# {NGN}HESI OB Maternity 2023 Version 1 (V1) Exit Exam (All 55 Qs) TB w/Pics Included!! A+

# GUARANTEED PASS

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A client who had her first baby three months ago and is breastfeeding her infant tells the nurse that she is currently using the same diaphragm that she used before becoming pregnant. Which information should the nurse provide this client?

- A After ceasing breastfeeding the diaphragm should be resized.
- B Avoid intercourse during ovulation until the size of the diaphragm has been evaluated.
- C If no more than 20 pounds was gained during pregnancy, the diaphragm is safe to use.
- D Use an alternate form of contraception until a new diaphragm is obtained.

4 = D

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The healthcare provider prescribes zidovudine 100 mg by mouth five times daily for a pregnant woman who is HIV positive. T
administer? (Enter numeric value only.)

10

5= 10

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The nurse is preparing a young couple and their 24-hour-old infant for discharge from the hospital. In conducting discharge

- A Ensure that they have the pediatric clinic's phone number.
- B Provide the results of the infant's hearing test to the parents.
- C Request a return demonstration of a diaper change.
- D Evaluate infant feeding techniques prior to discharge.

6=D

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A 30-year-old primigravida delivers a 9-pound (4082 gram) infant vaginally after a 30-hour labor. What is the **priority** nursing action for this client?

- A Gently massage fundus every 4 hours.
- B Observe for signs of uterine hemorrhage.
- C Encourage direct contact with the infant.
- D Assess the blood pressure for hypertension.

7 = A

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A multiparous client with active herpes lesions is admitted to the unit with spontaneous rupture of membranes. Which action should the nur

- A Obtain blood cultures.
- B Cover the lesion with a dressing.
- C Administer penicillin.
- D Prepare for a cesarean section.

8 = D

At 0600 while admitting a woman for a scheduled repeat cesarean section (C-section), the client tells the nurse that she drank a cup of coffee at 0400 because she wanted to avoid getting a
nurse take **first**?

- A Ensure preoperative lab results are available.
- B Inform the anesthesia care provider.
- C Start prescribed IV with Lactated Ringer's.
- D Contact the client's obstetrician.

9 = B



The nurse is caring for a postpartal client who is exhibiting symptoms of a spinal headache 24 hours following delivery of a normal newborn. Prior to the anesthesiologist's arrival on the unit, which action
perform?

- A Cleanse the spinal injection site.
- B Place procedure equipment at bedside.
- C Apply an abdominal binder.
- D Insert an indwelling Foley catheter.

10 = B

The nurse is caring for a newborn who is 18 inches long, weighs 4 pounds, 14 ounces (2.2 kg), has a head circumference of 13 inches (33 cm), and a chest circumference of 10 inches (25.4 cm). Based on these ph findings, assessment for which condition has the **highest** priority?

- A Hyperbilirubinemia.
- B Polycythemia.
- C Hyperthermia.
- D Hypoglycemia.

11 = D



While assessing a 40-week gestation primigravida in active labor, the client's membranes rupture spontaneously and the nurse notes that the amniotic fluid is meconium stained. Which additional finding is **most** important for the nurse to report to the healthcare provider?

- A Maternal blood pressure of 130/85 mmHg.
- B Fetal heart rate of 100 to 110 beats/minute.
- C Vaginal exam reveals a cervix 6 cm dilated.
- D Contractions occuring every 2 to 3 minutes.

12 = A

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The nurse is caring for a 35-week gestation infant delivered by cesarean section 2 hours ago. The nurse observes the infant's respiratory rate is 72 breaths/minute with nasal flaring, grunting, and retractions. The nurse should recognize these findings indicate which complication?

- A Persistent pulmonary hypertension of the newborn.
- B Transient tachypnea of the newborn.
- C Meconium aspiration syndrome.
- D Bronchopulmonary dysplasia.

13 = B

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A primipara client at 42-weeks gestation is admitted for induction. Within one hour after initiating an oxytocin infusion, her cervix is 100% effaced and 6 cm dilated, contractions are occurring every 1 minute with a 75 second duration. The nurse stops the oxytocin and starts oxygen. After 30 minutes of uterine rest, the contractions are occurring every 5 minutes with 20 second duration. Which intervention should the nurse implement?

- A Notify nursery about the client's response.
- B Check for clonus in both feet.
- C Stop oxygen per cannula.
- D Restart oxytocin infusion rate per protocol.

14 = D

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A primigravida arrives at the observation unit of the maternity unit because she thinks she is in labor. The nurse applies the external fetal heart monitor and determines that the fetal heart rate is 140 beats/minute and contra
are occurring irregularly every 10 to 15 minutes. Which assessment finding confirms to the nurse that the client is not in labor at this time?

- A Contractions decrease with walking.
- B 2+ pitting edema in lower extremities.
- C Cervical dilatation is 1 cm.
- D Membranes are intact.

15 = A

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A multigravida client in labor is receiving oxytocin 4 mu/minute to help promote an effective contraction pattern. The available solution is Lactated Ringer's 1,000 mL with oxytocin 20 units. The nurs
pump to deliver how many mL/hour? (Enter numeric value only.)

17 = ?

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A primigravida client with gestational hypertension and a Bishop score of 3 is scheduled for induction of labor. The nurse administers misoprostol at 0700, then observes regular contractions with cervical changes at 0900. Which action should the nurse take?

- A Administer misoprostol every 2 hours.
- B Ambulate the client after administration of misoprostol.
- C Start oxytocin infusion immediately.
- D Begin oxytocin 4 hours after misoprostol is given.

**16. D**

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The nurse is caring for a client whose fetus died in utero at 32 weeks gestation. After the fetus is delivered vaginally, the nurse implements routine fetal demise protocol and identification procedures. Whic
important for the nurse to take?

- A Explain reasons consent for an infant autopsy is needed.
- B Encourage the mother to hold and spend time with her baby.
- C Determine if the mother desires a visit from her clergy.
- D Create a memory box of baby's footprints and photographs.

**18. B**

Following a minor motor vehicle collision, a client at 36-weeks gestation is brought to the emergency center. She is lying supine on a backboard, is awake, and denies any complaints. Her blood pressure is 80/50 mmHg an heart rate is 130 beats/minute. Which action should the nurse implement **first**?

- A Palpate the abdomen for contractions.
- B Tilt the backboard sideways to displace the uterus laterally.
- C Obtain a blood sample for complete blood count.
- D Infuse 1,000 mL normal saline using a large bore IV.

**19. B**



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 "That is called caput succedaneum. It will have to be drained."
- B "That is called caput succedaneum. It will absorb and cause no problems."
- C "That is called a cephalhematoma. It will cause no problems."
- D "That is called a cephalhematoma. It can cause jaundice as it is absorbed."

**20. B**