize evidence-based practice research when proposing changes because it is part of the performance improvement process, but it is not the first intervention when investigating the problem.

3. The first intervention is to determine the extent of the problem and who owns the problem. The NCSBN NCLEX-RN test blueprint includes performance improvement (quality improvement) in the management of care content.

4. This action may need to be implemented once it is determined whether there is a problem with IV infection rates. However, this would be the second step in the process.

27. 1. **The ethical principle of justice** is to treat all clients fairly, without regard to age, socioeconomic status, or any other variable, including clients with special needs. This statement supports the adolescent’s right to her opinion even though she has Down syndrome.

2. If the adolescent needs clarification of the procedure, this would be an appropriate response, which is an example of the ethical principle of veracity or truth telling.

3. This statement is an example of the ethical principle of paternalism, in which the nurse knows what is best for the client.

4. This is an example of autonomy, in which the client has the right to self-determination. The Nuremburg code of ethics specifically supports the right of individuals with special needs against being forced to participate in procedures against their will.

28. 1. Although this may be the case, this is not client advocacy, and doing so may make the mother feel guilty about not being able to afford glasses for her child.

2. **This is an example of client advocacy** because many local service organizations, such as the Lions Club or the Rotary Club, will subsidize the cost of the vision test and glasses.

3. Medicaid does not pay for glasses, and it is not the school nurse’s business if the family is on Medicaid.

4. The nurse should not loan the mother money because this crosses professional boundaries.

29. 1. The 16-year-old client is not old enough to sign the permit; therefore, pain medication would not be withheld.

2. **Legally, a child under the age of 18 must have a parent or legal guardian sign for informed consent.** The nurse should determine whether the child is
aware of the situation and assents to the procedure.
3. The surgeon is responsible for explaining the procedure; the nurse is responsible for witnessing the signature on the operative permit.
4. The nurse is responsible for witnessing the signature. Having a visitor sign the operative permit is a violation of HIPAA.

30. 1. A written memo does not allow the staff to have input into how to correct the problem. This memo might lead to blaming and arguments among the staff.
2. The performance improvement committee is designed to improve client care, not to address management issues.
3. This is implying that the unit manager does not believe the central supply lost charges. If the unit manager has this concern, it should be addressed directly with the central supply supervisor.
4. Because the staff is responsible for following the hospital procedure for charging for items used in client care, the unit manager should discuss this with staff to determine what should be done to correct the problem.