Nursing

AACN-ACCNS-N-Neonatal

CNS Wellness through Acute Care

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Question: 1

Baby David's T98.6F after converting to Celsius. What is the correct answer?

A. 37 degrees.
B. 38 degrees.
C. 39 degrees.
D. 40 degrees.

Answer: A

Explanation:
37 degrees Celsius is the right temperature for T98.6F. This is obtained from the formula to convert Fahrenheit into Celsius using C = (F-32)5/9.

Question: 2

After baby John's mom leaves you find a rattle in his isolette. What course of action should nurse Ellen take?

A. Remove the rattle and give it to his mom when she returns.
B. Leave it in the isolette.
C. Put it in his hand and let him play with it.
D. Shake it near his head hard and sing a lullabye.

Answer: A

Explanation:
If the nurse finds a rattle of the baby's isolette, she must remove the rattle and give it to his mom when she returns. The baby cannot have that with him for safety reasons.

Question: 3

Many nurses find it difficult in to get accurate information when making their assessment using the stethoscope and it can near impossible with a crying or irritable baby. What can the nurse do in order to make her job a little easier?

A. Rock the baby to sleep before attempting the assessment.
B. Give the baby a pacifier or bottle as a temporary aid to stop the crying
C. Wait to the nursery becomes quiet and the baby stops crying

D. Just do the best she can and get whatever she can from her examination

Answer: B

Explanation:
Give the baby a pacifier or bottle as a temporary aid to stop the crying. The auscultation should not be delayed in the event there is something abnormal that may be occurring, especially if the baby is crying for what may seem like no apparent reason.

Question: 4

Julia gave birth to a baby girl who is 2,930 grams in weight. The baby was admitted at the NICU due to a low APGAR score because her mother had a prolonged second stage of labor. As a result, the neonate had asphyxia. Which of the following would a nurse expect to find in a newborn with asphyxia?

A. Hypocapnia
B. Ketosis
C. Acidosis
D. Hyperoxemia

Answer: C

Explanation:
A nurse would expect to find acidosis in a newborn with asphyxia. Asphyxia leads to acidosis, hypoxia, hypoxemia, and tissue anoxia. This results in hypercapnia (not hypocapnia) due to the increase in carbonic acid concentration in the fetal circulation because the carbon dioxide fails to get eliminated from the infant's lungs due to inadequate respiration. Ketosis is seen in diabetic ketoacidosis.

Question: 5

Sixteen hours after birth, the nurse noticed that the neonate is jittery, hyperactive, sneezes frequently, produces a high-pitched cry, and is having difficulty sucking. Evaluation reveals that the neonate has increased deep tendon reflexes and a decreased Moro reflex. The nurse should suspect a case of:

A. Syphilis in the neonate
B. Cerebral palsy
C. Fetal alcohol syndrome
D. Opiod withdrawal

Answer: D

Explanation:
The nurse should suspect a case of opiod drug withdrawal. The signs are indicative of opiod drug withdrawal in which typical changes occur in the central nervous system; it is a must to observe the neonate during the first 24-48 hours of life.

Question: 6

Baby Boy Mcintosh was immediately transferred from the birthing center to the neonatal intensive care unit because of myelomeningocele. The nurse assigned at the unit should immediately:

A. Provide newborn care
B. Start the prophylaxis (antibiotic)
C. Apply a sterile saline dressing
D. Assess for any signs of paralysis

Answer: C

Explanation:
The nurse at the unit should immediately apply a sterile saline dressing. This nursing intervention will help in the prevention of infection while keeping the membrane moist.

Question: 7

During the assessment, the nurse noticed that one of the admitted neonates, who is small-for-gestationalage, is jittery, has a high-pitched cry, and has irregular respirations. The nurse must be aware that these signs could be an indication of:

A. Hypercalcemia
B. Hypovolemia
C. Hypoglycemia
D. Hypothyroidism

Answer: C

Explanation:
The nurse must be aware that the signs presented are indicative of hypoglycemia. Neonates who are small-for-gestational-age may exhibit hypoglycemia (especially during the first 2 hours of life) due to depletion in glycogen storage, as well as inhibited gluconeogenesis.

Question: 8

Nurse Dolores is caring for a fifteen-day-old neonate who has a necrotizing enterocolitis (NEC). What nursing care plan should be included for the neonate?

A. Measure abdominal girth at least every two hours
B. Dilute the milk formula as ordered
C. Hyperventilate the neonate before each feeding
D. Introduce formula feeding by lavage

Answer: A

Explanation:
A nursing care plan should include measuring of the abdominal girth every two hours. Neonates who have NEC have prolonged gastric emptying; therefore, any increase in abdominal girth (>1 cm in 4 hours) is significant and it needs immediate intervention.

Question: 9

A neonate was admitted at the hospital due to hydrocephalus. After the insertion of a shunt to treat the disease, the nurse should evaluate the function of the shunt by:

A. Palpation of the anterior fontanel
B. Notation of the frequency of voiding
C. Assessment of periorbital edema
D. Observation of symmetric Moro reflex

Answer: A

Explanation:
After the insertion of a shunt to treat the disease, the nurse should evaluate the function of the shunt by palpation of the anterior fontanel. A bulging fontanel will be an indication of increased intracranial pressure. Other options are not significant indicators of increased intracranial pressure.

Question: 10

A one-week-old infant was admitted at the neonatal intensive care unit after surgery to treat esophageal atresia. What would be an immediate postoperative nursing priority for this patient?

A. Administering oral milk feeding slowly
B. Observing for signs of infection at the incision site
C. Reporting episodes of vomiting to the physician
D. Checking for the patency of nasogastric tube

Answer: D

Explanation:
An immediate postoperative nursing priority for this patient is checking for the patency of nasogastric tube. Postoperatively, the nasogastric tube is useful in decompression of the stomach and limits tension at the suture line.

Question: 11

A nurse is caring for a pregnant patient and is assessing the fetal heart rate. The nurse notes that the fetal heart rate is abnormal for the third time; this is made known to the physician to order a fetal scalp pH sample.
The nurse is aware that the fetus may be compromised if the fetal pH is:

A. 7.17
B. 7.22
C. 7.30
D. 7.34

Answer: A

Explanation:
The nurse is aware that the fetus may be compromised if the fetal pH is 7.17. This value is indicative of fetal hypoxia; any reading that is less than 7.20 is dangerous and requires an emergency birth. Any reading higher than 7.2 is not life-threatening.

Question: 12

The nurse is caring for several infants who are forty-eight hours old. Among the following infants, which should be given highest priority by the nurse?

A. A bottle-fed infant who takes 1-ounce of milk every three to five hours
B. A breastfed infant who lost 0.5 ounce of his weight
C. A bottle-fed infant who takes two to three ounces of milk every two to four hours
D. A breastfed infant who feeds every two to four hours

Answer: A

Explanation:
The infant that should be given highest priority by the nurse is a bottle-fed infant who takes 1-ounce of milk every three to five hours. The patient exhibits poor feeding (1 ounce = 30 ml), which indicates specific problems. The infant normally loses weight during the first week of life and he/she usually gains weight in the second week.

Question: 13

When caring for a neonate in acute respiratory distress from laryngotracheobronchitis who has a body temperature of 38.7 ºC, the nurse should give priority to:

A. Monitor the neonate's respiratory status continuously
B. Deliver 40% humidified oxygen
C. Provide support to decrease apprehension
D. Initiate measures to decrease fever

Answer: A

Explanation:
When caring for a neonate in acute respiratory distress from laryngotracheobronchitis who has a body temperature of 38.7 ºC, the nurse should give priority to monitor the neonate's respiratory status continuously. In this case, patency of the airway is determined by continuous monitoring for signs of respiratory distress as laryngeal spasms can occur abruptly.

Question: 14

The nurse is checking for cervical dilation of a patient who is in labor, when the nurse observes that the umbilical cord has prolapsed. The nurse's initial action would be to:

A. Obtain the fetal heart rate
B. Cover the cord with sterile saline soaks
C. Position the patient on her side
D. Place the patient in Trendelenburg's position

Answer: D

Explanation:
The nurse's initial action would be to place the patient in Trendelenburg's position. Placing the patient in this position will prevent further prolapse and relieves pressure on the cord.

Question: 15

A clinical nurse specialist is monitoring the blood glucose level of a neonate who was born to a diabetic mother. The nurse determined that the blood glucose level is 50 mg/dL. What would be the action of the nurse?

A. Feed the baby orally with 10% dextrose in water
B. Monitor the neonate continuously for the next twenty-four hours
C. Alert the physician and request an order of glucose 50%
D. Assess the cord serum glucose level

Answer: B

Explanation:
The action of the nurse should be to monitor the neonate continuously for the next twenty-four hours. The blood glucose level is within the normal range for neonates, so it doesn't require any measure aside from continuously monitoring the patient for the next twenty-four hours.

Question: 16

A nurse is caring for a patient who is receiving magnesium sulfate therapy intravenously for preeclampsia. The patient gives birth to a baby weighing 4.2 pounds in the 36th week of gestation. The nurse is aware that a finding in the newborn that may indicate magnesium sulfate toxicity is:

A. Tachycardia
B. Pallor
C. Hypotonia
D. Tremors

Answer: C

Explanation:
The nurse is aware that a finding in the newborn that may indicate magnesium sulfate toxicity is hypotonia. Hypotonia occurs with magnesium sulfate toxicity because of skeletal and smooth muscle relaxation.

Question: 17

A clinical nurse specialist is caring for a neonate who develops hyperbilirubinemia. The physician ordered phototherapy BID. During the therapy, the nurse should include which plan of care:

A. Keep the eye shield on continuously
B. Cover the patient with a blanket made of light material
C. Take the vital signs every hour
D. Give fluids at least every two hours

Answer: D

Explanation:
During the therapy, the nurse should include a plan of care to give fluids at least every two hours. During phototherapy, there is an increase in insensible and interstitial fluid losses, therefore extra fluids are needed to prevent dehydration.

Question: 18

Prior to discharge from the newborn nursery at forty-eight hours old, the nurse knows that murmurs are frequently assessed and are most often due to which factor?

A. A ventricular septal defect
B. Transition from fetal to pulmonic circulation
C. Heart disease of the newborn period
D. Cyanotic heart disease

Answer: B

Explanation:
The nurse knows that murmurs are frequently assessed and are most often due to transition from fetal to pulmonic circulation. As the transition occurs, the murmurs may become loud and then resolve.

Question: 19

A clinical nurse specialist is planning a nursing care for a pregnant patient who is admitted with a diagnosis of abruption placenta. The nurse should include a careful observation for signs and symptoms of:

A. Seizure
B. Jaundice
C. Hypovolemic shock
D. Hypertension

Answer: C

Explanation: T
he nurse should include a careful observation for signs and symptoms of hypovolemic shock.
In this case, uterine bleeding can lead to a massive internal hemorrhage that can cause hypovolemic shock.

Question: 20

A neonate with cardiac disease has been admitted to the nursery from the delivery room.
Which finding helps the nurse to differentiate between a cyanotic and an acyanotic defect?

A. Neonates with cyanotic heart disease feed poorly
B. The pulse oximeter does not read above 93%
C. Cyanotic heart disease causes high fevers
D. Neonates with cyanotic heart disease usually go directly to the operating room

Answer: B

Explanation:
A finding that helps the nurse to differentiate between a cyanotic and an acyanotic defect is that the pulse oximeter does not read above 93%. Cyanotic heart diseases are unlikely to produce a reading above 93%.

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