ATI PEDIATRICS PROCTORED EXAM 2024/2025 | ACTUAL EXAM WITH A STUDY GUIDE AND PRACTICE EXAM | ACCURATE REAL EXAM QUESTIONS AND ANSWERS | GUARANTEED PASS | LATEST UPDATE | GRADED A

A nurse is receiving change-of-shift report for four children. Which of the following children should the nurse assess first?
a) A toddler who has a concussion and an episode of forceful vomiting
b) An adolescent who has infective endocarditis and reports having a headache
c) An adolescent who was placed into halo traction 1 hr ago and reports pain as 6 on a scale of 0 to 10
d) A school-age child who has acute glomerulonephritis and brown-colored urine
A toddler who has a concussion and an episode of forceful vomiting
A nurse is providing dietary teaching to the guardian of a school-age child who has cystic fibrosis. Which of the following statements should the nurse make?
a) "You should offer your child high-protein meals and snacks throughout the day."
b) "You should decrease your child's dietary fat intake to less than 10% of their caloric intake."
c) "You should restrict your child's calorie intake to 1,200 per day."
d) "You should give your child a multivitamin once weekly."
a) "You should offer your child high-protein meals and snacks throughout the day."
) A nurse is providing discharge teaching to the guardians of a toddler who had lower leg cast applied 24 hr ago. The nurse should instruct the guardians to report which of the following finding to the provider?
a) Capillary refill time less than 2 seconds
b) Restricted ability to move the toes
c) Swelling of the casted foot when the leg is dependent
d) Pedal pulse +3 bilateral
b) Restricted ability to move the toes
A nurse is collecting date from a school-age Child. The nurse should identity that which of F the following findings is a manifestation of physical abuse?
a Multiple dental caries
Malnutrition
Recurrent urinary tract infections
Bruises at various stages of healing
Bruises at various stages of healing

A nurse is reinforcing teaching with an adolescent who has an inflamed nonperforated appendix and is scheduled for a laparoscopic assisted appendectomy. Which of the following instructions should the nurse include in the teaching?
"You can begin drinking fluids again 2 days after your surgery."
"You will need to ask for pain medication for the first 24 hours after surgery."
"You will have your vital signs monitored every 8 hours after surgery."
"You will sit in your chair at least twice a day after surgery."
"You will sit in your chair at least twice a day after surgery."
A nurse is reinforcing teaching about sudden infant death syndrome (SIDS) with the parent of a 1-month-old infant. Which of the following statements by the parent indicates an understanding of the teaching?a)
"I will let my baby sleep with me in bed at night."
"I will allow my baby to have a pacifier while sleeping."
"I will place my baby on a soft mattress to sleep."
"I will cover my baby with a quilt while he sleeping."
"I will allow my baby to have a pacifier while sleeping."
A nurse is assisting with the care of a child who is postoperative and received a transfusion during a surgical procedure. Which of the following findings indicates the child is havig a hemolytic reaction?
a) Chills and flank pain
b) Pruritus and flushing
c) Rales and cyanosis
d) Bradycardia and diarrhea
Chills and flank pain (Chills and flank pain are findings that indicate an incompatibility of the transfused blood product with the client's blood. The nurse should identify this finding as an indication that the child is having a hemolytic reaction.)
5. A guardian calls the clinic nurse after his child has developed symptoms of varicella and asks when his child will no longer be contagious. Which of the following responses should the nurse make?
a) “When your child no longer has a fever.”
b) “Three days after the rash started.”
c) “Six days after lesions appear if they are crusted.”
d) “When your child’s lesions disappear.”
"Six days after lesions appear if they are crusted." (The nurse should inform the guardian that a child will stop being contagious around 6 days after the lesions appeared, as long as they are crusted over.)
5. A nurse is collecting date from a child during a well-child visit. The nurse should recognize that which of the following findings places the child at a higher risk for abuse?
a) The child is 6 years old.
b) The child is male.
c) The child was born at 30 weeks of gestation.
d) The child was born via cesarean birth.
c) The child was born at 30 weeks of gestation. (The nurse should identify that children who are born prematurely are at greater risk for abuse because of the potential for impaired bonding during early infancy.)

5. A nurse is reinforcing teaching with the guardian of a child who has a new diagnosis of rheumatic fever. Which of the following statements by the guardian indicates an understanding of the teaching?
a) “I should not give my child aspirin for pain or fever.”
b) “My child will take antibiotic for 6 months.”
c) “My child might have a period of irregular movement of the extremities.”
d) “I should expect there to be blood in my child’s urine.”
"My child might have a period of irregular movement of the extremities."
(The nurse should instruct the guardian that the child might experience chorea weeks or months after the initial diagnosis. Chorea is a temporary lack of coordination and the presence of sudden, irregular movements or periods of clumsiness.)
5. A nurse is collecting data from an infant during a well-child visit. Which of the following sites should the nurse use when obtaining the infant’s heart rate?
a) Apical
b) Radial
c) Carotid
d) Femoral
a) Apical (The nurse should use the apical pulse to obtain the infant's heart rate and count it for a full minute, because it gives a reliable rate and rhythm and provides accurate baseline assessment data. In an infant, the apical heart rate is auscultated at the fourth intercostal space lateral to the midclavicular line.)
5. A nurse is preparing a toddler for suturing of a minor facial laceration. The nurse should place the toddler in which of the following restraints?
a) Mummy restraint
b) Jacket restraint
c) Elbow restraint
d) Wrist restraint
Mummy restraint (The nurse should use a mummy wrap when a short-term restraint is needed for treatment of the toddler that involves the head and neck. The nurse should always use the least amount of restraint necessary.)
5. A nurse is reinforcing dietary teaching with the parent of a 2-year-old toddler. Which of the following should the nurse include in the teaching?
a) "It is recommended that the toddler consumes no more than 12 ounces of fruit juice each day."
b) "An appropriate serving size is 1 tablespoon of food per year of age."
c) "Introduce healthy finger foods like carrots and celery sticks."
d) "Encourage 5 cups of low-fat milk each day."
"An appropriate serving size is 1 tablespoon of food per year of age." (The nurse should include that an appropriate serving size for a 2-year-old toddler is 1 tbsp of food per year of age.)
5. During a well-child visit, the parent of a toddler expresses concern to the nurse that the toddler takes several hours to fall asleep at night. Which of the following recommendations should the nurse make?
a) Vary the time the toddler goes to bed each night
b) Allow the toddler to watch television before bedtime
c) Provide the toddler with a favorite toy at bedtime.

d) Increase the toddler's activity prior to bedtime
c) Provide the toddler with a favorite toy at bedtime. (The nurse should recommend to the parent that providing the toddler with a favorite toy at bedtime will help the toddler to feel more secure and facilitate sleep.)

5. A nurse is assisting with the care for a 7-month-old infant who has a cleft palate. Which of the following actions should the nurse take to decrease the infant's risk for aspiration?
a) Feed the infant in supine position.
b) Encourage the mother to breastfeed the infant exclusively.
c) Burp the infant frequently during feedings.
d) Perform nasotracheal suctioning if coughing occurs
c) Burp the infant frequently during feedings. (Infants with a cleft palate have difficulty creating a seal around a bottle. Burping the infant frequently, following every ounce of fluid consumed, dissipates swallowed air and helps to prevent aspiration.)

5. A nurse is reviewing the laboratory values of a school-age child who has iron deficiency anemia. Which of the following findings should the nurse expect?
a) Hgb 9.0 g/dL
b) Hct 37%
c) Iron 100 mcg/dL
d) Total iron binding capacity 325 mcg/dL
a) Hgb 9.0 g/dL (The nurse should expect a child who has iron deficiency anemia to have an Hgb level below the expected reference range of 9.5 to 15.5 g/dL. An Hgb of 9.0 g/dL is below the expected reference range.)

5. A nurse is reinforcing teaching about vital signs with the guardian of a 1-year-old toddler. Which of the following statements by the guardian indicates an understanding of the teaching?
a) "My child's pulse could increase to 150 beats a minute with activity."
b) "My child's temperature should be 96.8 degrees Fahrenheit."
c) "My child should take 40 breaths a minute."
d) "My child's pulse could get as low as 60 beats a minute while asleep."
a) "My child's pulse could increase to 150 beats a minute with activity." (A pulse rate of 150/min is within the expected reference range for a toddler during physical activity.)

We have an expert-written solution to this problem!

5. A nurse is caring for an adolescent who has acne and anew prescription for isotretinoin. For which of the following adverse effects should the nurse monitor?
a) Hypersalivation
b) Depression
c) Bradycardia
d) Hyperreflexia
b) Depression (Clients taking isotretinoin can experience mental status changes, such as suicidal thoughts, aggression, emotional lability, and depression. The nurse should monitor the adolescent's mental status while taking isotretinoin.)