NEW GENERATION COMPREHENSIVE HESI EXAMS FOR PREGNANCY, LABOR, CHILDBIRTH, AND POSTPARTUM | REAL EXAMS WITH RATIONALE

Which action provides support for the fetal head as it is beingdelivered?

- Applying suprapubic pressure
- ✗ Placing a hand firmly against the perineum
- ✓ Distributing the fingers evenly around the head
- Maintaining pressure against the anterior fontanel

Rationale

Distribution of the fingers around the head will prevent a rapid change in intracranial pressure while the head is being born and keeps the head from 'popping out,' which could result in maternal perineal trauma. Applying suprapubic pressure will not aid in the birth of the head. Placing a hand firmlyagainst the perineum may interfere with the birth and harm the neonate.

Maintaining pressure against the anterior fontanel could injure the neonate.

Between contractions that are 2 to 3 minutes apart and last about45 seconds the internal fetal monitor shows a fetal heart rate (FHR) of 100 beats/min. Which is the priority nursing action?

- ✓ Notify the health care provider.
- ✗ Resume continuous fetal heart monitoring.
- Continue to monitor the maternal vital signs.
- Document the fetal heart rate as an expected response to contractions.

Rationale

The expected FHR is 110 to 160 beats/min between contractions. An FHR of 100 beats/min is bradycardia (baseline FHR slower than 110 beats/min) and indicates that the fetus may be compromised, requiring notifying the health care provider and medical intervention. Resuming continuous fetal heart monitoring may be dangerous. The fetus may be compromised, and time should not be spent on monitoring. Continuing to monitor the maternal vitalsigns is not the priority at this time. Although a fetal heart rate slower than 110 beats/minute should be documented, it is not an expected response.

Test-Taking Tip: Work with a study group to create and take practice tests. Think of the kinds of questions you would ask if you were composing the test.Consider what would be a good question, what would be the right answer, andwhat other answers might appear right but would in fact be incorrect.

Which physiological alteration does the nurse expect in a client's hematological system during the second trimester of pregnancy?

- An increase in hematocrit
- An increase in blood volume
- A decrease in sedimentation rate
- A decrease in white blood cells (WBCs)

Rationale

The blood volume increases by approximately 50% during pregnancy. Peakblood volume occurs between 30 and 34 weeks' gestation. The hematocrit decreases as a result of hemodilution. The sedimentation rate increases

because of a decrease in plasma proteins. WBCs count increases somewhat starting in the second trimester and peak in the third. WBCs are in the 5000 to15,000 range during pregnancy.

Which factor accounts for the greatest portion of weight gainduring pregnancy?

- Fetal growth
- Fluid retention
- Metabolic alterations
- Increased blood volume

Rationale

Weight gain during pregnancy averages 25 to 35 lb (11.3–15.9 kg). Of this amount, the fetus accounts for 7 to 8 lb (3.2–3.6 kg), or approximately 30%. Fluid retention accounts for 20% to 25% of weight gain. Metabolic alterations do not cause weight gain. Increased blood volume accounts for 12% to 16% of weight gain.

Correct (113)

Morning sickness generally disappears by the end of whichmonth?

- Fifth month
- Third month

- Fourth month
- Second month

Rationale

Because of a decrease in chorionic gonadotropin, morning sickness seldom persists beyond the first trimester. Morning sickness usually ends at the end ofthe third month, not the second month, when the chorionic gonadotropin level falls. It is still present in the second month because of the high level of chorionic gonadotropin but has usually diminished by the fifth month.

Which information would the nurse include in the dischargeteaching of a postpartum client?

- ✓ The prenatal Kegel tightening exercises should be continued.
- A bowel movement may not occur for up to a week after the birth.
- The episiotomy sutures will be removed at the first postpartum visit.
- A postpartum checkup should be scheduled as soon as mensesreturns.

Rationale

Kegel exercises may be resumed immediately and should be done for the restof the client's life because they help strengthen muscles needed for urinary continence and may enhance sexual intercourse. Episiotomy sutures do not have to be removed. Bowel movements should spontaneously return in 2 to 3days after the client gives birth; a delay of bowel movements promotes

constipation, perineal discomfort, and trauma. The usual postpartum examination is 6 weeks after birth; the menses may return earlier or later thanthis and should not be a factor when the client is scheduling a postpartum examination.

Test-Taking Tip: Pace yourself when taking practice quizzes. Because most nursing exams have specified time limits, you should pace yourself during the practice testing period accordingly. It is helpful to estimate the time that can be spent on each item and still complete the examination in the allotted time. You can obtain this figure by dividing the testing time by the number of itemson the test. For example, a 1-hour (60-minute) testing period with 50 items averages 1.2 minutes per question. The NCLEX exam is not a timed test. Both the number of questions and the time to complete the test vary according to each candidate's performance. However, if the test-taker uses the maximum of5 hours to answer the maximum of 265 questions, each question equals 1.3 minutes.

Which response would the nurse give to a postpartum client whoasks if she can drink a small glass of wine before breast-feeding the first time to help her relax?

- 'I think drinking 1 glass of wine won't be a problem. Go ahead.'
- 'You seem a little tense. Tell me how you feel about breast-feeding.'
- 'You seem to find it relaxing, but you should try to find another way to relax.'
- 'I think drinking 1 glass of wine is alright, but you had better checkwith your health care provider first.'

Rationale

Stating that the client seems tense and initiating a discussion honors the client's feelings and encourages expression of them; there is no reference to alcohol consumption and its relaxing eûects. Alcohol ingestion should not be encouraged, because it enters the breast milk. Stating that the client needs to find another way to relax reflects the client's statement but not her underlyingfeelings. Suggesting that she find another way to relax may make the client defensive and shut oû communication. Although alcohol ingestion should notbe encouraged because it enters breast milk, the primary health care provider need not be involved because health education is within the role of the nurse.

Which statement by a breast-feeding mother indicates that thenurse's teaching regarding stimulating the let-down reflex hasbeen successful?

- 'I will take a cool shower before each feeding.'
- 'I will drink a couple of quarts of fat-free milk a day.'
- 'I will wear a snug-fitting breast binder day and night.'

'I will apply warm packs and massage my breasts before each feeding.'

Rationale

Applying warm packs and massaging the breasts before each feeding help dilate milk ducts, promote emptying of the breasts, and stimulate further lactation. Taking a cool shower before each feeding will contract the milk ductsand interfere with the let-down reflex. Heavy consumption of milk products isnot required to stimulate the production of milk. Breast binders may inhibit lactation by fooling the body into thinking that milk secretion is no longer

needed.

A nonstress test (NST) is scheduled for a client with mild preeclampsia. During an NST, the client asks what it means whenthe fetal heart rate goes up every time the fetus moves. Which isan appropriate response?

- [x] 'These accelerations are a sign of fetal well-being.'
- [ ] 'These accelerations indicate fetal head compression.'
- [ ] 'Umbilical cord compression is causing these accelerations.
- [ ] 'Uteroplacental insuûciency is causing these accelerations.'

Rationale

The NST is performed before labor begins. Accelerations with movement anda baseline variability of 5 to 15 beats/min indicate fetal well-being. This reactive NST is considered positive. Early decelerations are associated with fetal head compression during a contraction stress test (CST) or during labor. Variable decelerations are associated with cord compression during a CST or during labor. Late decelerations during a CST or during labor are associated with uteroplacental insuûciency.

Which descriptor would the nurse use when explaining to a clienthow to time the frequency of contractions?

- [ ] From the end of 1 contraction to the end of the next contraction
- [ ] From the end of 1 contraction to the beginning of the nextcontraction

- From the beginning of 1 contraction to the end of the nextcontraction
- ✓ From the beginning of 1 contraction to the beginning of the nextcontraction

Rationale

The frequency of contractions is timed from the beginning of 1 contraction tothe beginning of the next; this is the definition of 1 contraction cycle. The beginning, not the end, of a contraction is the starting point for timing the frequency of contractions. The time between the end of 1 contraction and the beginning of the next contraction is the interval between contractions. Timingfrom the beginning of 1 contraction to the end of the next contraction is too long a time frame and will produce inaccurate information.

The first day of a client's last menstrual period was July 22. Whichis the estimated date of birth (EDB)?

- May 7
- ✓ April 29
- April 22
- March 6

Rationale

Her EDB is April 29. Naegele's rule is an indirect, noninvasive method for estimating the date of birth: EDB = last menstrual period + 1 year – 3 months

+ 7 days. May 7 is beyond the EDB. April 22 and March 6 are both before theEDB.

A client who is at 20 weeks' gestation visits the prenatal clinic for the first time. Assessment reveals temperature of 98.8°F (37.1°C),pulse of 80 beats per minute, blood pressure of 128/80 mm Hg, weight of 142 lb (64.4 kg) (prepregnancy weight was 132 lb [59.9 kg]), fetal heart rate (FHR) of 140 beats per minute, urine that isnegative for protein, and fasting blood glucose level of 92 mg/dL(5.2 mmol/L). Which would the nurse do after making these assessments?

- Report the findings because the client needs immediate intervention.
- Document the results because they are expected at 20 weeks'gestation.
- Record the findings in the medical record because they are not withinthe norm but are not critical.
- Prepare the client for an emergency admission because these findingsmay represent jeopardy to the client and fetus.

Rationale

All data presented are expected for a client at 20 weeks' gestation and should be documented. There is no need for immediate intervention or an emergencyadmission because all findings are expected.

A prenatal client's vaginal mucosa is noted to have a purplish

discoloration. Which sign would be documented in the client'sclinical record?

Hegar

Goodell

Chadwick

Braxton-Hicks

Rationale

A purplish coloration, called the Chadwick sign, results from the increased vascularity and blood vessel engorgement of the vagina. The Hegar sign is softening of the lower uterine segment. The Goodell sign is softening of thecervix. After the fourth month of pregnancy, irregular, painless uterine contractions, called Braxton-Hicks contractions, can be felt through the abdominal wall.

Test-Taking Tip: The following are crucial requisites for doing well on the NCLEX exam: (1) a sound understanding of the subject; (2) the ability to followexplicitly the directions given at the beginning of the test; (3) the ability to comprehend what is read; (4) the patience to read each question and set of options carefully before deciding how to answer the question; (5) the ability to use the computer correctly to record answers; (6) the determination to do well;and (7) a degree of confidence.

When a client at 39 weeks' gestation arrives at the birthing suiteshe says, 'I've been having contractions for 3 hours, and I think my water broke.' Which action would the nurse take to confirm

that the membranes have ruptured?

- Take the client's oral temperature.
- Test the leaking fluid with nitrazine paper.
- Obtain a clean-catch urine specimen
- Inspect the perineum for leaking fluid.

Rationale

Nitrazine paper will turn dark blue if amniotic fluid is present; it remains the same color in the presence of urine. Temperature assessment is not specific toruptured membranes at this time; vital signs are part of the initial assessment.Although this may be done as part of the initial assessment, a urine test is unrelated to leakage of amniotic fluid. Inspecting the perineum for leaking fluid will not confirm rupture of the membranes.

At which point during a human pregnancy does the embryobecome a fetus?

- During the 8th week of the pregnancy
- At the end of the 2nd week of pregnancy
- When the fertilized egg becomes implanted
- When the products of conception are seen on the ultrasound

Rationale

During the 8th week of pregnancy the organ systems and other structures are

developed to the extent that they take the human form; at this time the embryo becomes a fetus and remains so until birth. At the end of the 2nd week of pregnancy, the developing cells are called an embryo. At the time of implantation, the group of developing cells is called a blastocyst. The embryo can be visualized on ultrasound before it becomes a fetus.

Which technique would the nurse suggest to a laboring woman'spartner that involves gently stroking the woman's abdomen in rhythm with her breathing during a contraction?

- Massage
- Eüeurage
- Acupressure
- Counterpressure

Rationale

Eüeurage is the gentle stroking of the abdomen in rhythm with her breathingduring a contraction. Massage is the application of therapeutic touch and pressure on the body. Acupressure is the application of pressure along special acupressure points. Counterpressure is the application of pressure to the sacrum during a contraction.

A primigravida who is at 40 weeks' gestation arrives at the birthing center with abdominal cramping and a bloody show. Hermembranes ruptured 30 minutes before arrival. A vaginal examination reveals 1 cm of dilation and the presenting part at -1

station. Which action would the nurse take after obtaining thefetal heart rate and maternal vital signs?

- Teach the client how to push with each contraction.
- Provide the client with comfort measures for relaxation.
- Prepare to have the client's blood typed and cross-matched.
- Encourage the client to perform patterned, paced breathing.

Rationale

The client is experiencing the expected discomforts of labor; the nurse should initiate measures that will promote relaxation. The client is in early first-stage labor; pushing commences during the second stage. There is no evidence thatthe client's bleeding is excessive or unexpected and that a transfusion will be needed. Patterned, paced breathing should be used in the transition phase, not the early phase of the first stage of labor.

Test-Taking Tip: Answer every question. A question without an answer isalways a wrong answer, so go ahead and guess.

Which is the nurse's first action when a client in active laborstarts screaming, 'The baby is coming! Do something!'?

- Notify the practitioner of the imminent birth.
- Tell the client that it is too soon and encourage her to pant
- Check the perineal area for visibility of the presenting part.
- Help the client hold her knees together and explain what to expect.

Rationale

The first action by the nurse would be to confirm whether birth is imminent bychecking the perineal area to determine whether the presenting part is emerging. Confirming the client's sensation is the priority; the nurse would remain with the client and ask a colleague to call the practitioner if birth is imminent. Stating that birth is not imminent demeans the client, and she maybe correct. Holding the knees together is contraindicated. If birth is imminent,this could cause injury to the fetus, and if it is not imminent, this position is uncomfortable and unnecessary.

Which complication is prevented by coaching a client in the second stage of labor to take a breath at least every 6 secondswhile pushing with each contraction?

- Fetal hypoxia
- Perineal lacerations
- Carpopedal spasms
- Maternal hypertension

Rationale

Prolonged breath holding at this stage of labor can result in decreased placental/fetal oxygenation, which could lead to fetal hypoxia. Perineal lacerations occur with rapid, uncontrolled expulsion of the fetus. Carpopedalspasms and maternal hypertension are not caused by prolonged holding of the breath.

Test-Taking Tip: If the question asks for an immediate action or response, all the answers may be correct, so base your selection on identified priorities for action.

Which immediate action would the nurse take if a client in theactive phase of labor says, 'I feel all wet. I think I wet myself.'?

- Give her the bedpan.
- Change the bed linens.
- Inspect her perineum.
- Take an oral temperature.

Rationale

Inspection of the perineum is performed to determine whether rupture of themembranes has occurred and whether the umbilical cord has prolapsed.

Giving the client the bedpan is not a priority. Changing the bed linens is not the priority, although it is done eventually if the membranes have ruptured. Anoral temperature should be taken after it has been established that the membranes have ruptured.

Which client statement indicates understanding of teachingabout a nonstress test?

- 'I'll need to have an intravenous (IV) line so the medication can beinjected before the test.'
- 'My baby may get very restless after I have this test.'
- 'I hope this test doesn't cause my labor to start too early.'

'If the heart reacts well, my baby should do OK when I give birth.'

Rationale

The nonstress test is used to evaluate the response of the fetus to movement and activity. A reactive test indicates that the fetus is healthy. No injections of any kind are used during a nonstress test; it involves only the use of a fetal monitor to record the fetal heart rate during periods of activity. The nonstresstest will not influence the activity of the fetus because no exogenous stimulusis used. Early labor is unlikely because the nonstress test is noninvasive.

Test-Taking Tip: Never leave a question unanswered. Even if answering is no more than an educated guess on your part, go ahead and mark an answer. Youmight be right, but if you leave it blank, you will certainly be wrong and lose precious points.

Which statement made by a pregnant client after a prenatal classon fetal growth and development indicates the need for additional teaching?

'The baby is smaller if the mother smokes.'

'The baby gets food from the amniotic fluid.'

'The baby's oxygen is provided by the mother.'

'The baby's umbilical cord has 2 arteries and 1 vein.'

Rationale

The amniotic fluid serves as a protective environment; the fetus depends on the placenta, along with the umbilical blood vessels, to supply blood containing nutrients and oxygen. 'The baby is smaller if the mother smokes,''The baby's oxygen is provided by the mother,' and 'The baby's umbilical cordhas 2 arteries and 1 vein' are all true statements, and further teaching would not be required.

Which statement indicates that a pregnant client requires furtherteaching about fetal growth and development?

- 'The fetus keeps growing throughout pregnancy.
- ' 'The fetus gets nutrients from the amniotic fluid.'
- 'The fetus may be underweight if it's exposed to smoke.'
- 'The fetus gets oxygen from blood coming through the placenta.'

Rationale

The amniotic fluid provides protection, not nutrition; the fetus depends on theplacenta, along with the umbilical blood vessels, for nutrients and oxygen. Thestatements that the fetus keeps growing throughout pregnancy, that it may beunderweight if exposed to smoke, and that it gets oxygen from blood in the placenta all indicate that the client understands the teaching.

Which statements regarding the involution process are correct?Select all that apply. One, some, or all responses may be correct.

- Involution begins immediately after expulsion of the placenta.

- [ ] Involution is the self-destruction of excess hypertrophied tissue.
- [x] Involution progresses rapidly during the next few days after birth.
- [x] Involution is the return of the uterus to a nonpregnant state after birth.
- [ ] Involution may be caused by retained placental fragments andinfections.

Rationale

The involution process is the return of the uterus to a nonpregnant state afterbirth; it begins immediately after expulsion of the placenta and contraction ofthe uterine smooth muscle. This process progresses rapidly during the first few days after birth. Subinvolution is the self-destruction of excess hypertrophied tissue; this process may be caused by retained placental fragments or infection.

Which instruction would the nurse give to a client in labor whobegins to experience dizziness and tingling of her hands?

- (x) Breathe into her cupped hands.
- ( ) Pant during the next 3 contractions.
- ( ) Hold her breath with the next contraction.
- ( ) Use a fast, deep, or shallow breathing pattern.

Rationale

Dizziness and tingling of the hands are signs of respiratory alkalosis, most likely the result of hyperventilating. Breathing into cupped hands or a paper bag promotes the rebreathing of carbon dioxide. Panting during the next 3 contractions could cause the client to hyperventilate more. Holding her breathwith the next contraction will not improve the client's respiratory alkalosis.
Using a fast, deep, or shallow breathing pattern could cause the client tohyperventilate more.

In which location is the presenting part of the fetus when it is at 0station?

- Entering the vagina
- Floating within the bony pelvis
- At the level of the ischial spines
- Above the level of the ischial spines

Rationale
The ischial spines are used as landmarks in relation to the fetus's head becausethey reflect the progression of labor; 0 station indicates that the presenting part is at the ischial spines. When the head enters the vagina, it is below the ischial spines and its position is designated with positive numbers (+1 to +4).
When the presenting part is floating, the fetus is at –5 station. A positionabove the ischial spines is designated by a minus number (–1 to –4).

Test-Taking Tip: Answer every question. A question without an answer isalways a wrong answer, so go ahead and guess.

Which recommendation would the nurse make to a pregnant client who sits almost continuously during her working hours?

'Try to walk around every few hours during the workday.'

'Ask for time in the morning and afternoon to elevate your legs.

' 'Tell your boss that you won't be able to work beyond the second

trimester.'

'Ask for time in the morning and afternoon so you can go getsomething to eat.'

Rationale

Maintaining the sitting position for prolonged periods may constrict the vessels of the legs, particularly those in the popliteal spaces, and may diminishvenous return. Walking causes the leg muscles to contract and applies gentle pressure to the veins, thereby promoting venous return. Walking around several times each morning and afternoon will improve circulation; the legs may be elevated while the client is sitting at her desk. If the client is feeling well, there are no contraindications to working throughout her pregnancy.

Adequate nourishment can be obtained during mealtimes; the client does notrequire extra nutrition breaks.

When the cervix of a woman in labor is dilated 9 cm, she statesthat she has the urge to push. Which action would the nurse implement at this time?

Having her pant-blow during contractions Placing her legs in

stirrups to facilitate pushing