VATI RN Maternal Newborn 2023/2024 GRADED A 150 QUESTIONS AND ANSWERS WITH RATIONALE

A charge nurse is teaching a newly licensed nurse about substance use disorders during pregnancy. Which of the following statements by the newly licensed nurse indicates an understanding of the teaching? - CORRECT ANSWER Encourage client who are prescribed methadone to breastfeed.

-The nurse should encourage clients who are prescribed methadone during pregnancy to breastfeed their newborns to help with withdrawal symptoms.

A nurse is caring for a client who received terbutaline subcutaneously. Which of the following findings is an indication the medication was effective? - CORRECT ANSWER Decreased frequency of contractions.

-Terbutaline is a tocolytic medication that is used to halt preterm labor. Terbutaline cause relaxation of smooth muscle, which decrease uterine activity. Therefore, the nurse should identify that a decrease in frequency of contractions is an indication that terbutaline was effective.

A charge nurse is discussing care of clients who are in labor with a newly licensed nurse. Which of the following actions should the charge nurse include in the teaching regarding situations requiring an amniotomy? - CORRECT ANSWER Placing a fetal scalp electrode.

-A fetal scalp electrode is attached to the presenting part of the fetus in order to provide accurate continuous monitoring of the fetal heart rate. If the client's membranes are intact, the amniotic sac must be artificially ruptured prior to attaching the electrode to enable access to the presenting part.

A nurse is reviewing the medical record of a client who has preeclampsia prior to administering labetalol. For which of the following findings should the nurse withhold the medication? - CORRECT ANSWER Heart rate 54/min

-The nurse should identify that a heart rate of 54/min is below the expected reference range of 60 to 100/min. During pregnancy, the heart rate increases 10 to 15/min due to increased blood volume and increase tissue demands for oxygen. Bradycardia is a contraindication for the administration of labetalol, an antihypertensive medication. Therefore, the nurse should withhold the medication and notify the provider.

A nurse is caring for a client who is at 30 weeks of gestation and observes the client choking while eating lunch. The client is unable to speak or cough. Identify the sequence of steps the nurse should take to clear the airway obstruction. - CORRECT ANSWER 1. Stand posterior to the client.

2. Position arms under the client's axilla and across the client's chest.

3. Place thumb-side of a clenched fist to the client's mid-sternum area.

4. Initiate chest thrust to the client using a backward motion.

-If the client becomes unconscious, the nurse should perform CPR and activate emergency medical services.

A nurse is preparing to administer an opioid analgesic to a client who is in active labor. Which of the following assessments should the nurse perform? (SATA) - CORRECT ANSWER Maternal blood pressure.

-Opioid analgesic can cause hypotension. The nurse should assess the clients blood pressure before and after administering opioids.

Pain level.

-The nurse should assess the clients baseline pain level prior to administering pain medication and again after administering pain medication to determine the effectiveness of the medication. Opioid analgesic are indicated for the relief of moderate to sever labor pain.

Fetal heart rate.

-Opioid analgesics can cause fetal bradycardia and changes in variability. The nurse should assess the fetal heart rate prior to administering an opioid analgesic to ensure the rate is within the expedited reference range and to have a baseline for future assessments. The nurse should provide ongoing assessments of fetal heart rate throughout labor according to facility protocol.

A nurse is reviewing the medical records of a client who is at 8 wks. of gestation. Which of the following findings should the nurse identify as a risk factor for developing preeclampsia? - CORRECT ANSWER Rheumatoid Arthritis.

-The presence of a connective tissue disease, such as rheumatoid arthritis or systemic lupus erythematosus, increase a clients risk for developing preeclampsia.

A nurse is reviewing the laboratory results for a postpartum client who is receiving warfarin for deep-vein thrombosis. Which of the following laboratory tests should the nurse monitor? - CORRECT ANSWER International normalized ratio (INR).

-The nurse should monitor the INR of a client who is taking warfarin. Prothrombin time(PT) is also measure to regulate warfarin therapy. However, PT values are more difficult to interpret. INR determined by multiplying the PT by a correction factor based on the specific thromboplastin preparation used for the test, as a way of equalizing laboratory to laboratory variations.

A nurse is monitoring a client who is in the active phase of labor and has an intrauterine pressure catheter and fetal scalp electrode. Which of the following findings should the nurse expect? - CORRECT ANSWER Montevideo units (MVU) of 220 mm Hg.

- The nurse should identify that an MVU of 220 mm Hg is within the expected range during the active phase of labor. MVUs generally range between 100 to 250 mm Hg during the first stage of labor and increase to 300 to 400 mm Hg during the second stage of labor. MVUs are calculated by subtracting the baseline uterine pressure from the peak contraction pressure for every contraction that occurs during a 10-min period. The nurse then adds the pressure produced by each contraction during that time to determine the MVUs.

A nurse is assessing a client who has just undergone a cesarean birth and was given epidural morphine for postpartum pain relief 1hr ago. The nurse notes that the clients respiratory rate is 10/min. Which of the following actions should the nurse take first? - CORRECT ANSWER Administer oxygen by nonrebreather face mask.

-The first action the nurse should take when using the airway, breathing, circulation approach to client care is to administer oxygen by nonrebreather mask to treat manifestations of respiratory depression due to morphine administration.

A nurse is assessing a client who has placenta previa and is receiving fetal monitoring. Which of the following clinical findings should the nurse expect? - CORRECT ANSWER Painless vaginal bleeding.

-The placenta implants in the lower uterine segment, partially or completely covering the cervix. With cervical changes, the placental blood vessels can tear, which results in bleeding.

A nurse is assessing a client who is at 33wks of gestation. Which of the following findings should the nurse report to the provider? - CORRECT ANSWER Episodes of blurred vision.

-Blurred vision is a manifestation of preeclampsia. Arterial vasospasms and decreased perfusion to the retina cause visual disturbances, such as blurred vision, double vision, or dark spots in the visual field.

A nurse is assessing a client who is at 8wks of gestation and has hyperemesis gravidarum. Which of the following are findings of this condition? (SATA) - CORRECT ANSWER 1. Tachycardia.

-Hyperemesis gravidarum typically occurs during the first trimester and results in electrolyte imbalance, excessive weight loss, ketonuria, and nutritional deficiencies.

2. Dry mucous membranes.

3. Poor skin turgor.

A nurse is reviewing the laboratory results for a client who is at 29wks of gestation. Which of the following results should the nurse identify as an indication of a prenatal complication? - CORRECT ANSWER BUN 30 mg/dL

-Above the expected reference range of 10-20 mg/dL for a client who is pregnant. The BUN typically decreases during pregnancy due to the increase in the glomerular filtration rate. The nurse should identify that an elevated BUN is a manifestation of preeclampsia or HELLP syndrome, potentially serous complications of pregnancy's.

A nurse is assessing a client who is 2hr postpartum and has saturated a perineal pad in 15min. The clients skin is cool and clammy to touch. Which of the following actions should the nurse take first? - CORRECT ANSWER Firmly massage the fundus.

-The greatest risk for a postpartum client who is experiencing excessive vaginal bleeding is the development of hypovolemic shock, which can lead to coma and death. Uterine atony is a frequent cause of excessive vaginal bleeding. Therefore, the first action the nurse should take is

to massage the clients fundus to encourage muscular contractions, which will decrease bleeding.

A nurse is caring for a client who is at 28wks of gestation and has received two doses of terbutaline subcutaneously. Which of the following adverse effects is the priority for the nurse to report to the provider? - CORRECT ANSWER Heart rate: 132/min

-The nurse should notify the provider of tachycardia greater than 130/min; therefore, this is the priority finding. The client might also report chest discomfort, palpitations and have arrhythmias.

A nurse is providing teaching for a client who is 2wks postpartum and has mastitis. Which of the following instructions should the nurse include in the teaching? - CORRECT ANSWER Apply moist heat to the affected breast.

-The application of warm compresses prior to feeding or pumping promotes the flow of the breast milk and assists to ensure complete emptying of the breast. This is important to prevent the development of further complications such as the formation of a breast abscess or chronic mastitis.

A nurse is teaching routine prenatal care to a group of clients who are pregnant. Which of the following statements by a client indicates an understanding of the teaching? - CORRECT ANSWER I will have monthly prenatal visits for the first 28wks of pregnancy.

-The initial visit should occur in the first trimester with monthly visits through week 28, and every 2 weeks until week 36, and then every week until the birth of the newborn.

A nurse is providing client teaching regarding an intrauterine device (IUD). Which of the following statements should the nurse include in the teaching? (SATA) - CORRECT ANSWER 1. You might have to have cultures for sexually transmitted infections prior to placement of the device.

-If the provider determines the client is at risk of STI they might require the collection of cultures for STI prior to the placement of the IUD.

2. You might experience irregular spotting the first few months after placement of the device.

3. You will need to sign informed consent prior to the procedure.