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## CCRN Pediatric Practice Exam Questions and Answers 2024 from AACN

To promote effective grieving in a 6-year-old sibling following the death of an infant, the nurse should:

- A) Recommend that the sibling not attend the infant's memorial service
- B) Encourage the parents to minimize their expression of grief with the sibling
- C) Explain to the sibling that the infant went to heaven
- D) Explain to the sibling that thoughts and wishes did not cause the infant's death

Answer: D) Explain to the sibling that thoughts and wishes did not cause the infant's death: At age 6, children may take words literally and because of their egocentrism, they believe that thoughts are all-powerful. They may truly believe they caused the death of their sibling. A simple, honest explanation of why the sibling died is indicated. This intervention is consistent with Caring Processes.

- A) Recommend that the sibling not attend the infant's memorial service: This intervention is not a solution to the problem and will not promote effective grieving for the sibling. It is not consistent with Caring Processes.
- B) Encourage the parents to minimize their expression of grief with the sibling: This intervention will lead to ineffective grieving for the sibling and is not consistent with Caring Processes
- C) Explain to the sibling that the infant went to heaven: This intervention will not address the sibling's problem

A 5-year-old with a history of congenital hydrocephalus and VP shunt placement at four weeks of age is admitted with increased somnolence, decreased appetite, and increased complaints of headache. This morning the child vomited twice. The nurse should anticipate:

- A) The physician ordering lumbar puncture and blood and urine cultures
- B) the patient having a CT scan followed by possible shunt revision
- C) Administering mannitol or hypertonic saline
- D) Administering phenytoin (Dilantin) or fosphenytoin (Cerebyx)

Answer: B) The patient having a CT scan followed by possible shunt revision: This patient is demonstrating signs of increased intracranial pressure. The most likely etiology is malfunction of the VP shunt as a result of blockage or disconnection, which is particularly likely over time as the child grows. The definitive diagnosis is made by a CT scan and a shunt series. Surgical intervention for a shunt revision would be indicated.

- A) The physician ordering lumbar puncture and blood and urine cultures: These interventions will not address the most likely primary problem, which is suspected VP shunt malfunction. Additionally, lumbar puncture is contraindicated in the presence of increased intracranial pressure, because downward herniation of the brainstem can occur.
- C) Administering mannitol or hypertonic saline: These medications are indicated for the medical management of increased intracranial pressure, of which this patient has

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## AACN Critical Care Nursing Exam Sample Questions (Q81-Q86):

### NEW QUESTION # 81

A child with hepatic failure received volume replacement. Following this therapy, laboratory tests reveal:

- \* PT: 14 sec
- \* PTT: 40 sec
- \* Hct: 36%
- \* Albumin: 3.5 g/dL

Before the patient undergoes a closed liver biopsy, further replacement should include:

- A. 5% albumin
- **B. Fresh frozen plasma**
- C. Cryoprecipitate
- D. PRBCs

### Answer: B

Explanation:

APT of 14 seconds and PTT of 40 seconds are at the upper limit of normal, and the patient has hepatic failure, which can lead to coagulopathy. Prior to liver biopsy-a high-risk procedure for bleeding-FFP is administered to replace all clotting factors and reduce bleeding risk.

"Patients with liver dysfunction undergoing procedures should receive FFP if coagulopathy is present, as it replaces multiple clotting factors synthesized in the liver." (Referenced from CCRN Pediatric - Direct Care: Hematology, Coagulation and Transfusion Support)

### NEW QUESTION # 82

Following a MVC with prolonged entrapment of the legs, a 7-year-old has:

- \* BP: 75/40
- \* HR: 145
- \* K#: 5.9 mEq/L
- \* Hypocalcemia
- \* Elevated CK

What urine output should the nurse expect?

- **A. Red-brown "tea" color urine**
- B. Anuria
- C. >4 cc/kg of clear, colorless urine
- D. Yellow urine with clots of blood

### Answer: A

Explanation:

This is consistent with rhabdomyolysis, which causes muscle breakdown and release of myoglobin into the bloodstream. Myoglobinuria results in dark red-brown or "tea-colored" urine, and is nephrotoxic, contributing to acute kidney injury. "Crush injuries and elevated CK levels are hallmarks of rhabdomyolysis. Myoglobinuria presents as dark, tea-colored urine, and requires prompt fluid management to prevent renal damage." (Referenced from CCRN Pediatric - Direct Care: Renal, Electrolyte Imbalances and Rhabdomyolysis)

### NEW QUESTION # 83

A 15-year-old girl was recently diagnosed of idiopathic scoliosis. She is worried about being different from her friends and upset about the treatment regimen. How would the nurse help her to develop a positive self-image:

- A. refer her to a psychiatrist for consult.

- B. remind her that her back would be crooked if she doesn't adhere to the treatment
- **C. assist her in selecting clothes to improve her appearance**
- D. be focus on her positive rather her negative attributes

**Answer: C**

Explanation:

Explanation: The nurse would help her by selecting appropriate clothing that will help minimize the appearance of a brace, especially if an effort is made to wear the current style.

**NEW QUESTION # 84**

During a discussion with a group of mother, the nurse informs that scoliosis is most notable when a child reaches the age of:

- **A. 10-12 years**
- B. 3-6 years
- C. 7-9 years
- D. 15-18 years

**Answer: A**

Explanation:

Explanation: Preadolescence is the time when scoliosis is most likely to become evident. Although scoliosis may occur at any age like in the case of idiopathic scoliosis, the most common type tends to become evident during preadolescent years.

**NEW QUESTION # 85**

A nurse conducts teaching among adolescents about STD's. One of the Participants asks about any early sign or symptom of Syphilis. The nurse should state that it is:

- **A. lesion on genitals**
- B. rashes on genitals
- C. difficulty in urination
- D. pus on genitals

**Answer: A**

Explanation:

Explanation: Lesion on genitals is the earliest sign of syphilis. During a dark-field exam of the scraping will reveal the causative agent - *Treponema pallidum*.

**NEW QUESTION # 86**

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