100 NCLEX-Style Questions on Pediatric Nursing Care

Gastrointestinal and Elimination Alterations

Question 1

A 2-year-old child is admitted with severe diarrhea and vomiting for the past 24 hours. The nurse notes dry mucous membranes, decreased urine output, and lethargy. Which intervention should the nurse prioritize?

A. Administering an antiemetic medication B. Initiating IV fluid therapy C. Providing frequent small sips of clear liquids D. Collecting a stool sample for culture

Answer: B. Initiating IV fluid therapy

Rationale: The child is exhibiting signs of moderate to severe dehydration (dry mucous membranes, decreased urine output, lethargy) due to fluid loss from diarrhea and vomiting. IV fluid therapy is the priority intervention to rapidly correct fluid and electrolyte imbalances. While antiemetics, oral rehydration, and diagnostic testing are important, correcting dehydration is the most immediate need to prevent hemodynamic compromise.

Question 2

A nurse is caring for a 5-year-old with confirmed rotavirus gastroenteritis. Which infection control measures should the nurse implement? (Select all that apply)

A. Airborne precautions B. Contact precautions C. Droplet precautions D. Standard precautions E. Hand hygiene with alcohol-based hand sanitizer F. Hand hygiene with soap and water

Answer: B, D, F

Rationale: Rotavirus is transmitted through the fecal-oral route and requires contact precautions (B) in addition to standard precautions (D). Hand hygiene with soap and water (F) is more effective than alcohol-based sanitizers for removing rotavirus from hands, as the virus is not effectively killed by alcohol-based products. Airborne and droplet precautions are not indicated for rotavirus infections.

Question 3

The nurse is providing discharge instructions to parents of a 3-year-old recovering from acute gastroenteritis. Which statement by the parents indicates a need for further teaching?

A. "We'll continue to give small amounts of fluids frequently." B. "We'll avoid dairy products for the next 2-3 weeks." C. "We'll monitor for signs of dehydration like decreased urination." D. "We'll gradually reintroduce a regular diet as tolerated."

Answer: B. "We'll avoid dairy products for the next 2-3 weeks."

Rationale: Avoiding dairy products for 2-3 weeks is unnecessarily restrictive. While temporary lactose intolerance can develop following gastroenteritis, most children can resume their normal diet, including dairy, within 24-48 hours as tolerated. Gradual reintroduction of regular diet, continued oral rehydration, and monitoring for dehydration are appropriate discharge instructions.

Question 4

A 1-year-old child with acute gastroenteritis has been receiving IV fluids for severe dehydration. The nurse recognizes that the child is ready for oral rehydration when:

A. The child is afebrile for 24 hours B. Vomiting has completely stopped C. Diarrhea has completely resolved D. Oral mucosa is moist and urine output is adequate

Answer: D. Oral mucosa is moist and urine output is adequate

Rationale: Adequate hydration status, as evidenced by moist mucous membranes and appropriate urine output, indicates that the child is ready to transition from IV to oral rehydration. Fever, vomiting, and diarrhea may still be present but improving as the child recovers. The goal is to transition to oral intake as soon as dehydration is corrected, even if other symptoms persist.

Question 5

The nurse is caring for a 4-year-old with a diagnosis of intussusception. Which assessment finding would the nurse expect in this child?

A. Projectile vomiting after feeding B. Clay-colored stools C. Current-jelly stools D. Tarry stools

Answer: C. Current-jelly stools

Rationale: "Current-jelly" stools (red mucus mixed with stool) are characteristic of intussusception due to the telescoping of one portion of the intestine into another, causing blood and mucus in the stool. Projectile vomiting is typically associated with pyloric stenosis, clay-colored stools with biliary obstruction, and tarry stools (melena) with upper GI bleeding.

Question 6

A 13-year-old is admitted with suspected inflammatory bowel disease. Which laboratory finding would the nurse expect to be elevated in this condition? (Select all that apply)

A. Erythrocyte sedimentation rate (ESR) B. C-reactive protein (CRP) C. White blood cell count D. Amylase E. Liver enzymes

Answer: A, B, C

Rationale: Inflammatory bowel disease (IBD) causes systemic inflammation, resulting in elevated inflammatory markers including ESR (A), CRP (B), and white blood cell count (C). Amylase is typically elevated in pancreatic disorders, not IBD. Liver enzymes may be elevated if there is extraintestinal involvement of the liver, but this is not a primary finding in IBD.

Question 7

While assessing a 5-year-old with suspected appendicitis, which finding would most specifically suggest this diagnosis?

A. Diffuse abdominal pain B. Pain in the right lower quadrant with rebound tenderness C. Pain relieved by defecation D. Periumbilical pain radiating to the back

Answer: B. Pain in the right lower quadrant with rebound tenderness

Rationale: Localized pain in the right lower quadrant (McBurney's point) with rebound tenderness is a classic finding in appendicitis. As inflammation progresses, the initially diffuse or periumbilical pain typically localizes to the right lower quadrant. Diffuse abdominal pain is nonspecific, pain relieved by defecation suggests irritable bowel syndrome, and periumbilical pain radiating to the back is more consistent with pancreatitis.

Question 8

A 2-month-old infant diagnosed with pyloric stenosis is scheduled for a pyloromyotomy. The nurse should expect which clinical manifestation in this infant?

A. Diarrhea with mucus B. Projectile vomiting C. Blood-streaked stool D. Progressive abdominal distention

Answer: B. Projectile vomiting

Rationale: Projectile (forceful) non-bilious vomiting is the classic presentation of pyloric stenosis due to the hypertrophy and narrowing of the pyloric sphincter, which obstructs gastric emptying. Diarrhea with mucus may indicate an infectious process, blood-streaked stool suggests intestinal inflammation or intussusception, and progressive abdominal distention is more consistent with intestinal obstruction.

Question 9

A nurse is caring for an infant with gastroesophageal reflux disease (GERD). Which nursing interventions would be appropriate? (Select all that apply)

A. Positioning the infant flat after feeding B. Elevating the head of the crib 30 degrees C. Thickening formula with rice cereal as prescribed D. Administering feedings continuously via feeding pump E. Burping the infant frequently during and after feeding

Answer: B, C, E

Rationale: For an infant with GERD, appropriate interventions include elevating the head of the crib (B) to reduce reflux by gravity, thickening feeds with rice cereal as prescribed (C) to increase the weight of stomach contents, and frequent burping (E) to release swallowed air. The infant should not be positioned flat after feeding (A) as this promotes reflux. Continuous feedings via pump (D) are not a first-line treatment for uncomplicated GERD.

Question 10

A 7-year-old with Crohn's disease has been prescribed corticosteroids. Which nursing assessment is most important when monitoring this child?

A. Daily weight measurements B. Hourly intake and output C. Twice daily blood glucose levels D. Weekly complete blood count

Answer: C. Twice daily blood glucose levels

Rationale: Corticosteroids can cause significant hyperglycemia as a side effect, especially in children. Monitoring blood glucose levels is essential to detect this complication early. While weight measurements, intake/output, and blood counts are important aspects of care for a child with Crohn's disease, blood glucose monitoring is specifically pertinent to corticosteroid therapy.

Question 11

A nurse is assessing a 4-year-old child with acute diarrhea. Which finding indicates severe dehydration requiring immediate intervention?

A. Slightly decreased urine output B. Irritability and restlessness C. Sunken eyes and delayed capillary refill greater than 3 seconds D. Dry lips and slightly decreased skin turgor

Answer: C. Sunken eyes and delayed capillary refill greater than 3 seconds

Rationale: Sunken eyes and delayed capillary refill greater than 3 seconds indicate severe dehydration requiring immediate intervention. Slightly decreased urine output, irritability/restlessness, and dry lips with slightly decreased skin turgor are more consistent with mild to moderate dehydration, which is concerning but less emergent.

Question 12

The nurse is educating the parents of a 3-year-old with celiac disease. Which statement by the parents indicates understanding of the dietary restrictions?

A. "We need to limit high-sugar foods in our child's diet." B. "We should avoid all products containing gluten, including wheat, rye, and barley." C. "We should eliminate all dairy products from our child's diet." D. "We need to provide a low-fat diet for our child."

Answer: B. "We should avoid all products containing gluten, including wheat, rye, and barley."

Rationale: Celiac disease requires strict avoidance of gluten, which is found in wheat, rye, and barley. This is the only correct approach to managing celiac disease, as gluten consumption causes intestinal damage in affected individuals. Limiting sugar, eliminating dairy, or following a low-fat diet will not address the autoimmune reaction to gluten that characterizes celiac disease.

Question 13

A 6-year-old child has been diagnosed with chronic constipation. Which nursing intervention should be included in the care plan? (Select all that apply)

A. Encouraging increased fluid intake B. Establishing a regular toileting schedule C. Recommending increased dietary fiber D. Limiting physical activity to prevent dehydration E. Administering daily stool softeners as prescribed

Answer: A, B, C, E

Rationale: Management of chronic constipation includes increasing fluid intake (A), establishing a regular toileting schedule (B), increasing dietary fiber (C), and using stool softeners as prescribed (E). Limiting physical activity (D) is not appropriate; in fact, regular physical activity helps promote normal bowel function and should be encouraged.

Question 14

A nurse is caring for a 2-month-old infant with biliary atresia. Which clinical finding would the nurse expect to observe?

A. Hypoglycemia B. Jaundice C. Hematemesis D. Projectile vomiting

Answer: B. Jaundice

Rationale: Biliary atresia is characterized by jaundice due to the obstruction of bile flow from the liver to the duodenum, resulting in conjugated hyperbilirubinemia. Hypoglycemia is not typical of biliary atresia, hematemesis would suggest bleeding from the upper GI tract, and projectile vomiting is associated with pyloric stenosis.

Question 15

A 10-year-old is admitted with a diagnosis of ulcerative colitis. The nurse should monitor this patient for which complication?

A. Constipation B. Hypoglycemia C. Anemia D. Respiratory distress

Answer: C. Anemia

Rationale: Ulcerative colitis causes chronic inflammation and ulceration of the intestinal mucosa, which can lead to bleeding and subsequent anemia. Constipation is not a feature of ulcerative colitis (diarrhea is more common), hypoglycemia is not typically associated with this condition, and respiratory

distress would not be directly related to ulcerative colitis unless there were severe systemic complications.

Question 16

A nurse is preparing to administer TPN to a 6-year-old with short bowel syndrome. Which nursing intervention is essential to prevent complications?

A. Changing the dressing at the insertion site daily B. Ensuring strict aseptic technique C. Infusing the solution at room temperature D. Flushing the line with heparin after administration

Answer: B. Ensuring strict aseptic technique

Rationale: Strict aseptic technique is essential to prevent catheter-related bloodstream infections in patients receiving TPN, which is a nutrient-rich medium that can support microbial growth if contaminated. Dressing changes follow specific protocols (not always daily), TPN solutions should be warmed to room temperature gradually, and line flushing protocols vary based on institutional policy and catheter type.

Question 17

The nurse is caring for a 5-year-old with acute pancreatitis. Which position would most likely decrease the child's abdominal pain?

A. Supine with legs extended B. Prone with head elevated C. Side-lying with knees flexed D. Fowler's position

Answer: C. Side-lying with knees flexed

Rationale: A side-lying position with knees flexed (fetal position) often provides comfort for patients with pancreatitis by reducing tension on the abdominal organs and minimizing pressure on the inflamed pancreas. Supine with legs extended and prone positions may increase abdominal discomfort, while Fowler's position may help but is generally not as comfortable as side-lying with knees flexed.

Question 18

A 3-year-old is diagnosed with encopresis. The nurse understands that this condition is characterized by:

A. Involuntary urination during sleep B. Painful bowel movements and constipation C. Fecal incontinence not due to organic causes D. Alternating diarrhea and constipation

Answer: C. Fecal incontinence not due to organic causes

Rationale: Encopresis refers to fecal incontinence in a child who has already been toilet trained, typically involving involuntary passage of stool in inappropriate places. It is often associated with chronic constipation and retention with overflow soiling, but the key characteristic is the fecal incontinence itself. Involuntary urination during sleep describes enuresis, painful bowel movements are a symptom of various conditions, and alternating diarrhea/constipation could suggest irritable bowel syndrome.

Question 19

A nurse is teaching the parents of a 12-month-old with gastroesophageal reflux disease (GERD). Which instruction should the nurse include? (Select all that apply)

A. "Feed smaller, more frequent meals." B. "Position your baby flat after feeding." C. "Add cereal to formula as prescribed." D. "Keep your baby upright for 30 minutes after feeding." E. "Wake your baby every 2 hours for feeding."

Answer: A, C, D

Rationale: Appropriate management for an infant with GERD includes smaller, more frequent feedings (A) to decrease gastric distention, adding cereal to formula as prescribed (C) to thicken feeds and reduce reflux, and keeping the baby upright after feedings (D) to use gravity to prevent reflux. Positioning the baby flat after feeding (B) would worsen reflux. Waking a baby every 2 hours (E) is unnecessary and may interfere with rest unless the baby has specific growth concerns.

Question 20

A 14-year-old is admitted with inflammatory bowel disease (IBD). Which nutritional intervention would be most appropriate?

A. High-fiber diet B. Clear liquid diet C. High-protein, high-calorie diet D. Low-residue diet

Answer: C. High-protein, high-calorie diet

Rationale: Adolescents with IBD often have increased metabolic demands and may experience malabsorption, weight loss, and growth delays. A high-protein, high-calorie diet helps meet nutritional needs and support growth. A high-fiber diet may exacerbate symptoms during active disease, a clear