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Nursing

RNC-LRN

NCC Low Risk Neonatal Nursing - 2025

Question: 846

A term infant, now 72 hours old, born to a mother with hepatitis C, weighs 3.3 kg and received no prophylaxis at birth. Labs show a WBC of 15,000/mm³, neutrophils 40%, lymphocytes 50%, and IgM <5 mg/dL. The CRP is 8 mg/L. What does the IgM level indicate, and what infection control measure should the nurse enforce?

A. Normal immunity; continue routine care
B. Acute infection; apply contact precautions
C. Limited antibody production; enforce handwashing
D. Maternal antibody failure; limit visitation

Answer: C

Explanation: Undetectable IgM (<5 mg/dL) is normal, reflecting the infant's inability to produce antibodies, increasing hepatitis C risk. Strict handwashing prevents pathogen spread, critical given the immature immune system and potential exposure.

Question: 847
A 33-year-old G3P2 woman at 38 weeks gestation with a triplet pregnancy delivers via cesarean section due to fetal distress in Triplet C. Birth weights are Triplet A 2,600 g, Triplet B 2,400 g, and Triplet C 1,900 g. Triplet C's hematocrit is 58%, and blood viscosity is elevated. What neonatal complication is most likely for Triplet C?

A. Polycythemia
B. Respiratory distress syndrome
C. Hypoglycemia
D. Intrauterine growth restriction

Answer: A

Explanation: In multiple gestations, Triplet C's low weight (1,900 g) and high hematocrit (58%) suggest polycythemia, possibly from unequal placental sharing. IUGR is present but secondary, while RDS and hypoglycemia are less directly tied to these lab findings.

Question: 848

A term infant, now 48 hours old, born via emergency cesarean, is on nasal cannula at 1 L/min with an

FiO2 of 30%. The infant weighs 3.7 kg, and an ABG shows pH 7.42, PaCO2 36 mmHg, PaO2 68 mmHg, and HCO3 23 mEq/L. The SaO2 is 95%. What should the nurse do?

A. Switch to CPAP at 5 cm H2O with 30% FiO2
B. Increase FiO2 to 35%
C. Maintain current settings
D. Reduce flow to 0.5 L/min

Answer: C

Explanation: Normal pH (7.42), PaCO2 (36 mmHg), and adequate oxygenation (PaO2 68 mmHg, SaO2 95%) indicate stability on nasal cannula. Maintaining settings is appropriate. Increasing FiO2 or switching to CPAP is unnecessary, and reducing flow risks hypoxemia.

Question: 849

A 35-week neonate with a history of prolonged rupture of membranes develops jittery movements and irritability on day 2. Serum glucose is 55 mg/dL, calcium is 7.5 mg/dL, and CSF analysis shows 80 WBCs/mm³ (90% neutrophils), glucose 20 mg/dL, and protein 150 mg/dL. What is the most likely underlying condition mimicking jitteriness?

A. Hypocalcemia
B. Subdural hematoma
C. Hypoglycemia
D. Meningitis

Answer: D

Explanation: Jittery movements and irritability with CSF pleocytosis (80 WBCs/mm³), low glucose (20 mg/dL), and high protein (150 mg/dL) indicate meningitis, likely from prolonged rupture of membranes. Normal serum glucose (55 mg/dL) rules out hypoglycemia, mild hypocalcemia (7.5 mg/dL) is unlikely to cause this alone, and subdural hematoma would not explain the CSF findings.

Question: 850

A 34-year-old G3P2 woman at 35 weeks gestation presents with severe epigastric pain, nausea, and a blood pressure of 165/105 mmHg. Laboratory results show a platelet count of 85,000/mm³, AST 220 U/L, ALT 250 U/L, and LDH 950 U/L. The neonate is delivered emergently via cesarean section with an umbilical artery pH of 7.16, PCO2 60 mmHg, and base deficit -13 mEq/L. What maternal condition most likely contributed to the neonatal acidosis?

A. Placental abruption
B. HELLP syndrome
C. Chorioamnionitis
D. Cord prolapse

Answer: B

Explanation: The maternal symptoms (epigastric pain, hypertension) and labs (thrombocytopenia, elevated liver enzymes, high LDH) indicate HELLP syndrome, a severe preeclampsia variant. This condition causes placental insufficiency, leading to fetal hypoxia and acidosis (pH 7.16, base deficit -13 mEq/L). Placental abruption involves bleeding, chorioamnionitis requires infection signs, and cord prolapse causes variable decelerations, not this pattern.

Question: 851

A 34-year-old mother delivered a term infant 6 days ago and is taking fluoxetine 20 mg daily for postpartum depression. The infant is exclusively breastfed, gaining 25 g/day, but exhibits irritability and poor sleep. Fluoxetine levels in breast milk are 50 ng/mL (therapeutic range: 20–100). What is the most likely medication effect on this infant?

A. Gastrointestinal irritation from fluoxetine
B. Reduced milk quality from maternal depression
C. Drug withdrawal from inconsistent exposure
D. Serotonin excess causing neurobehavioral changes

Answer: D

Explanation: Irritability and poor sleep with fluoxetine levels of 50 ng/mL suggest serotonin excess in the infant via breast milk, a known side effect of SSRIs. Milk quality, withdrawal, and GI irritation are less consistent with the infant's normal weight gain and exposure pattern.

Question: 852

A 38-week gestation male neonate, now 3 days old, is noted to have a reducible mass in the left inguinal canal during a bath. The neonate is asymptomatic, feeding well, and has normal bowel movements. What is the most appropriate management for this inguinal hernia?

A. Emergent surgical repair
B. Observation for spontaneous resolution
C. Elective repair within 1-2 months
D. Manual reduction and truss application

Answer: C

Explanation: A reducible inguinal hernia in an asymptomatic neonate does not require emergent surgery but should be repaired electively within 1-2 months to prevent incarceration, a risk due to the patent processus vaginalis. Observation alone is insufficient, and trusses are not standard care. Timing balances risk and surgical readiness.

Question: 853

A 34-week preterm neonate presents with short limbs, a large head with frontal bossing, and a narrow thorax on X-ray. The neonate develops respiratory distress, and skeletal survey confirms rhizomelic shortening and metaphyseal flaring. Genetic testing reveals an FGFR3 mutation. What is the most likely diagnosis and its inheritance pattern?

A. Cystic fibrosis with autosomal recessive inheritance
B. Trisomy 21 with nondisjunction
C. Achondroplasia with autosomal dominant inheritance
D. DiGeorge syndrome with microdeletion

Answer: C

Explanation: The short limbs, large head, narrow thorax, and FGFR3 mutation confirm achondroplasia, an autosomal dominant skeletal dysplasia, often a new mutation. Trisomy 21 lacks skeletal findings, cystic fibrosis affects lungs and pancreas, and DiGeorge involves 22q11.2 deletion, not FGFR3.

Question: 854
A neonate is delivered at 43 weeks gestation with a birth weight of 3,400 g (25th percentile), length of 52 cm (50th percentile), and head circumference of 36 cm (50th percentile). Physical exam shows dry cracked skin, long nails, and meconium staining. The neonate develops seizures at 12 hours. What is the most likely classification and complication?

A. Post-term with perinatal asphyxia
B. Term with hypoglycemia
C. Late preterm with respiratory distress
D. Preterm with hypothermia

Answer: A
Explanation: At 43 weeks with post-term features (cracked skin, long nails) and AGA measurements, the neonate is post-term. Seizures suggest perinatal asphyxia, a risk from placental dysfunction. Other options do not align with gestation or symptoms.

Question: 855

A term infant, now 72 hours old, presents with lethargy and a glucose of 28 mg/dL (normal: >50). The infant weighs 3.5 kg, and the nurse starts D10W at 80 mL/kg/day via a peripheral IV. A metabolic panel shows sodium 134 mEq/L (normal: 135–145) and calcium 7.8 mg/dL (normal: 8.5–10.5). What should the nurse prioritize?

A. Monitor urine output for fluid balance
B. Increase dextrose to 12.5% in the IV fluid
C. Administer calcium gluconate 100 mg/kg IV
D. Request a sodium bolus to correct hyponatremia

Answer: C

Explanation: Hypocalcemia (7.8 mg/dL) with severe hypoglycemia (28 mg/dL) and lethargy requires urgent calcium correction to prevent complications like seizures. Glucose is addressed, urine monitoring is secondary, and mild hyponatremia (134 mEq/L) doesn't need a bolus.

Question: 856
A neonate born at 36 weeks gestation weighs 2,500 g (50th percentile), with a length of 46 cm (50th percentile) and head circumference of 32 cm (50th percentile). Physical exam shows soft ears, minimal lanugo, and a calcium level of 7.0 mg/dL at 24 hours with jitteriness. What is the most likely classification and complication?

A. Preterm with apnea
B. Late preterm with hypocalcemia
C. Term with polycythemia
D. Post-term with jaundice

Answer: B
Explanation: At 36 weeks with AGA measurements (50th percentile) and late preterm features (soft ears), the neonate is late preterm. Hypocalcemia (7.0 mg/dL) causes jitteriness, a common issue in late preterm infants due to immature parathyroid function. Other options mismatch gestation or findings.

Question: 857

A term infant, now 6 days old, is receiving morphine 0.1 mg/kg/dose IV every 4 hours for postoperative pain after a pyloromyotomy. The infant weighs 3.8 kg, and the NIPS score is 4 (moderate pain) despite three doses. A blood level is 25 ng/mL (therapeutic: 10–40 ng/mL). What pharmacological intervention should the nurse consider?

A. Add acetaminophen as an adjunct
B. Increase the dose to 0.15 mg/kg for better control
C. Switch to fentanyl for faster onset
D. Reduce the interval to every 3 hours

Answer: A

Explanation: A NIPS score of 4 with a therapeutic level (25 ng/mL) suggests inadequate pain control. Adding acetaminophen enhances analgesia without escalating opioid risks. Increasing dose or frequency risks toxicity, and switching to fentanyl is unnecessary with morphine's efficacy.

Question: 858
A 36-week gestation male neonate, now 7 days old, has a urine output of 0.6 mL/kg/hour and a serum sodium of 150 mEq/L. The neonate is on formula feeds and has no edema. Ultrasound shows normal kidneys. What is the most likely cause of this renal function alteration?

A. Diabetes insipidus
B. Dehydration
C. Syndrome of inappropriate ADH
D. Renal tubular acidosis

Answer: B

Explanation: Low urine output with hypernatremia and normal kidneys suggest dehydration, likely from inadequate fluid intake or losses, common in preterms transitioning to feeds. Diabetes insipidus causes dilute urine, SIADH causes hyponatremia, and renal tubular acidosis involves acidosis, none aligning with this presentation.

Question: 859

A nurse assesses the gag reflex in a 2-day-old neonate with a PaCO2 of 55 mmHg and HCO3 of 28 mEq/L. The reflex is present but weak. What is the most likely cause?

A. Cranial nerve damage
B. Normal variation in reflex strength
C. Metabolic alkalosis enhancing the reflex
D. Respiratory acidosis weakening the reflex

Answer: D

Explanation: PaCO2 55 mmHg and HCO3 28 mEq/L indicate respiratory acidosis with partial compensation, which can cause lethargy and weaken reflexes like the gag. Option B is incorrect as a weak gag is not typical.

Question: 860

A preterm infant born at 35 weeks gestation, now 5 days old, is receiving sucrose 24% orally for pain during a venous puncture. The infant's heart rate is 165 bpm (baseline 140), and the N-PASS score is 3 (mild pain). What nonpharmacological intervention should the nurse add?

A. Increase ambient light for distraction
B. Apply a cold pack to the site
C. Swaddle the infant during the procedure
D. Delay the puncture for 30 minutes

Answer: C

Explanation: A score of 3 with tachycardia (165 bpm) indicates mild pain despite sucrose. Swaddling enhances comfort and reduces stress, complementing sucrose. Cold packs numb but don't soothe, light increases distress, and delay doesn't address immediate pain.

Question: 861
A 38-week gestation male neonate, now 3 days old, undergoes circumcision with a Plastibell device. On day 7, the parents note the ring has not fallen off, and the penis is swollen with a grayish discoloration. What is the most likely postoperative complication requiring intervention?

A. Retained Plastibell ring
B. Necrosis from tight ring
C. Wound infection
D. Adhesion formation

Answer: B

Explanation: Delayed ring detachment with swelling and grayish discoloration suggest necrosis from a tight Plastibell ring compromising blood flow, requiring urgent removal. Infection involves fever, retained ring alone doesn't cause discoloration, and adhesions form later, none matching this ischemic picture.

Question: 862

A 34-week preterm neonate presents with holoprosencephaly, polydactyly, and a midline facial cleft. Karyotype analysis shows 47,XY,+13, and the neonate develops apnea requiring ventilation. What is the most appropriate family counseling point regarding recurrence risk?

A. High risk due to autosomal recessive inheritance
B. Recurrence risk is low due to sporadic nondisjunction
C. Moderate risk due to parental translocation
D. No risk as it's a de novo mutation

Answer: B

Explanation: The features (holoprosencephaly, polydactyly, midline cleft) and karyotype 47,XY,+13 confirm Trisomy 13, typically a sporadic nondisjunction event with low recurrence risk (<1%) unless a parental translocation is identified (not suggested here). Recessive inheritance and de novo mutation mischaracterize this condition.

Question: 863

During a neurological exam, a nurse strokes the sole of a 3-day-old neonate's foot from heel to toe in an inverted "J" pattern. The big toe dorsiflexes, and the other toes fan outward bilaterally. The neonate's serum ionized calcium is 4.0 mg/dL (normal: 4.4-5.2 mg/dL), and magnesium is 1.8 mg/dL. How should the nurse interpret this Babinski reflex finding?

A. Abnormal response indicating upper motor neuron dysfunction
B. Hypocalcemia-induced exaggeration of the reflex

C. Normal finding for a neonate of this age
D. Potential spinal cord injury requiring imaging

Answer: C

Explanation: A positive Babinski reflex (dorsiflexion of the big toe with fanning of others) is normal in neonates up to 12-24 months due to immature corticospinal tracts. The slightly low ionized calcium (4.0 mg/dL) may cause neuromuscular irritability, but it does not alter the Babinski reflex's expected presence in a 3-day-old.

Question: 864

A 33-year-old mother delivered a term infant 6 days ago and is supplementing breastfeeding with formula due to perceived low supply. The infant's weight gain is 25 g/day, and the mother asks about the composition of formula compared to breast milk. Lab results show infant iron at 55 µg/dL (normal: 60–170). What should the nurse explain?

A. Formula lacks antibodies found in breast milk
B. Formula has higher iron to prevent anemia
C. Formula contains more fat than breast milk
D. Formula is lower in carbohydrates

Answer: B

Explanation: Low iron (55 µg/dL) and normal weight gain (25 g/day) highlight a nutritional gap. Formula is fortified with higher iron than breast milk to prevent anemia, a key compositional difference. Antibodies, fat, and carbs vary, but iron is most relevant here.

Question: 865
A 28-year-old G1P0 woman at 39 weeks gestation undergoes a cord gas analysis at delivery due to prolonged second stage labor. The umbilical artery pH is 7.10, PCO2 is 60 mmHg, and base deficit is -15 mEq/L. The neonate's Apgar scores are 5 at 1 minute and 7 at 5 minutes. What is the most likely neonatal complication?

A. Cerebral palsy
B. Hypoxic-ischemic encephalopathy
C. Respiratory distress syndrome
D. Seizures

Answer: B

Explanation: Severe acidosis (pH 7.10, base deficit -15 mEq/L) and low Apgar scores indicate perinatal asphyxia, increasing the risk of hypoxic-ischemic encephalopathy. Cerebral palsy is a long-term outcome, not an immediate complication. Respiratory distress and seizures may occur but are secondary to HIE.

Question: 866

A term infant, now 72 hours old, is being treated for suspected neonatal sepsis with intravenous gentamicin. The ordered dose is 4 mg/kg every 24 hours, and the infant weighs 3.2 kg. The nurse administers 12.8 mg at 0800, but a trough level drawn at 0700 the next day is 2.5 µg/mL (therapeutic: 0.5–2 µg/mL; toxic: >2 µg/mL). What pharmacokinetic principle should guide the nurse's next action?

A. Hold the next dose and notify the provider
B. Adjust the dose downward due to reduced clearance
C. Increase the dosing interval to 36 hours
D. Continue the current regimen and recheck in 24 hours

Answer: A

Explanation: A trough level of 2.5 µg/mL exceeds the therapeutic range, indicating accumulation due to immature renal clearance in a 72-hour-old infant. Holding the dose and notifying the provider prevents toxicity, aligning with pharmacokinetic monitoring of blood drug levels. Adjusting without consultation, altering intervals arbitrarily, or continuing risks harm.

Question: 867

A term neonate born to a mother with a history of unexplained stillbirth presents on day 4 with pallor, hematocrit of 30%, hemoglobin of 10 g/dL, reticulocyte count of 12%, and total bilirubin of 16 mg/dL (direct 0.6 mg/dL). DAT is negative. What is the most likely underlying condition?

A. Fetal-maternal hemorrhage
B. Physiologic anemia
C. Hereditary spherocytosis
D. Sickle cell disease

Answer: A

Explanation: The pallor, anemia (hematocrit 30%, hemoglobin 10 g/dL), high reticulocyte count (12%), and unconjugated hyperbilirubinemia (15.4 mg/dL) with a negative DAT and maternal history of stillbirth suggest fetal-maternal hemorrhage causing acute blood loss. Hereditary spherocytosis would likely have a positive DAT or spherocytes, physiologic anemia occurs later, and sickle cell disease would show HbSS on screening.

Question: 868

A 34-week preterm infant, now 10 days old, has a serum calcium of 6.3 mg/dL, phosphorus of 8.8 mg/dL, and alkaline phosphatase of 480 U/L. The infant is on TPN with minimal enteral feeds. What is a potential consequence if this condition persists?

A. Pathologic fractures
B. Cataracts

C. Adrenal insufficiency
D. Hepatomegaly

Answer: A

Explanation: The infant’s hypocalcemia (6.3 mg/dL), hyperphosphatemia (8.8 mg/dL), and elevated alkaline phosphatase (480 U/L) indicate metabolic bone disease of prematurity. If untreated, poor bone mineralization can lead to pathologic fractures, a significant consequence in preterm infants with prolonged TPN use.

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