Test Bank for Maternal Child Nursing Care
4th Edition by Perry

Chapter 46: Respiratory Dysfunction

Test Bank

MULTIPLE CHOICE

1. What best describes why children have fewer respiratory tract infections as they grow older?
   a. The amount of lymphoid tissue decreases.
   b. Repeated exposure to organisms causes increased immunity.
   c. Viral organisms are less prevalent in the population.
   d. Secondary infections rarely occur after viral illnesses.

ANS: B

Children have increased immunity after exposure to a virus. The amount of lymphoid
tissue increases as children grow older. Viral organisms are not less prevalent, but older children have the ability to resist invading organisms. Secondary infections after viral illnesses include Mycoplasma pneumoniae and groups A and B streptococcal infections.

PTS: 1 DIF: Cognitive Level: Comprehension REF: 1309
OBJ: Client Needs: Physiologic Integrity TOP: Nursing Process: Assessment

2. Cool-mist vaporizers rather than steam vaporizers are recommended in home treatment of respiratory tract infections because:
   a. They are safer.
   b. They are less expensive.
   c. Respiratory secretions are dried.
   d. A more comfortable environment is produced.

ANS: A

Cool-mist vaporizers are safer than steam vaporizers, and limited evidence exists to show any advantages to steam. The cost of cool-mist and steam vaporizers is comparable. Steam loosens secretions, not dries them. Both may promote a more comfortable
environment, but decreased risk for burns and growth of organisms exist in cool-mist vaporizers.

PTS: 1  DIF: Cognitive Level: Comprehension  REF: 1304
OBJ: Client Needs: Physiologic Integrity  TOP: Nursing Process: Implementation

3. Decongestant nose drops are recommended for a 10-month-old infant with an upper respiratory tract infection. Instructions for nose drops should include:


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a. Avoiding use for more than 3 days.
b. Keeping drops to use again for nasal congestion.
c. Administering drops until nasal congestion subsides.
d. Administering drops after feedings and at bedtime.

ANS: A

Vasoconstrictive nose drops such as Neo-Synephrine should not be used for more than 3
days to avoid rebound congestion. Drops should be discarded after one illness because they may become contaminated with bacteria. Vasoconstrictive nose drops can have a rebound effect after 3 days of use. Drops administered before feedings are more helpful.

PTS: 1 DIF: Cognitive Level: Comprehension REF: 1305
OBJ: Client Needs: Physiologic Integrity TOP: Nursing Process: Implementation

4. When caring for an infant with an upper respiratory tract infection and elevated temperature, an appropriate nursing intervention is to:
   a. Give tepid water baths to reduce fever.
   b. Encourage food intake to maintain caloric needs.
   c. Have child wear heavy clothing to prevent chilling.
   d. Give small amounts of favorite fluids frequently to prevent dehydration.

ANS: D

Preventing dehydration by small frequent feedings is an important intervention in the febrile child. Tepid water baths may induce shivering, which raises temperature. Food
should not be forced; it may result in the child vomiting. The febrile child should be dressed in light, loose clothing.

PTS: 1 DIF: Cognitive Level: Application REF: 1306
OBJ: Client Needs: Physiologic Integrity TOP: Nursing Process: Implementation

5. The parent of an infant with nasopharyngitis should be instructed to notify the health professional if the infant:
   a. Becomes fussy. c. Has a fever over 99° F.

ANS: D
If an infant with nasopharyngitis has a fever over 101° F, there is early evidence of respiratory complications. Irritability and a slight fever are common in an infant with a viral illness. Cough can be a sign of nasopharyngitis.

PTS: 1 DIF: Cognitive Level: Application REF: 1310
OBJ: Client Needs: Physiologic Integrity TOP: Nursing Process: Implementation
6. It is generally recommended that a child with acute streptococcal pharyngitis can return
to school:
   a. When the sore throat is better.  c. After taking antibiotics for 24 hours.
   b. If no complications develop.  d. After taking antibiotics for 3 days.

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ANS:  C
After children have taken antibiotics for 24 hours, even if the sore throat persists,
they are
no longer contagious to other children. Complications may take days to weeks to
develop.

PTS: 1  DIF: Cognitive Level: Comprehension  REF: 1311
OBJ: Client Needs: Physiologic Integrity  TOP: Nursing Process: Implementation

7. A child is diagnosed with influenza, probably type A disease. Management includes:
   a. Clear liquid diet for hydration.
   b. Aspirin to control fever.
c. Amantadine hydrochloride to reduce symptoms.
d. Antibiotics to prevent bacterial infection.

ANS: C

Amantadine hydrochloride may reduce symptoms related to influenza type A if administered within 24 to 48 hours of onset. It is ineffective against type B or C. A clear liquid diet is not necessary for influenza, but maintaining hydration is important. Aspirin is not recommended in children because of increased risk of Reye’s syndrome. Acetaminophen or ibuprofen is a better choice. Preventive antibiotics are not indicated for influenza unless there is evidence of a secondary bacterial infection.

PTS: 1 DIF: Cognitive Level: Application REF: 1314

OBJ: Client Needs: Physiologic Integrity TOP: Nursing Process: Implementation

8. Chronic otitis media with effusion (OME) is differentiated from acute otitis media (AOM) because it is usually characterized by:
a. Fever as high as 40° C (104° F). c. Nausea and vomiting.
b. Severe pain in the ear. d. A feeling of fullness in the ear.
OME is characterized by an immobile or orange-discolored tympanic membrane and nonspecific complaints and does not cause severe pain. Fever and severe may be signs of AOM. Nausea and vomiting are associated with otitis media.

9. Which statement is characteristic of acute otitis media (AOM)?

a. The etiology is unknown.

b. Permanent hearing loss often results.

c. It can be treated by intramuscular antibiotics.

d. It is treated with a broad range of antibiotics.

ANS: D
Historically AOM has been treated with a range of antibiotics, and it is the most common disorder treated with antibiotics in the ambulatory setting. The etiology of AOM may be Streptococcus pneumoniae, Haemophilus influenzae and Moraxella catarrhalis, or a viral agent. Recent concerns about drug-resistant organisms have caused authorities to recommend judicious use of antibiotics and that antibiotics are not required for initial treatment. Permanent hearing loss is not a frequent cause of properly treated AOM. Intramuscular antibiotics are not necessary. Oral amoxicillin is the treatment of choice.

PTS: 1 DIF: Cognitive Level: Comprehension REF: 1315
OBJ: Client Needs: Physiologic Integrity TOP: Nursing Process: Assessment

10. An infant’s parents ask the nurse about preventing otitis media (OM). What should the nurse recommend?

a. Avoid tobacco smoke.
b. Use nasal decongestant.
c. Avoid children with OM.
d. Bottle-feed or breastfeed in supine position.
Eliminating tobacco smoke from the child’s environment is essential for preventing OM and other common childhood illnesses. Nasal decongestants are not useful in preventing OM. Children with uncomplicated OM are not contagious unless they show other upper respiratory infection symptoms. Children should be fed in an upright position to prevent OM.

11. Which type of croup is always considered a medical emergency?
   a. Laryngitis  
   b. Epiglottitis  
   c. Spasmodic croup  
   d. Laryngotracheobronchitis (LTB)

   ANS: B

   Epiglottitis is always a medical emergency needing antibiotics and airway support for treatment. Laryngitis is a common viral illness in older children and adolescents, with
hoarseness and upper respiratory infection symptoms. Spasmodic croup is treated with humidity. LTB may progress to a medical emergency in some children.

12. The nurse encourages the mother of a toddler with acute laryngotracheobronchitis to stay at the bedside as much as possible. The nurse’s rationale for this action is primarily that:

a. Mothers of hospitalized toddlers often experience guilt.
b. The mother’s presence will reduce anxiety and ease child’s respiratory efforts.
c. Separation from mother is a major developmental threat at this age.
d. The mother can provide constant observations of the child’s respiratory efforts.

ANS: B

The family’s presence will decrease the child’s distress. The mother may experience
guilt, but this is not the best answer. Although separation from the mother is a developmental threat for toddlers, the main reason to keep parents at the child’s bedside is to ease anxiety and therefore respiratory effort. The child should have constant cardiorespiratory monitor and noninvasive oxygen saturation monitoring, but the parent should not play this role in the hospital.

PTS: 1 DIF: Cognitive Level: Application REF: 1321
OBJ: Client Needs: Psychosocial Integrity
TOP: Nursing Process: Implementation

13. A school-age child has had an upper respiratory tract infection for several days and then began having a persistent dry, hacking cough that was worse at night. The cough has become productive in the past 24 hours. This is most suggestive of:

a. Bronchitis.  c. Viral-induced asthma.


ANS: A

Bronchitis is characterized by these symptoms and occurs in children older than 6 years.
Bronchiolitis is rare in children older than 2 years. Asthma is a chronic inflammation of the airways that may be exacerbated by a virus. Acute spasmodic laryngitis occurs in children between 3 months and 3 years.

PTS: 1  DIF: Cognitive Level: Comprehension  REF: 1321
OBJ: Client Needs: Physiologic Integrity  TOP: Nursing Process: Diagnosis

14. Skin testing for tuberculosis (the Mantoux test) is recommended:

a. Every year for all children older than 2 years.
b. Every year for all children older than 10 years.
c. Every 2 years for all children starting at age 1 year.
d. Periodically for children who reside in high-prevalence regions.

ANS: D

Children who reside in high prevalence regions for TB should be tested every 2 to 3 years. Annual testing is not necessary. Testing is not necessary unless exposure is likely or an underlying medical risk factor is present.

PTS: 1  DIF: Cognitive Level: Comprehension  REF: 1328
15. The mother of a toddler yells to the nurse, “Help! He is choking to death on his food.”

The nurse determines that lifesaving measures are necessary based on:

a. Gagging.  c. Pulse over 100 beats/min.

b. Coughing.  d. Inability to speak.

ANS: D

The inability to speak indicates a foreign-body airway obstruction of the larynx. Abdominal thrusts are needed for treatment of the choking child. Gagging indicates irritation at the back of the throat, not obstruction. Coughing does not indicate a complete airway obstruction. Tachycardia may be present for many reasons.
16. The nurse is caring for a child with acute respiratory distress syndrome (ARDS) associated with sepsis. Nursing actions should include:

   a. Force fluids.  
   b. Monitor pulse oximetry.  
   c. Institute seizure precautions.
   d. Encourage a high-protein diet.

ANS: B

Monitoring cardiopulmonary status is an important evaluation tool in the care of the child with ARDS. Maintenance of vascular volume and hydration is important and should be done parenterally. Seizures are not a side effect of ARDS. Adequate nutrition is necessary, but a high-protein diet is not helpful.

PTS: 1  DIF: Cognitive Level: Comprehension  REF: 1332
OBJ: Client Needs: Physiologic Integrity  TOP: Nursing Process: Implementation

17. The nurse is caring for a child with carbon monoxide (CO) poisoning associated with smoke inhalation. What is essential in this child’s care?

   a. Monitor pulse oximetry.
   b. Monitor arterial blood gases.
   c. Administer oxygen if respiratory distress develops.
d. Administer oxygen if child’s lips become bright, cherry red.

ANS: B

Arterial blood gases and COHb levels are the best way to monitor CO poisoning. PaO2 monitored with pulse oximetry may be normal in the case of CO poisoning.

100% O2 should be given as quickly as possible, not only if respiratory distress or other symptoms develop.

18. Asthma in infants is usually triggered by:

a. Medications. c. Exposure to cold air.

b. A viral infection. d. Allergy to dust or dust mites.

ANS: B

Viral illnesses cause inflammation that causes increased airway reactivity in asthma.

Medications such as aspirin, nonsteroidal antiinflammatory drugs, and antibiotics may
aggravate asthma, but not frequently in infants. Exposure to cold air may exacerbate already existing asthma. Allergy is associated with asthma, but 20% to 40% of children with asthma have no evidence of allergic disease.


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PTS: 1  DIF: Cognitive Level: Comprehension  REF: 1334  
OBJ: Client Needs: Physiologic Integrity  TOP: Nursing Process: Assessment

19. A child has a chronic, nonproductive cough and diffuse wheezing during the expiratory phase of respiration. This suggests:

b. Pneumonia.  d. Foreign body in the trachea.

ANS: A

Children with asthma usually have these chronic symptoms. Pneumonia appears with an acute onset and fever and general malaise. Bronchiolitis is an acute condition caused by
respiratory syncytial virus. Foreign body in the trachea will occur with acute respiratory distress or failure and maybe stridor.

20. It is now recommended that children with asthma who are taking long-term inhaled steroids should be assessed frequently because they may develop:


ANS: C

The growth of children on long-term inhaled steroids should be assessed frequently to assess for systemic effects of these drugs. Cough is prevented by inhaled steroids. No evidence exists that inhaled steroids cause osteoporosis. Cushing’s syndrome is caused by long-term systemic steroids.
21. *-Adrenergic agonists and methylxanthines are often prescribed for a child with an asthma attack. What is their action?

a. Liquefy secretions.  
c. Reduce inflammation of the lungs.

b. Dilate the bronchioles.  
d. Reduce infection.

ANS: B

These medications work to dilate the bronchioles in acute exacerbations. These medications do not liquefy secretions or reduce infection. Corticosteroids and mast cell stabilizers reduce inflammation in the lungs.

PTS: 1  DIF: Cognitive Level: Comprehension  REF: 1339

OBJ: Client Needs: Physiologic Integrity  TOP: Nursing Process: Implementation

22. A parent whose two school-age children have asthma asks the nurse in what sports, if any, they can participate. The nurse should recommend:

a. Soccer.  
c. Swimming.


ANS: C

Swimming is well tolerated in children with asthma because they are breathing air fully saturated with moisture and because of the type of breathing required in swimming. Exercise-induced bronchospasm is more common in sports that involve endurance such as soccer, running, and basketball. Prophylaxis with medications may be necessary.

PTS: 1  DIF: Cognitive Level: Application  REF: 1340

23. Which statement expresses accurately the genetic implications of cystic fibrosis (CF)?
a. If it is present in a child, both parents are carriers of this defective gene.
b. It is inherited as an autosomal dominant trait.
c. It is a genetic defect found primarily in non-Caucasian population groups.
d. There is a 50% chance that siblings of an affected child also will be affected.

ANS: A
CF is an autosomal recessive gene inherited from both parents and is found primarily in Caucasian populations. An autosomal recessive inheritance pattern means that there is a 25% chance that a sibling will be infected but a 50% chance a sibling will be a carrier.

PTS: 1 DIF: Cognitive Level: Comprehension REF: 1346
OBJ: Client Needs: Physiologic Integrity TOP: Nursing Process: Assessment

24. The earliest recognizable clinical manifestation(s) of cystic fibrosis (CF) is:
   
a. Meconium ileus.
   
b. History of poor intestinal absorption.
   
c. Foul-smelling, frothy, greasy stools.
   
d. Recurrent pneumonia and lung infections.

ANS: A

The earliest clinical manifestation of CF is a meconium ileus, which is found in about 10% of children with CF. Clinical manifestations include abdominal distention, vomiting, failure to pass stools, and rapid development of dehydration. History of malabsorption is a later sign that manifests as failure to thrive. Foul-smelling stools and recurrent
respiratory infections are later manifestations of CF.

PTS:  1  DIF:  Cognitive Level: Comprehension  REF:  1347
OBJ:  Client Needs: Physiologic Integrity  TOP:  Nursing Process: Assessment

25. Cystic fibrosis (CF) is suspected in a toddler. Which test is essential in establishing this diagnosis?

  a. Bronchoscopy  c. Urine creatinine
  b. Serum calcium  d. Sweat chloride test

ANS:  D


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A sweat chloride test result greater than 60 mEq/L is diagnostic of CF. Although bronchoscopy is helpful for identifying bacterial infection in children with CF, it is not diagnostic. Serum calcium is normal in children with CF. Urine creatinine is not diagnostic of CF.

PTS:  1  DIF:  Cognitive Level: Comprehension  REF:  1348
26. A child with cystic fibrosis is receiving recombinant human deoxyribonuclease (rhDNase). This drug:
   a. May cause mucus to thicken.
   b. May cause voice alterations.
   c. Is given subcutaneously.
   d. Is not indicated for children younger than 12 years.

ANS: B

Two of the only adverse effects of DNase are voice alterations and laryngitis. DNase decreases viscosity of mucus, is given in an aerosolized form, and is safe for children younger than 12 years of age.

PTS: 1 DIF: Cognitive Level: Comprehension REF: 1349

OBJ: Client Needs: Physiologic Integrity TOP: Nursing Process: Implementation

27. Pancreatic enzymes are administered to the child with cystic fibrosis. Nursing considerations should include:
   a. Do not administer pancreatic enzymes if the child is receiving antibiotics.
b. Decrease dose of pancreatic enzymes if the child is having frequent, bulky stools.

c. Administer pancreatic enzymes between meals if at all possible.

d. Pancreatic enzymes can be swallowed whole or sprinkled on a small amount of food taken at the beginning of a meal.

ANS: D

Enzymes may be administered in a small amount of cereal or fruit at the beginning of a meal or swallowed whole. Pancreatic enzymes are not a contraindication for antibiotics.

The dose of enzymes should be increased if the child is having frequent, bulky stools.

PTS: 1  DIF: Cognitive Level: Application  REF: 1349

OBJ: Client Needs: Physiologic Integrity  TOP: Nursing Process: Implementation

28. In providing nourishment for a child with cystic fibrosis (CF), which factor should the nurse keep in mind?

a. Diet should be high in carbohydrates and protein.

b. Diet should be high in easily digested carbohydrates and fats.

b. Most fruits and vegetables are not well tolerated.
d. Fats and proteins must be greatly curtailed.

ANS: A


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Children with CF require a well-balanced, high-protein, high-calorie diet because of impaired intestinal absorption. Enzyme supplementation helps digest foods; other modifications are not necessary. A well-balanced diet containing fruits and vegetables is important. Fats and proteins are a necessary part of a well-balanced diet.

PTS: 1  DIF: Cognitive Level: Application  REF: 1349

OBJ: Client Needs: Physiologic Integrity  TOP: Nursing Process: Implementation

29. Cardiopulmonary resuscitation is begun on a toddler. Which pulse is usually palpated because it is the most central and accessible?

a. Radial  c. Femoral

b. Carotid  d. Brachial
ANS: B

In a toddler the carotid pulse is palpated. The radial pulse is not considered a central pulse. The femoral pulse is not the most central and accessible. The brachial pulse is felt in infants younger than 1 year.

PTS: 1 DIF: Cognitive Level: Comprehension REF: 1357

OBJ: Client Needs: Physiologic Integrity TOP: Nursing Process: Assessment

30. Which drug is considered the most useful in treating cardiac arrest?
   a. Bretylium  c. Epinephrine hydrochloride
   b. Lidocaine hydrochloride  d. Naloxone (Narcan)

ANS: C

Epinephrine HCl works on &alpha;- and &beta;-receptors in the heart and is the most useful drug in cardiac arrest. Bretylium is no longer used in pediatric cardiac arrest management. Lidocaine HCl is used for ventricular arrhythmias only. Naloxone is useful only to reverse effects of opioids.

PTS: 1 DIF: Cognitive Level: Application REF: 1359
31. The Heimlich maneuver is recommended for airway obstruction in children older than:
   a. 1 year  c. 8 years
   b. 4 years  d. 12 years

ANS: A

The Heimlich maneuver is recommended for airway obstruction in children older than 1 year. In children younger than 1 year, back blows and chest thrusts are administered.

PTS: 1  DIF: Cognitive Level: Comprehension  REF: 1358

32. An appropriate nursing intervention when caring for a child with pneumonia is to:
   a. Encourage rest.
   b. Encourage the child to lie on the unaffected side.

c. Administer analgesics.

d. Place the child in the Trendelenburg position.

ANS: A

Encouraging rest by clustering care and promoting a quiet environment is the best intervention for a child with pneumonia. Lying on the affected side may promote comfort by splinting the chest and reducing pleural rubbing. Analgesics are not indicated. Children should be placed in a semierect position or position of comfort.

PTS: 1  DIF: Cognitive Level: Application  REF: 1325

OBJ: Client Needs: Physiologic Integrity  TOP: Nursing Process: Implementation

MULTIPLE RESPONSE

1. An infant has developed staphylococcal pneumonia. Nursing care of the child with pneumonia includes (choose all that apply):

   a. Cluster care to conserve energy.

   b. Round-the-clock administration of antitussive agents.

   c. Strict intake and output to avoid congestive heart failure.
d. Administration of antibiotics.

ANS: A, D

Antibiotics are indicated for a bacterial pneumonia. Often the child will have decreased pulmonary reserve, and the clustering of care is essential. Round-the-clock antitussive agents and strict intake and output are not included in the care of the child with pneumonia.

PTS: 1 DIF: Cognitive Level: Comprehension REF: 1325

OBJ: Client Needs: Physiologic Integrity TOP: Nursing Process: Implementation

2. The nurse is caring for a 10-month-old infant with respiratory syncytial virus (RSV) bronchiolitis. Which interventions should be included in the child’s care? Choose all that apply.
   a. Place in a mist tent.
   b. Administer antibiotics.
   c. Administer cough syrup.
   d. Encourage infant to drink 8 ounces of formula every 4 hours.
   e. Cluster care to encourage adequate rest.
f. Place on noninvasive oxygen monitoring.

ANS: D, E, F

Hydration is important in children with RSV bronchiolitis to loosen secretions and prevent shock. Clustering of care promotes periods of rest. The use of noninvasive oxygen monitoring is recommended.

PTS: 1  DIF: Cognitive Level: Application  REF: 1323, 1324  
OBJ: Client Needs: Physiologic Integrity  TOP: Nursing Process: Implementation


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3. The nurse is caring for a 5-year-old child who is scheduled for a tonsillectomy in 2 hours.

Which actions should the nurse include in the child’s postoperative care plan? (Choose all that apply.)

a. Notify the surgeon if the child swallows frequently.

b. Apply a heat collar to the child for pain relief.

c. Place the child on the abdomen until fully awake.

d. Allow the child to have diluted juice after the procedure.
e. Encourage the child to cough frequently.

ANS: A, C, D

Frequent swallowing is a sign of bleeding in children after a tonsillectomy. The child should be placed on the abdomen or the side to facilitate drainage. The child can drink diluted juice, cool water, or popsicles after the procedure.

PTS: 1 DIF: Cognitive Level: Analysis REF: 1312, 1313
OBJ: Client Needs: Physiologic Integrity TOP: Nursing Process: Implementation

MATCHING

The nurse enters a room and finds a 6-year-old child who is unconscious. After calling for help and before being able to use an automatic external defibrillator, what steps should the nurse take? Place in correct order.

a. Place on a hard surface.
b. Administer 30 chest compressions with two breaths.
c. Feel carotid pulse while maintaining head tilt with the other hand.
d. Use the head tilt–chin lift maneuver and check for breathing.
e. Place heel of one hand on lower half of sternum with other hand on top.
f. Give two rescue breaths.

1. Place on a hard surface.

2. Use the head tilt–chin lift maneuver and check for breathing.

3. Give two rescue breaths.

4. Feel carotid pulse while maintaining head tilt with the other hand.

5. Place heel of one hand on lower half of sternum with other hand on top.

6. Administer 30 chest compressions with two breaths.

1. ANS: A  PTS: 1  DIF: Cognitive Level: Analysis
    REF: 1355, 1357  OBJ: Client Needs: Physiologic Integrity
    TOP: Nursing Process: Implementation

2. ANS: D  PTS: 1  DIF: Cognitive Level: Analysis
    REF: 1355, 1357  OBJ: Client Needs: Physiologic Integrity
    TOP: Nursing Process: Implementation
3. ANS: F  PTS: 1  DIF: Cognitive Level: Analysis

REF: 1355, 1357  OBJ: Client Needs: Physiologic Integrity


TOP: Nursing Process: Implementation

4. ANS: C  PTS: 1  DIF: Cognitive Level: Analysis

REF: 1355, 1357  OBJ: Client Needs: Physiologic Integrity

TOP: Nursing Process: Implementation

5. ANS: E  PTS: 1  DIF: Cognitive Level: Analysis

REF: 1355, 1357  OBJ: Client Needs: Physiologic Integrity

TOP: Nursing Process: Implementation

6. ANS: B  PTS: 1  DIF: Cognitive Level: Analysis

REF: 1355, 1357  OBJ: Client Needs: Physiologic Integrity

TOP: Nursing Process: Implementation