

CCRN (Pediatric)Direct Care Eligibility Pathway Exam

AACN CCRN-Pediatric

Version Demo

Total Demo Questions: 16

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Topic Break Down

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QUESTION NO: 1

A patient has visitors whose loud talking and laughing disrupts other patients and visitors in the ICU. Which of the following is the most effective way for a nurse to address this situation?

- A. Initiate discussions about a visiting plan that includes behavioral limits
- B. Consult the social worker to create a visiting contract
- C. Create a visiting contract that includes behavioral limits and present it to the family
- D. Discuss the developmental needs of the patient with the family

ANSWER: A

Explanation:

“Initiate discussions about a visiting plan that includes behavioral limits” is the most effective response because it addresses the disruptive behavior promptly while preserving a therapeutic, family-centered relationship. The nurse should speak privately and respectfully with the visitors, describe the observed impact of excessive noise on the ICU environment, and collaboratively establish clear expectations for future visits. A visiting plan can identify practical limits such as maintaining quiet voices, limiting the number of people at the bedside, and stepping out of the unit for extended conversations or laughter. This approach supports the patient’s need for rest and healing, protects the comfort and privacy of nearby patients and families, and gives the visitors an opportunity to participate in setting realistic expectations rather than simply receiving a directive. AACN’s healthy work environment standards emphasize skilled communication, which involves clear, respectful, and authentic dialogue to address concerns and reach shared solutions. Family-centered critical care likewise recognizes families as important partners while maintaining a safe, healing environment for everyone in the unit. The plan should be communicated consistently among the care team and revisited if the behavior continues. See AACN’s [Healthy Work Environments](#) resources and the [Society of Critical Care Medicine family-centered care guidelines](#).

QUESTION NO: 2

Which therapy is expected in the management of persistent pulmonary hypertension of the newborn (PPHN)?

- A. PAOP monitoring and dobutamine
- B. O₂ therapy and RBC transfusion
- C. PAOP monitoring and sodium nitroprusside
- D. O₂ therapy and alkalinization

ANSWER: D

Explanation:

O₂ therapy and alkalinization is correct because the immediate management of PPHN is directed at lowering pulmonary vascular resistance and improving oxygen delivery. In PPHN, pulmonary vascular resistance remains abnormally elevated after birth, producing right-to-left extrapulmonary shunting and severe hypoxemia. Supplemental oxygen is a potent pulmonary vasodilator in the newborn and is used, with respiratory support as needed, to achieve appropriate oxygenation while avoiding both hypoxemia and unnecessary hyperoxia. Maintaining a normal-to-slightly alkaline pH has also traditionally been used to support pulmonary vasodilation, because acidosis increases pulmonary vascular resistance. Alkalinization may be achieved through ventilatory management and, in selected circumstances, buffering of significant metabolic acidosis. Careful monitoring is essential because aggressive hyperventilation or bicarbonate administration can cause important adverse physiologic effects. If hypoxemia and elevated pulmonary pressures persist despite optimized oxygenation, ventilation, hemodynamics, and correction of acidosis, inhaled nitric oxide is a selective pulmonary vasodilator; extracorporeal membrane oxygenation may be considered for refractory disease. See the [Merck Manual overview of PPHN](#) and the [NCBI StatPearls review of PPHN](#).

QUESTION NO: 3

While ventilating with 100% FiO₂ via Ambu bag, an intubated child desaturates. Breath sounds are decreased in all fields. What is the best action?

- A. Continue ventilating with Ambu bag
- B. Administer a bronchodilator
- C. Extubate and bag-mask ventilate
- D. Obtain a chest x-ray and ABG
- E. Pass a suction catheter through the endotracheal tube to assess for obstruction and suction secretions

ANSWER: E

Explanation:

Pass a suction catheter through the endotracheal tube to assess for obstruction and suction secretions. This child has acute oxygen desaturation despite manual ventilation with 100% oxygen, accompanied by globally diminished breath sounds. In an intubated patient, this pattern requires immediate bedside evaluation for an airway or tube problem, particularly partial or complete obstruction from retained secretions, a mucus plug, or kinking. Passing the suction catheter is both a rapid diagnostic maneuver and an intervention: inability to advance it suggests tube obstruction or malposition requiring urgent airway management, while successful passage permits removal of secretions that may be impairing ventilation. The clinician should simultaneously assess chest rise, bag resistance, tube position, and the ventilator circuit, but restoring airway patency takes priority in a rapidly desaturating child. Pediatric resuscitation guidance emphasizes prompt identification and correction of reversible causes of ineffective ventilation, including airway obstruction, during respiratory deterioration. See the American Heart Association's pediatric life-support resources at <https://cpr.heart.org/en/resuscitation-science/cpr-and-ecc-guidelines/pediatric-basic-and-advanced-life-support> and airway troubleshooting guidance from [OpenAnesthesia](#).

QUESTION NO: 4

A patient is admitted with severe anemia requiring urgent intervention. The parents refuse the transfusion due to religious beliefs. The most appropriate action by the nurse is to:

- A. Consult the hospital's ethics committee and legal team while providing alternative treatments
- B. Convince the parents to change their mind by emphasizing the severity and potential for fatality
- C. Immediately administer the transfusion to save the patient's life, regardless of the parents' wishes
- D. Respect the family's wishes to withhold the blood transfusion, and document their refusal

ANSWER: A

Explanation:

Consult the hospital's ethics committee and legal team while providing alternative treatments is correct because the nurse's immediate professional responsibility is to advocate for the child's best interests while escalating a potentially life-threatening treatment refusal through established institutional channels. In pediatric care, parents ordinarily provide permission for treatment, but their authority is not absolute when refusal places a child at substantial risk of serious harm or death. Prompt notification of the treating clinician, ethics resources, and legal/risk-management personnel supports an organized, time-sensitive plan that considers the child's clinical urgency, applicable state law, available court or protective mechanisms, and the family's religious values. The nurse should continue close assessment, communicate respectfully and clearly with the family and interprofessional team, document the refusal and escalation, and facilitate clinically appropriate nonblood or blood-conservation measures when feasible. This approach reflects AACN's ethical emphasis on advocacy, collaboration, and protecting vulnerable patients, while ensuring decisions about emergent care are made under appropriate medical and legal authority rather than by the nurse alone. See the [AACN ethics resources](#) and the American Academy of Pediatrics discussion of [conflicts involving religious beliefs and a child's medical care](#).

QUESTION NO: 5

A nursing practice council is reviewing a protocol for flushing unused IV lines. A team member questions the use of saline vs. dextrose. What should the council do first?

- A. Identify the outcomes
- B. Develop research methods
- C. Determine the problem
- D. Plan interventions

ANSWER: C

Explanation:

Determine the problem is the appropriate first action because the council must clearly define the practice concern before selecting outcomes, designing methods, or planning a change. In this situation, the concern is not simply that two solutions are available; it is the specific uncertainty about which flush solution is appropriate for unused IV lines in the relevant pediatric population and clinical context. Defining the problem allows the council to formulate a focused, answerable clinical question, such as whether saline rather than dextrose affects line patency, medication compatibility, or patient safety. A well-constructed question identifies the population, intervention or comparison, and outcomes of interest, which then directs an efficient search for evidence and supports a meaningful review of the current protocol. This sequence reflects evidence-based practice: clinicians first identify a clinical problem or knowledge gap, then acquire and appraise evidence before implementing and evaluating practice changes. AACN identifies evidence-based practice as a component of professional nursing practice and provides resources to support its use in critical care. See the [AACN Evidence-Based Practice resources](#) and the [Agency for Healthcare Research and Quality evidence-based practice tools](#).

QUESTION NO: 6

A family member asks permission to visit a patient after work at 12:30 AM. On previous visits, the family member has been disruptive. To address the situation, a nurse should:

- A. Ask the family member to visit before work
- B. Ask the family member to visit during scheduled visiting hours
- C. Not allow the visit, as the patient will be sleeping
- D. Allow the family member to visit after setting behavioral limits

ANSWER: D

Explanation:

“Allow the family member to visit after setting behavioral limits” is correct because family presence is an important component of patient- and family-centered critical care, including pediatric critical care. A late visit may be especially meaningful when work obligations prevent the family member from attending at conventional times. The prior disruptive behavior does require intervention, but it is best addressed proactively through clear, respectful, and individualized expectations rather than automatically withholding access. Before the visit, the nurse should communicate specific limits that protect the patient’s rest, privacy, safety, and the therapeutic environment. These limits may include speaking quietly, limiting the number of visitors, avoiding interference with care, following staff directions, and leaving if behavior becomes disruptive. The nurse should also explain the consequences of not following these expectations and document relevant concerns and the agreed plan according to unit policy. This approach balances the family member’s opportunity to participate in the patient’s care and support with the nurse’s responsibility to maintain a safe, healing environment. AACN supports flexible, patient-centered family visitation practices and recognizes that visitation plans may need individual boundaries to preserve safety and quality of care. See AACN’s [Family Presence: Visitation in the Adult ICU](#) practice alert and the Society of Critical Care Medicine’s [family-centered care guidelines](#).

QUESTION NO: 7

For a child with disseminated intravascular coagulation (DIC), administration of fresh frozen plasma (FFP) will replace:

- A. All clotting factors
- B. Factors I, III, and IX only
- C. Fibrinogen
- D. Factors I, V, and VII only

ANSWER: A

Explanation:

All clotting factors is correct because fresh frozen plasma is the plasma portion of whole blood frozen promptly after collection and retains a broad complement of functional coagulation proteins. This includes fibrinogen and both stable and labile factors, such as factors V and VIII, as well as the other factors required for coordinated thrombin generation and fibrin clot formation. In DIC, pathologic systemic activation of coagulation consumes platelets and multiple coagulation factors; affected children may then develop clinically significant bleeding with prolonged coagulation studies. When replacement is clinically indicated—particularly for active bleeding or before an invasive procedure—FFP provides the comprehensive, multi-factor replacement needed to support hemostasis while clinicians identify and treat the underlying cause of DIC. It is therefore not a single-factor product; its relevant therapeutic role is replacement of the broad factor deficiency that can occur with consumptive coagulopathy. Guidance on plasma transfusion describes FFP as containing all coagulation factors and supports its use for bleeding associated with multiple-factor deficiency, including DIC. See [StatPearls: Fresh Frozen Plasma](#) and [Merck Manual: Disseminated Intravascular Coagulation](#).

QUESTION NO: 8

In a patient with status asthmaticus on a terbutaline drip, serum electrolytes are ordered because frequent administration of a beta-agonist can cause:

- A. Hyperglycemia and hypochloremia
- B. Hypoglycemia and mild hypermagnesemia
- C. Hypernatremia and hypocalcemia
- D. Hypokalemia and hypophosphatemia

ANSWER: D

Explanation:

Hypokalemia and hypophosphatemia is correct. Terbutaline is a beta₂-adrenergic agonist, and continuous or frequent beta-agonist therapy can produce clinically important intracellular electrolyte shifts. Beta₂ stimulation activates sodium-potassium ATPase activity, driving potassium from the extracellular space into cells and lowering the measured serum potassium concentration. This effect can be amplified in critically ill children receiving high-dose or continuous therapy and may contribute to weakness or cardiac dysrhythmia risk, particularly when other potassium-lowering factors are present.

Beta-agonist stimulation can also lower serum phosphate through intracellular redistribution and increased cellular uptake. Phosphate is essential for ATP generation, oxygen delivery through red-cell metabolism, and skeletal and respiratory muscle function. In status asthmaticus, identifying and correcting significant hypophosphatemia is important because respiratory muscle fatigue may complicate recovery. Therefore, monitoring serum electrolytes during a terbutaline infusion supports timely recognition of these anticipated treatment-associated abnormalities. The terbutaline prescribing information identifies hypokalemia as a potential beta-adrenergic effect, and published evidence describes decreases in both potassium and phosphate during intensive beta-agonist treatment for acute asthma. See [DailyMed terbutaline information](#) and [the PubMed-indexed study of electrolyte changes during beta-agonist therapy](#).

QUESTION NO: 9

When preparing a 2-month-old with hypoplastic left heart syndrome for a cardiac transplant, which of the following findings is most alarming?

- A. O₂ saturation of 75%
- B. Temperature of 102.2° F (39° C)
- C. Increased RV pressure
- D. BP of 72/48

ANSWER: B

Explanation:

Temperature of 102.2° F (39° C) is the most alarming finding because a fever in a 2-month-old awaiting heart transplantation requires immediate evaluation for a serious infection, including bacteremia or sepsis. Young infants can deteriorate rapidly with infection, and an infant with hypoplastic left heart syndrome has limited cardiovascular reserve to compensate for the increased metabolic demand, tachycardia, vasodilation, and potential myocardial dysfunction associated with fever and systemic inflammation. Infection also has direct implications for transplant readiness: an active uncontrolled infection must be identified and treated before transplantation, because proceeding to transplant would require immunosuppression and could markedly worsen an infectious process. The pediatric critical care response should include prompt assessment of perfusion and cardiorespiratory status, acquisition of appropriate cultures and laboratory studies, and timely antimicrobial therapy when clinically indicated. The American Academy of Pediatrics recognizes fever in infants younger than 60 days as a condition requiring careful, urgent assessment for invasive bacterial infection; this child is only slightly older and has major congenital heart disease, which further increases clinical concern. Heart-transplant candidate guidance likewise emphasizes evaluating and managing active infection before transplant. See the [American Academy of Pediatrics febrile-infant guideline](#) and the [ISHLT guideline for heart-transplant candidates](#).

QUESTION NO: 10

A 6-month-old patient presents with bronchiolitis and respiratory distress. Upon admission, the patient has mild retractions, scattered crackles, copious secretions, diarrhea with significant diaper dermatitis, and weight/height/head circumference less than the 5th percentile. The patient's vital signs are:

BP: 80/45

HR: 150

RR: 42

Temp: 98.8°F (37.1°C)

SpO₂: 96% on 4L heated high flow nasal cannula

A nurse should consider that the patient:

- A. Needs an arterial blood gas
- B. Requires a wound care consult
- C. Needs CPAP
- D. Requires a nutrition assessment

ANSWER: D

Explanation:

Requires a nutrition assessment is correct because this infant has multiple findings that raise concern for impaired growth and nutritional compromise. Weight, length, and head circumference below the 5th percentile warrant prompt evaluation of growth trends, intake, feeding tolerance, hydration, and possible underlying causes. Diarrhea can contribute to fluid and nutrient losses, while severe diaper dermatitis may accompany frequent stooling and can further interfere with comfort and

feeding. In an infant with bronchiolitis, increased work of breathing also increases energy expenditure and can make oral feeding more difficult, placing a child with limited nutritional reserves at greater risk for deterioration.

A comprehensive pediatric nutrition assessment should include review of prior growth measurements, weight-for-length and head-growth trajectory, recent feeding history, formula preparation or breast-feeding adequacy, stool characteristics, hydration status, and the need for dietitian involvement. Early identification of malnutrition or feeding impairment supports an individualized plan for safe caloric and protein delivery while respiratory illness is managed. The American Academy of Pediatrics emphasizes that growth assessment is a central component of pediatric nutritional evaluation, particularly when growth parameters are low or faltering. See the [American Academy of Pediatrics Bright Futures resources](#) and the [CDC clinical growth charts](#).

QUESTION NO: 11

An infant is admitted with tonic-clonic movement of the lower extremities. The most likely etiology of the seizure is:

- A. Lead poisoning
- B. A febrile illness
- C. A brain tumor
- D. An arteriovenous malformation

ANSWER: B

Explanation:

A febrile illness is the most likely etiology because febrile seizures are the most common seizure type associated with childhood fever, occurring most often from 6 months through 5 years of age. They occur when a child has a fever without evidence that the seizure is caused by a central nervous system infection, a major metabolic abnormality, or a prior unprovoked seizure. The motor activity may include tonic stiffening followed by rhythmic clonic jerking of the extremities. In a previously healthy infant within the usual age range, an acute febrile illness is therefore an important and statistically common explanation for a new convulsive event. Clinical evaluation should establish the presence and source of fever and assess for features that suggest a more serious infection or another acute cause. The American Academy of Pediatrics describes febrile seizures as seizures occurring in association with fever in young children and provides guidance for evaluating a child after a simple febrile seizure. The National Institute of Neurological Disorders and Stroke also notes that febrile seizures occur in infants and young children during fever. See the [American Academy of Pediatrics guideline](#) and [NINDS overview of febrile seizures](#).

QUESTION NO: 12

Parent teaching for a child with encephalopathy should include which of the following?

- A. Neurologic damage will be minimal
- B. The condition is caused by a contagious agent
- C. Antibiotics are effective
- D. Often, no causative agent is found

ANSWER: D

Explanation:

Often, no causative agent is found is appropriate teaching because encephalopathy describes diffuse cerebral dysfunction rather than one single disease process. In children, the clinical syndrome may occur with a broad range of metabolic, toxic, hypoxic-ischemic, infectious, inflammatory, genetic, or systemic contributors. Even after a careful history, examination, laboratory testing, neuroimaging, and targeted studies, an immediately identifiable cause is not always established. Parents need clear, honest counseling that the team will continue to evaluate potentially reversible contributors while providing

supportive neurologic and critical care based on the child's presentation. This discussion helps families understand why diagnostic testing may be extensive and why treatment may focus on stabilizing airway, breathing, circulation, seizures, nutrition, and metabolic abnormalities while the evaluation proceeds. The term encephalopathy itself therefore does not establish a specific etiology; communicating diagnostic uncertainty when present is both accurate and important for realistic family expectations. Clinical references similarly characterize encephalopathy as a diffuse brain dysfunction with diverse causes and emphasize assessment directed at identifying treatable underlying conditions. See the [NCBI Bookshelf review of encephalopathy](#) and the [Merck Manual overview of impaired consciousness and diffuse cerebral dysfunction](#).

QUESTION NO: 13

Why are unit admission and discharge criteria developed?

- A. Identify criteria for withholding treatment
- B. Address triage decisions
- C. Provide ethical decision-making guidelines**
- D. Secure managed care contracts

ANSWER: B

Explanation:

Unit admission and discharge criteria are developed to address triage decisions. In pediatric critical care, demand for specialized beds, monitoring, equipment, and expert staffing may exceed immediate availability. Predetermined, clinically appropriate criteria help the interprofessional team decide which patients require the unit's level of care, when transfer to a less acute setting is appropriate, and how to prioritize access when capacity is limited. This creates a consistent framework for matching patient acuity and anticipated benefit with available critical care resources.

Triage criteria also support timely reassessment as a child's condition changes. A patient may need admission because of actual or potential physiologic instability, while discharge readiness reflects whether critical-care interventions and surveillance are no longer necessary. Using established criteria promotes transparent, equitable, and defensible allocation decisions while maintaining patient safety and continuity of care. This application of objective unit standards is consistent with AACN's emphasis on ethical practice and responsible stewardship of healthcare resources. See AACN's [Ethics resources](#) and the Society of Critical Care Medicine's [ICU Admission, Discharge, and Triage Guidelines](#).

QUESTION NO: 14

Four hours after congenital heart surgery, a child develops tachycardia, hypotension, rising central venous pressure, and muffled heart sounds. Chest tube output has abruptly decreased despite persistent mediastinal widening on chest x-ray. The nurse should suspect:

- A. Cardiac tamponade**
- B. Hypovolemic shock from ongoing chest tube loss
- C. Acute left-sided heart failure from volume overload
- D. Vasodilatory shock from a medication reaction

ANSWER: A

Explanation:

Cardiac tamponade is the most likely complication. The combination of hypotension, elevated central venous pressure, tachycardia, diminished heart sounds, and decreased chest tube drainage after cardiac surgery suggests accumulation of blood in the pericardial space, possibly because of obstructed chest tube drainage. Increasing intrapericardial pressure limits ventricular filling and rapidly decreases cardiac output. This is a surgical emergency requiring immediate notification of the

cardiac surgical team and preparation for urgent intervention. Fluid administration alone may provide temporary support but does not relieve the obstruction to cardiac filling.

QUESTION NO: 15

An infant with a sternal wound infection has a negative-pressure wound therapy device in place. A nurse should recognize that the primary purpose of the device is to speed healing of the wound through:

- A. Maintenance of a seal around the wound
- B. Maintenance of a clean, moist wound environment
- C. Removal of exudate and stimulation of vascular growth
- D. The use of subatmospheric pressure through suction

ANSWER: C

Explanation:

Removal of exudate and stimulation of vascular growth is correct because negative-pressure wound therapy promotes healing through several physiologic effects produced by controlled subatmospheric pressure. The system continuously removes wound drainage, edema fluid, and infectious material into a collection canister, which helps reduce local swelling and improves the wound bed. The negative pressure also causes mechanical deformation (microdeformation) at the wound surface. This mechanical stimulus supports cellular activity, angiogenesis, and the formation of healthy granulation tissue. Improved local perfusion and granulation are especially valuable in deep or complex wounds, including an infected sternotomy wound in an infant, where management of drainage and development of a vascularized wound bed are essential to healing. Although a sealed dressing and suction are necessary components of delivering therapy, the clinically meaningful purpose is the resulting exudate management and stimulation of granulation and vascular growth. The U.S. Food and Drug Administration describes negative-pressure wound therapy as applying suction to remove fluid and assist wound healing. The Wound, Ostomy and Continence Nurses Society also identifies fluid removal, edema reduction, and promotion of granulation tissue among its therapeutic effects. See the [FDA overview of NPWT devices](#) and the [WOCN Society](#).

QUESTION NO: 16

A school-age child is admitted in acute respiratory failure requiring mechanical ventilation. Endotracheal aspirate Gram staining is positive for an acid-fast bacillus. The nurse's initial action should be to:

- A. Initiate antiviral therapy
- B. Contact the parents and discuss the implications of the laboratory findings
- C. Send another specimen for repeat laboratory examination
- D. Move the patient to a negative-pressure room

ANSWER: D

Explanation:

Move the patient to a negative-pressure room is the priority because acid-fast bacilli in a respiratory specimen raise immediate concern for pulmonary tuberculosis, which can be transmitted through airborne droplet nuclei. Infection-control measures must begin when tuberculosis is suspected; they should not wait for culture identification or confirmation. The appropriate placement is an airborne infection isolation room (AIIR), commonly called a negative-pressure room. This room maintains directional airflow so air moves into, rather than out of, the room, limiting exposure of other patients, visitors, and healthcare personnel. Because the child is mechanically ventilated, the airway circuit should remain closed as much as possible, and respiratory care procedures should be performed using airborne-precaution practices. The nurse should promptly coordinate safe transfer and notify the infection-prevention and respiratory-care teams while maintaining necessary lifesaving ventilatory support. The CDC states that patients with suspected or confirmed infectious tuberculosis should be placed in an AIIR under airborne precautions. CDC guidance on preventing transmission of *Mycobacterium tuberculosis* in

healthcare settings is available at [CDC: Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings](#); current isolation-precaution principles are summarized at [CDC: Isolation Precautions](#).