2019 HESI MATERNITY CORECT ANSWERS TO THE SCREENSHOTS

1. A primipara has delivered a stillborn fetus at 30 weeks gestation. To assess the parents in the grieving process which intervention is most for the nurse to implement?
   - ✓ provide a time for the parents to hold their infant in privacy
2. What is the priority nursing assessment immediately following the birth of an infant with esophageal atresia and a tracheoesophageal (the) fistula?
   - ✓ Time of first void
3. What is the most important assessment for the nurse to conduct the following the administration of epidural anesthesia to a client who is at 40 weeks gestation?
   - ✓ Maternal blood pressure
4. A 34-week primigravida with preeclampsia is receiving Lactated Ringer's 500 ML with magnesium sulfate 20 grams at the rate of 3 grams/hour. How many mL/hours should be the nurse program into the infusion pump?
   - ✓ 75mL/hour
5. A 6-year old with heart failure (HF) gained 2 pounds in the last 24 hours. Which intervention is most important for the nurse to implement?
   - ✓ Assess bilateral lung sounds
6. A mother of a 3-year-old boy has just given birth to a new baby girl. The little boy asks the nurse, "why is my baby sister eating my mommy's breast?" How should the nurse respond? (Select all that apply.)
   - ✓ Remind him that his mother breastfed him too
   - ✓ Reassure the older brother that it does not hurt
   - ✓ Explain that newborns get milk mothers this way
7. The nurse is examining an infant for possible cryptorchidism. Which exam technique should be used?
   - ✓ Place the infant in warm room and use a calm approach
8. The nurse is planning care for a client at 30-weeks' gestation who is experiencing preterm labor. What maternal prescription is most important in preventing this fetus from developing respiratory distress syndrome?
   - ✓ Betamethasone (Celestone) 12 mg deep IM.
9. Insulin therapy is initiated for a 12-year-old child who is admitted with diabetic ketoacidosis (DKA). Which action is important for the nurse to include in the child plan of care?
   - ✓ Monitor serum glucose for adjustment in infusion rate of regular insulin (Novolin R).
10. A 3-month-old with myelomeningocele and atonic bladder is catheterized every four hours to prevent urinary retention. The home health nurse notes that the child has developed episodes of sneezing, urticaria, watery eyes, ad a rash in the diaper area. What action is most important for the nurse to take?
    - ✓ Change to latex - free gloves when handling infant
11. The healthcare provider prescribes amoxicillin 500 mg PO every eight hours for a child who weighs 77 pounds. The available suspension is labeled, amoxicillin suspension 250 mg/5 ml. The recommended maximum does is 50 mg/kg/24 hour. How many mL should the nurse administer in a single dose based on the child's weight? (enter the numerical value only. If rounding is required, round to the whole number.)
    - ✓ 10mL/dose

12. The nurse is caring for a female client, a primigravida with preeclampsia. Findings include +2 proteinuria, BP 172/112 mmHg, facial and hand swelling, complains of blurry vision and a severe frontal headache. Which medication should the nurse anticipate for this client?
    - ✓ Magnesium Sulfate
13. A client at 35 weeks gestation complains of a "pain whenever the baby moves." On assessment, the nurse notes the client's temperature to be 101.2 F, with severe abdominal or uterine tenderness on palpation. The nurse knows that these findings are indicative of what condition?
    - ✓ Chorioamnionitis
14. A four-year-old boy was recently diagnosis with Duchenne muscular dystrophy (DMD). Which characteristic of the disease is most important for the nurse to focus on during initial teaching?
    - ✓ Lower legs become progressively weaker, causing a wedding, unsteady gait
15. A male infant with a 2-day history of fever and diarrhea is brought to the clinic by his mother who tells the nurse that the child refuses to drink anything. The nurse determines that the child has a weak cry with no tears. What prescription is most important to implement?
    - ✓ Infuse normal saline intravenously
16. A one-day-old neonate develops a cephalohematoma. The nurse should closely assess this neonate for which common complication?
    - ✓ Jaundice
17. While caring for a laboring client on continuous fetal monitoring, the nurse notes a fetal heart rate pattern that falls and rises abruptly with a "v" shaped appearance. What action should the nurse take first?
    - ✓ Change maternal position (for U shaped too)
18. The parents of a newborn tell the nurse that their newborn is already trying to walk. How should the nurse respond?
    - ✓ Explain the newborns normal stepping reflex
19. The nurse is conducting postpartum teaching with a mother who is breastfeeding her infant. When discussing birth control, which method should the nurse recommend to this client as best for her to use in preventing an unwanted pregnancy?
    - ✓ Condoms and contraceptive foam or gel
20. The nurse is planning discharge teaching for a client who had an evacuation of gestational trophoblastic disease (GTD) two days ago. Which information is most important for the nurse to include in this client's teaching plan?
    - ✓ OCP at least one year
21. The nurse places one hand above the symphysis while massaging the fundus of a multiparous client whose uterine tone is boggy 15 minutes after delivering a 7 pound 10 ounce infant. Which information should the nurse provide the client about this finding?
    - ✓ Both lower uterine segment and fundus need to be massaged
22. A primigravida arrives at the observation unit of the maternity unit because thinks is in labor. The nurse applies the external fetal heart monitor and determines that the fetal heart rate is 140 beats/minute and the contractions are occurring irregularly every 10 to 15 minutes. What assessment finding confirms to the nurse that the client is not labor at this time?
    - ✓ Contractions decrease with walking

23. A client delivers a viable infant, but begins to have excessive uncontrolled vaginal bleeding after the IV Pitocin is infused. When notifying the healthcare provider of the client's condition, what information is most important for the nurse to provide?
    - ✓ Maternal blood pressure
24. The current vital signs for a primipara who delivered vaginally during the previous shift are: temperature 100.4 F, heart rate 58 beats/minute, respiratory rate 16 breaths/minute, and blood pressure 130/74. What action should the nurse implement?
    - ✓ Document vital signs in record (normal)
25. A 4-day postpartum client calls the clinic and reports that her nipples are so sore that she does not know if she can continue to breastfeed her infant. What instruction is best for the nurse to provide?
    - ✓ Apply hot packs just before each feeding.
26. An infant is placed in a radiant warmer immediately after birth. At one hour of age, the nurse finds the infant to be jittery, tachypneic, and hypotonic. What is the first action that the nurse should take?
    - ✓ Determine infants blood sugar level
27. A 36-week primigravida is admitted to labor and delivery with severe abdominal pain and bright red vaginal bleeding. Her abdomen is rigid and tender to touch. The fetal heart rate (FHR) is 90 beats/minute, and the maternal heart rate is 120 beats/minute. What action should the nurse implement first?
    - ✓ Notify healthcare provider at patients' bedside
28. A client whose labor is being augmented with an oxytocin (Pitocin) infusion requests an epidural for pain control. Findings of the last vaginal exam, performed 1 hour ago, were 3 cm cervical dilatation, 60% effacement, and a -2 station. What action should the nurse implement first?
    - ✓ Determine current cervical dilation
29. The nurse is assessing a 38-week gestation newborn infant immediately following a vaginal birth. Which assessment finding best indicates that the infant is transitioning well to extrauterine life?
    - ✓ Cries vigorously when stimulated
30. What goal is most important for the nurse to include in the plan of care for a client with gestational diabetes?
    - ✓ Restrict carbohydrate intake
31. A laboring client's membranes rupture spontaneously. The nurse notices that the amniotic fluid is greenish-brown. What intervention should the nurse implement first?
    - ✓ Assess fetal heart rate
32. Artificial rupture of the membranes of a laboring client reveals meconium-stained fluid. What intervention has the greatest priority?
    - ✓ Have a meconium aspirator available at delivery
33. Presumptive signs: amenorrhea, n/v, increase size/tenderness in breasts, pronounced nipples, urinary frequency, quickening (woman thinks she feels movements), fatigue
34. Probable signs: uterine enlargement, Hegar sign (softening of uterus), Chadwicks sign (blueish color cervix), Goodells sign (softening of cervical cap), ballottement (rebound fetus), positive test with hcg
35. Positive signs: FHR, active fetal movements palpable by examiner, outline of fetus on US

36. A postpartum client is Rh-negative refuses to receive Rho(D) immune globulin (RhoGram) after delivery of an infant who is Rh-positive. What information should the nurse provide to this client?
    - ✓ RhoGram prevents maternal antibody formation for future Rh-positive babies
37. A full-term 24-hour old infant in the nursery regurgitates and suddenly turns cyanotic. What should the nurse do first?
    - ✓ Stimulate the infant to cry
38. At 20 weeks' gestation, a client who has gained 20 pounds during pregnant states that she is felling fetal movement. Fundal height measurement is 20 cm, and the clients only complaint is that her breasts are leaking clear fluid. Which assessment finding warrants further evaluation?
    - ✓ Gestational weight gain.
39. A client at 40-weeks' gestation presents to the obstetrical floor and indicates that the amniotic membranes ruptured spontaneously at home. She is in active labor, and feels the need to bear down and push. What information is most important foe the nurse to obtain first?
    - ✓ Color and consistency of fluid
40. An infant with tetralogy of fallot becomes acutely cyanotic and hyperpneic. What action should the nurse implement first?
    - ✓ Place the infant in a knee -chest position
41. A one-day-old infant develops a cephalohematoma. The nurse closely assesses this neonate for which common complication?
    - ✓ Jaundice.
42. One day after vaginal delivery of a full-time baby, a postpartum client's white blood cell count is 15,000/mm3. What action should the nurse take first?
    - ✓ Check the differential since the WBC is normal for this client.
43. A community health nurse visits a family in which a 16-year old unmarried daughter is pregnant with her first child and is at 32 weeks gestation. The client tells the nurse that she has been intermittent back pain since the night before. What is the priority nursing intervention?
    - ✓ ask the client if she has experienced any recent changes in vaginal discharge
44. The nurse observes a mother giving her 11-month-old ferrous sulfate, followed by 2 ounces of orange juice. What should the nurse do next?
    - ✓ Give positive feedback about way she administered the sulfate
45. The 6-week-old infant diagnosed with pyloric stenosis has recently developed projectile vomiting. Which assessment finding indicates to the nurse that the infant is becoming dehydrated?
    - ✓ A weak cry without any tears.
46. The nurse is assessing a 2 hour-old infant born by cesarean delivery at 39-weeks' gestation. Which finding should receive the highest priority when planning the infants care?
    - ✓ Respiratory rate of 76 breaths per min
47. A primipara has delivered a stillborn fetus at 30 weeks gestation. To asses the parents in the grieving process which intervention is most for the nurse to implement ?
    A. explain the possible cause of the fetal demise
    B. Provide a time for the parents to hold their infant in privacy
    C. Encourage the parents to seek counseling within the next few weeks
    D. Assist the couple to request autopsy

48. What is the priority nursing assessment immediately following the birth of an infant with esophageal atresia and a tracheoesophageal (the) fistula ?

    A. body temperature
    B. level of pain
    C. time of first void
    D. number of vessels in the cord
49. A 34-week primigravida with pregnancy induced hypertension (PIH) is receiving Ringer's Lactate 500 ml with magnesium sulfate 20 grams at the rate of 3 grams/hour. How many ml/hour should the nurse program the infusion pump? (Enter numeric value only)
    A. 120
    B. 70
    C. 65
    D. 75

50. A 6-month old child who had a cleft-lip repair has elbow restraints in place. What nursing intervention should the nurse plan to implement?
    A. remove restraints q4h for 30 minutes and place gloves on the child's hands
    B. record observations of the restraints q2h and ensure that they are in place at all times
    C. obtain the HCP advice as to when the restraints should be removed
    D. remove restraints one at a time to provide ROM exercises

51. A new mother calls the nurse stating that she wants to start feeding her 6-month-old child something besides breast milk, but is concerned that the infant is too young to start eating solid foods. How should the nurse respond?
    A. encourage the mother to schedule a developmental assessment of the infant
    B. advise the mother to wait at least another month before starting any solid foods
    C. instruct the mother to offer a few spoons of 2-3 pureed fruit at each meal
    D. reassure the mother that the infant is old enough to eat iron-fortified cereal
52. A 6-week-old infant diagnosed with pyloric stenosis has recently developed projectile vomiting. Which assessment finding indicates to the nurse that the infant is becoming dehydrated?
    A. Weak cry without any tears
    B. Bulging fontanel
    C. Visible peristaltic wave.
    D. Palpable mass in the right upper quadrant
53. A full-term, 24-hour-old infant in the nursery regurgitates and suddenly turns cyanotic. What should the nurse do first?
    A. Suction the oral and nasal passages
    B. Give oxygen by positive pressure
    C. Stimulate the infant to cry
    D. Turn the infant onto the right side
54. The nurse is reviewing the serum laboratory finding for a 5-day-old infant with congenital adrenal hyperplasia. Which laboratory results should be reported to the

healthcare provider immediatly?
A. Bilirubin of 1.5 mg/dl
B. Glucose of 80 mg/dl
C. Potassium of 4.5 mEq/L
D. Sodium of 119 mEq/L

55. At 39-weeks gestation, a multigravida is having a non-stress test (NST). The fetal heart rate (FHR) has remained nonreactive during the 30 minutes of evaluation. Based on this finding, which action should the nurse implement?
A. Initiate an intravenous infusion
B. Observe the FHR pattern for 30 more minutes
C. Schedule a biophysical profile
D. Place an acoustic stimulator on the abdomen
56. Albumin 25% IV is prescribed for a child with nephrotic syndrome. Which assessment finding indicates to the nurse that the medication is having the desired effect?
A. Weight gain
B. Reduction of fever
C. Improved caloric intake
D. Reduction of edema
57. A breastfeeding infant, screened for congenital hypothyroidism, is found to have low levels of thyroxine (t4) and high levels of thyroid stimulating hormone (TSH)/ What is the best explanation for this finding?
A. The thyroxine level is low because the TSH level is high.
B. High thyroxine levels normally occur in breastfeeding infants.
C. The thyroid gland does not produce normal levels of thyroxine for several weeks after birth
D. The TSH is high because of the low production of T4 by the thyroid.
58.
59. At 20-weeks gestation, a client who has gained 20 pounds during this pregnancy tells the nurse that she is feeling fetal movement. Fundal height measurement is 20 cm, and the clients only complaint is that her breasts are leaking clear fluid. Which assessment finding warrants further evaluation?
A. Presence of fetal movements.
B. Gestational weight gain
C. Fundal height measurement
D. Leakage from breasts
60. A pregnant woman in the first trimester of pregnancy has a hemoglobin of 8.6 mg/dl and a hematocrit of 25.1%. What food should the nurse encourage this client to include in her diet?
A. Carrots
B. Chicken
C. Yogurt
D. Cheese
61. The newborn nursery admission protocol includes a prescption for phytonadione (Vitamin K1, AquaMEPHYTON) 0.5 mg IM to newborns upon admission. The ampoule provides 2 mg/ml. How
many ml should the nurse administer?

- ✓ 0.3

62. The nurse is preparing to administer methylergonovine maleate (Methergine) to a postpartum client. Based on what assessment finding should the nurse withhold the drug?
    A. Respiratory rate of 22 breaths/min
    B. A large amount of lochia rubra
    C. Blood pressure 149/90
    D. Positive Homan's sign
63. At 6-weeks gestation, the rubella titer of a client indicates she is non-immune. When is the best time to administer a rubella vaccine to this client?
    - ✓ Early postpartum, within 72 hours of delivery.
64. A client receiving oxytocin (Pitocin) to augment early labor. Which assessment is most important for the nurse to obtain each time the infusion rate is increased?
    A. Pain level
    B. Blood pressure
    C. Infusion site
    D. Contraction pattern
65. A neonate who has congenital adrenal hypoplasia (CAH) presents with ambiguous genitalia. What is the primary nursing consideration when supporting the parents of a child with this anomaly?
    A. Discuss the need for cortisol and aldosterone replacement therapy after discharge
    B. Support the parents in their decision to assign sex of their child according to their preference
    C. Offer information about ultrasonography and genotyping to determine sex assignment
    D. Explain that corrective surgical procedures consistent with sex assignment can be delayed
66. During a 26-week gestation prenatal exam, a client reports occasional dizziness and lightheadness when she is lying down. What intervention is best for the nurse to recommend to this client.
    - ✓ Elevate the head with two pillows while sleeping.
67. A 4-day postpartum client calls the clinic and reports that her nipples are so sore that she does not know if she can continue to breastfeed her infant. What instruction is best for the nurse to provide?
    - ✓ Apply hot packs just before each feeding.
68. A loading dose of terbutaline (Bretine) 250 mcg IV is prescribed for a client in preterm labor. Brethine 20 mg is added to 1000 ml D5W. How many ml of the solution should the nurse administer? (Enter numeric value only)
    - ✓ 13
69. A newborn with myelomeningocele is admitted to the neonatal intensive care unit. Which preoperative nursing intervention should the nurse implement first?
    - ✓ Place the infant on the abdomen to protect the sac.
70. The mother of a 5-week-old tells the nurse that her baby has acne and asks if she can use her teenage son's acne cream, benzoyl peroxide, on the baby's face. Which answer should the nurse to provide?

- ✓ " Your baby may be showing signs of a systemic disease and needs to be seen by a healthcare provider"

71. The nurse weighs a 6-month-old infant during a well-baby check-up and determines that the baby's weight has triple compared to the birth weight of 7 pounds 8 ounces. The mother asks if the baby is gaining enough weight. What response should the nurse offer?
    - ✓ "What food does your baby usually eat in a normal day?"
72. A client with gestational diabetes is undergoing a non-stress test at 34 weeks gestation. Fetal heart beat is 144 beats / min. The client is instructed to mark the fetal monitor paper by pressing each time the baby moves. After 20 mins the nurse evaluates the fetal monitor strip
    A. The mother perceives and marks at least four fetal movements
    B. Fetal movements must be elicited with a vibroacoustic stimulator
    C. Two fetal heart accelerations of 15 beats/ min x 15 seconds are recorded
    D. No FHR late decelerations occur in response to fetal movement
73. A newborn who was a breech presentation is admitted to the nursery. Which assessment procedure is a priority for the nurse to perform?
    - ✓ Babinski's reflex.
74. A 16-year-old gravida 1, para 0 client has just been admitted to the hospital with a diagnosis of eclampsia. She is not presently convulsing. Which intervention should the nurse plan to include in this client's nursing care plan?
    - ✓ Monitor Blood pressure, pulse, and respirations q4h.
75. The nurse is interacting with a female client who is diagnosed with postpartum depression. Which finding should the nurse document as an objective signs of depression? (Select all that apply.)
    A. Avoids eye contact.
    B. Interacts with a flat affect.
    C. Reports feeling sad.
    D. Expresses suicidal thoughts.
    E. Has a disheveled appearance.
76. In preparing a gravid client for a triple screen analysis, which action should the nurse take?
    A. Prepare to draw blood for analysis.
    B. Encourage the client to drink 8 oz of water.
    C. Assist the client to left lateral tilt position.
    D. Apply an external fetal monitor to the abdomen.
77. During a routine first trimester prenatal exam, a pregnant client tells the nurse that she has noticed an increase in vaginal discharge that is white, thin, and watery. What action should the nurse implement?
    A. Inform her that this is a normal physiological change.
    B. Notify the healthcare provider of the complaint.
    C. Recommend an over-the-counter yeast medication.
    D. Prepare the client for a sterile speculum exam.
78. Following a precipitous labor, a postpartum client has a continuous trickling of bright red blood from her vagina. Her uterus is firm and her vital signs are within normal limits. The nurse determines that this sign may indicate which condition?

A. Early postpartum hemorrhage.
B. Laceration on the cervix
C. Expected course in the fourth stage of labor.
D. A full urinary bladder.

79. A new mother asks the nurse about an area of swelling on her baby's head near the posterior fontanel that lies across the suture line. How should the nurse respond?
A. "This is called caput succedaneum. It will absorb and cause no problems."
B. "This is called caput succedaneum. It will have to be drained."
C. "This is called a cephalohematoma. It will cause no problems."
D. "This is called cephalohematoma. It can cause jaundice as it is absorbed."
80. The parents of a male newborn have signed an informed consent for circumcision. What priority intervention should the nurse implement upon completion of the circumcision?
A. Offer a pacifier dipped in glucose water.
B. Give PRN dose of liquid acetaminophen.
C. Place petrolatum gauze dressing on the site.
D. Wrap the infant in warm receiving blankets.
81. The nurse is caring for a newborn who is 18 inches long, weighs 4 pounds, 14 ounces, has a head circumference of 13 inches, and a chest circumference of 10 inches. Based on these physical findings, assessment for which condition has the highest priority?
A. Hyperthermia
B. Hyperbilirubinemia
C. Polycythemia
D. Hypoglycemia
82. A primipara at 20-weeks gestation is scheduled for an ultrasound. In preparing the client for the procedure, the nurse should explain that the primary reason for conducting this diagnostic study is to obtain which information?
A. Sex and size of the infant.
B. Fetal growth and gestational age.
C. Chromosomal abnormalities.
D. Lecithin-sphingomyelin ration.
83. A 38-week primigravida is admitted to labor and delivery after a non-reactive stress test (NST). The nurse begins a contraction stress test (CST) with an oxytocin (Pitocin) infusion. Which finding is most important for the nurse to report to the healthcare provider?
A. Spontaneous rupture of membranes.
B. Fetal heart rate accelerations with fetal movement.
C. Absences of uterine contraction of 20 minutes.
D. A pattern of fetal late decelerations.
84. In determining the one minute Apgar score of a male infant the nurse asses a heart rate of 120 per min....respiration.. He has a loud cry with stimualtion, good muscle tone, color is acrocyanotic . What should the nurse assign?
A. 7
B. 8
C. 9
D. 10

85. The nurses assessment on a preterm infant reveals decreased muscle tone , sign of respiratory distress , irritability , mottled cool skin.Which intervention should the nurse implement first ?
    A. Position a radiant warmer on the crib
    B. Asses infant blood glucose level
    C. Place infant in side lying position
    D. Nipple feed 1 ounce of 5%glucose in water
86. Vaginal prostiglandin gel is used to induce labor women who are 42 weeks of gestation. Thirty minutes after insertion of the gel , the client complains of vaginal warmth, and is experiencing 90 second contractions with fetal heart deceleration. What action should the nurse implement first
    A. Assess maternal vital signs
    B. Notify the healthcare provider
    C. Increase the IV infusion rate
    D. Turn to a side lying position
87. A primigravida at 40 weeks gestation is contraction q2 minutes her cervix is 9cm dilated and 100% effaced. The fetus heart rate is 120 beats per minute. The client is screaming and her husband is alarmed. What intervention should the nurse do?A. Notify rapid response
    B. Have delivery table set up
    C. Ask husband to step out
    D. Administer a PRN narcotic
88. The nurse is assessing a client at 29 weeks gestation. Which assessment measure would provide the most accurate determination of fetal position?
    A. Ultrasound
    B. Vaginal examination
    C. Leopolds maneuver
    D. Doppler
89. A client at 28 weeks gestation is admitted to the obstetrical unit following her involvement in a motor vehicle collision. While stabilizing the patient , the nurse obtains fetal monitor reading. Which action should the nurse take if the fetus is tachycardic is on the monitor?
    A. Recount the heart rate manually to confirm a monitor malfunction
    B. Explain that there is no indication the fetal heart rate is due to trauma
    C. Evaluate the presence of preterm labor by performing a vaginal
    D. Contact the healthcare provider after initiating oxygen per face mask
90. On the first postpartum day, the nurse examines the breasts of the new mother. Which condition is the nurse most likely to.
    A. Slightly firm with immediate let down response
    B. Filing and secreting colostrum
    C. Soft, with no change from before delivery
    D. Firm, larger very tender to touch
91. The nurse who is working at a prenatal clinic notes a woman that is at 18 weeks of gestation has two elevated maternal alpha feto-protein (MSAFP) values. What action should the nurse implement?
    A. Instruct the client to increase intake of folic acid supplements